

Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

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Presidential Address: Vale: Emeritus Professor Robert Emde

By
Campbell Paul, Melbourne, Australia

Associate Professor, President of WAIMH

Dear friends and colleagues,

Sadly, Professor Bob Emde died recently in Denver. Bob was one of the founding members of WAIMH, a driving force throughout the revolution of WAIMH and made an Honorary President of WAIMH in 2006. He was Emeritus Professor of Psychiatry at the University of Colorado Medical School and had a profoundly productive career that spanned many more than 40 years.

I first met Bob in 1990 at his clinical service and research laboratory in Denver and I was struck with his enthusiastic generosity and his infectious commitment to understanding infants and young children, and their families within societal and cultural networks. I remember him talking about how he, as a young medical student, experienced the intense spark of curiosity about how from the beginning of life we become who we



WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH

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Submission guidelines

APA 7th Edition.

12-point font.

1.5 or double spaced.

Maximum 3000 words, including references.

All in-text citations, references, tables, and figures to be in APA 7th edition format.

Papers with tables and figures: Please submit the paper as a word-format document with separate files attached for each table and/or figure.

We welcome photos of babies and families. All photos need to be sent in a separate file with a resolution of at least 72 pixels/inch. All photos need to include a permission statement from the author for WAIMH to publish the photo in Perspectives and also on WAIMH online social media platforms.

To inquire about Perspectives in Infant Mental Health or to submit articles, please contact: Maree Foley (PhD) (Editor-in-Chief)

Email: perspectives@waimh.org



are. This spark became an enduring flame which drove his research and clinical career thereafter.

Bob's career involved research in the early socioemotional and moral development of infants and young children and from this passion for research in understanding early development, Bob influenced the direction of many early intervention and clinical programs for troubled across the world. At our Brisbane Congress in June this year we were very pleased to acknowledge Bob's contributions as an amazing and creative researcher, clinician, theoretician and especially his commitment to mentoring young researchers across many disciplines and across many countries and diverse cultures.

He was a key founder in the IPA Research Training Program which led to many innovative and transforming research projects. He was a key person in the Zero to Three organisation and with his interest in diagnosis and classification of early childhood mental health difficulties he was instrumental in the development of the DC 0 to 3 Classification.

Bob Emde devoted his professional life to the development of the field of infant mental health. He was a wonderful family man, and we extend our deep condolences to his partner Mary Ann, his children, and grandchildren. His late wife, Joyce, also contributed much to WAIMH over many years.

Bob was very keen that we celebrate the process of mentoring and supporting young enthusiastic researchers through WAIMH, and we will have a symposium devoted to this at the next WAIMH Congress in Ireland. We will have additional opportunities in the future through WAIMH to honour Bob and his contribution to infant mental health and to the professional careers of innumerable people. We will certainly miss Bob, but his enduring legacy for all children is very much an alive, vibrant, and creative one.

Campbell Paul,

President of WAIMH

WAIMH Executive Director Corner

Dear colleagues and friends,

It is with great pride and joy that I can say that we have successfully completed the first ever hybrid WAIMH World Congress in Brisbane. In addition to the wonderful content of the scientific and clinical program, the Local Organizing Committee chaired by Elisabeth Hoehn and Libby Norton, our President Campbell Paul and the ICMS Australasia also organized attractive social events for those congress delegates who were able to attend the congress on site. I think many of us looked at the beautiful videos and photos thinking: "I wish I could be there". And more good news: if you missed the congress in June, you may still register for the on-demand part of the program and view it until 6th December 2021. I encourage you to go on exploring the rich content of both the scientific and the clinical presentations that are available for you.

After the Brisbane Congress the WAIMH Board of Directors had its biannual meeting, still online due to the pandemic. In the meeting the Board appointed Elisabeth Hoehn to chair the Program Committee for the 18th WAIMH World Congress in Dublin, July 15–19, 2023. The preparations for the WAIMH Dublin Congress 2023 have already begun, and one of the decisions made in the Board meeting was to go for an on-site World Congress. However, we will explore the possibility of having an on-demand part in the Dublin Congress, too, as it received quite a lot of positive feedback from the online delegates of the Brisbane Congress.

The time since the onset of the pandemic has probably made us all realize how important social gatherings and informal meetings and discussions are for us all, particularly for keeping up our sense of belonging to a group of colleagues and friends. This was the main reason why the WAIMH Board decided to start preparing for Dublin with the hope that we can actually meet each other there in person. With the vaccinations it looks like this could be possible as more and more countries return to life without Covid-19 restrictions. Let us keep our fingers crossed!

Another important decision that the Board made was to start collaboration between WAIMH, Sick Kids Toronto, Tampere University and Tampere University Hospital for preparing a webinar series on Infant Mental Health, with Board member Chaya Kulkarni and the WAIMH Executive Director taking the lead. The webinars will start running in the beginning of 2022, and we will post information to our social media once the topics and presenters are confirmed. The webinars are a good way to reach out to members and colleagues from all over the world and communicate basic and new facts on Infant Mental Health. We will try to cover both scientific and clinical perspectives on the topics in each webinar, and also to be mindful of viewpoints of different countries and cultures.

It has been an eventful year so far at the WAIMH Office, but luckily we got a new administrative assistant Neea Aalto who started working with us at the end of January. With the new webinar series and the Dublin Congress preparations I believe we will be busy from now on, but we invite you to be in contact with the Office with your feedback and questions!

With warm wishes to you all,

Kaija





From the Editors

By Maree Foley (Switzerland), Patricia O'Rourke (Australia), Jody Todd Manly (USA), Azhar Abu Ali (United Arab Emirates), Salisha Maharaj (South Africa), Chaya Kulkarni (Canada) and Minna Sorsa (Finland)

Welcome to this Fall (2021) edition of *WAIMH Perspectives in Infant Mental Health*. Since the last issue, COVID-19 remains a constant for many of us across the globe. The impact has been and continues to be harshly indiscriminate, especially for families with infants, toddlers, and young children.

We acknowledge every baby across the globe and strengthen our resolve to be actively engaged in ensuring that every baby is seen, protected, and provided with nurturing care, along with their families and their communities. We acknowledge all infant and early childhood mental health professionals who are working relentlessly with, and on behalf of babies and their families amidst this COVID-19 pandemic.

This issue begins with an in Memorium of Professor Robert Emde, written by Assoc Prof Campbell Paul, WAIMH President. This year has been one where many of us have faced the loss of loved ones and within WAIMH, the loss of Bob Emde is a huge loss to our global community. Our WAIMH President Campbell Paul shares beautifully about Bob and offers a glimpse of who this amazing man was and the legacy he has gifted to all babies and everyone who cares for, and supports the care of babies. He will be forever remembered and treasured.

WAIMH Executive Director Prof Kaija Puura provides an update and her reflections; as always, her contribution connects with us as readers; as if we were in conversation with her.

This issue also includes ongoing information about the hybrid WAIMH Congress that was held in Brisbane, Australia (June 23-27) and across the

globe. It is still a miracle that this congress occurred and it represents an enormous amount of work. We thank the whole Congress team for their perseverance, creativity, and commitment to create a WAIMH Congress that was and that remains accessible to WAIMH, and our allied global community.

This issue includes four main new papers. First, is a paper by colleagues in Denver, USA: *WePlay Denver: Introducing a Flexible, Caregiver-Led Parent-Child Group* is a paper by Lauren Gross, Kelly Lavin, Kayce Moormeier, Esha Pahwa, Mariana Cerqueira, and Tracy Moran Vozar. Next, the focus shifts to the innovative use of child and adolescent psychiatry residents in Portugal during COVID-19: *The experience of Child and Adolescent Psychiatry residents at a COVID-19 Testing Centre* by Sofia Vaz Pinto, Catarina Garcia Ribeiro, Mónica Filipe da Mata, Mariana Pereira Alves, Nuno Araújo Duarte, Madalena Ferro Rodrigues, Cristina Martins Halpern, and Pedro Caldeira da Silva.

Next the focus shifts to paediatrics and foster care; a paper by colleagues in Minnesota, USA: *A Case Study of the Early Childhood Mental Health Therapeutic Consultation Protocol within a Specialty Multidisciplinary Pediatric Clinic for Adopted and Foster Care Children* by Alyssa R. Palmer, Claire Dahl, Judith K. Eckerle, MaryJo Spencer, Kimara Gustafson and Maria Kroupina.

We also draw attention to lived experience of "contemplating help seeking", as identified by Minna Sorsa and colleagues from Finland. Minna Sorsa from Finland contributes *A review on contemplating help-seeking in perinatal psychological distress*.

The focus then shifts to celebrating and honouring two WAIMH members, Dr Denise Guy from New Zealand and Dr Julie Stone from Australia. Dr Guy and Dr Stone have each recently received national honours for their work in infant mental health in their countries. The IMHAANZ affiliate shares with us about the New Zealand national honour Dr Guy received and Emma Toone from Australia shares with us about the Australian national honour that Dr Stone received. On behalf of WAIMH, we congratulate both Dr Guy

and Dr Stone for being recipients of these prestigious honours.

Next, a recently published book by Fernanda (2020): *Babys und Kleinkinder in Not. Psychopathologie und Behandlung*, is reviewed by Éva Hédervári-Heller, from Berlin, Germany. Another new book is also featured: *Four Decades in Infant Mental Health*, by Michael Trout.

The issue closes with some Perspectives in Infant Mental Health administrative updates that include the updated Perspectives Flyer, Author Submission guidelines, and the Call for abstracts regarding the forthcoming Perspectives in Infant Mental Health Special issue on IMH Public health and Policy. Information is also provided about the Infant Mental Health Journal.

As a reminder, Perspectives papers can be accessed online, with past issues dating back to 1993 currently available by following this link: <https://perspectives.waimh.org/perspectives-archive/>. Also, past articles are available online in text format, which in turn can be shared: <https://perspectives.waimh.org/>.

Finally, the WAIMH office staff, led by Dr Minna Sorsa and Neea-Leena Aalto continue to do an amazing job in the office. They share with us an update on the WAIMH Office news.

May you and your families and friends, stay safe and well.

Maree Foley, Editor-in-Chief

Patricia O'Rourke, Associate Editor

Jody Todd-Manly, Associate Editor

Azhar AbuAli, Associate Editor

Chaya Kulkarni, WAIMH Board Member
Associate Editor

Salisha Maharaj, Intern Editor

Minna Sorsa, Production Editor

WAIMH 2021

WAMH 2021 was originally scheduled for June 2020 fully face-to-face at the Brisbane Convention and Exhibition Centre. The full program with 15 concurrent rooms and over 700 presentations was finalised and put together across a 4 day meeting in Finland in December 2019.

Not long after this, the COVID pandemic begin in early 2020, resulting in a decision in April 2021 to postpone WAIMH for 12 months, to June 2021.

In July 2020, the new dates for June 2021 were announced as 22 – 26 June 2021.

As 2020 progressed, it was clear that it was unlikely that international travel was going to be possible by June 2021. Therefore in early 2021, the announcement was made that WAIMH would be a hybrid Congress and offer both in-person and virtual registration options.

With the 12 month delay and the hybrid delivery, the program needed to be adapted to suit. Many presentations were withdrawn, however a large number still proceeded to present in the hybrid format.

The 15 concurrent streams needed to be reworked to then take into account time-zones etc.

The committee came to a decision to have 2 different sub programs for WAIMH 2021 Hybrid;

1. Live program – delivered live via zoom and in-person at BCEC between 22 – 26 June
2. On-demand – all pre-recorded content to be available in a gallery for 24/7 viewing

The live program element (22 – 26 June) was then broken down into those presenting via zoom and those that would be presenting in person at the BCEC.

Two different programs were put together;

1. A virtual attendee program
2. In-person attendee program

The in-person attendee program included the sessions that would be broadcast live at the Brisbane Convention & Exhibition Centre. The



Photo: WAIMH 2021 Congress Program Committee during a meeting in December 2019. From left: Elizabeth Hoehn, Campbell Paul, Miri Keren, Giampaolo Nicolais, David Oppenheim, Reija Latva and Kaija Puura. Photo by Minna Sorsa.



Photo text: WAIMH 2021 Congress co-chairs Libby Morton and Elizabeth Hoehn.

in-person program also included newly developed Bi-National sessions, focused around Australian policy in infant mental health. These sessions were only available to in-person registered attendees, and were developed as a way of incentive for people to travel to Brisbane.

Virtual platform

The live presentations during 22 – 26 June were presenting using Zoom and then live streamed by SuperTribe into the custom built virtual platform.

The on-demand content was submitted via a custom built submission form affectionately called 'Betty'. This was

Table 1. The fees of the on-demand participation at #WAIMH2021.

Registration Type	Rates
Member	\$480
Non Member	\$600
Student*/Low & Low Middle Income Countries	\$270
Upper Middle Income Countries	\$460

developed by Super Tribe. Upon approval of the submissions, they were automatically populated into the on-demand section of the platform.

Attendees had the option to watch the live sessions during 22 – 26 June via the platform which were all recorded and then on-demand, so those who missed sessions, could catch up.

All of the recordings and all of the on-demand pre-recorded content is available via the platform for 6 months post Congress.

The custom virtual platform, had the below features;

- Live program – including live Q&A, presenter information, presenter abstract, handouts
- On-demand gallery – including orals, workshops, symposiums, posters – all included speaker details, discussion/question forum, abstracts and handouts
- Meet other delegates
- Sponsor and exhibitor profiles
- Additional information such as a cultural space, competitions, information relating to the hosts etc.
- Bookmarking and saving of presentations
- Customised time-zones for each attendee profile
- Support

Registration is still open

The content is available to all currently registered WAIMH delegates. The Congress is still offering on-demand registration opportunities to gain access to the virtual platform and all of the on-demand content. The on-demand registration information and rates can be found here:

<https://waimh2021.org/registration.php>

On-demand Registration Rates

Access to WAIMH 2021 on-demand content for 6 months. Registration fees are quoted in Australian dollars and are inclusive of 10% Goods and Services Tax (GST).

Detailed information about the congress

- President of WAIMH: Campbell Paul, Consultant Infant and Child Psychiatrist, Royal Children's Hospital Melbourne
- Co Host: Australian Association for Infant Mental Health (AAIMH)
- Congress Chairs: Elisabeth Hoehn, Medical Director, Consultant Child Psychiatrist, Queensland Centre for Perinatal and Infant Mental Health and Libby Morton, Queensland Centre for Perinatal and Infant

Mental Health

- Full name of the event: The 17th World Congress of the World Association for Infant Mental Health
- Date: 22 – 26 June 2021
- Venue: Hybrid Congress
- Virtual Platform: www.waimh2021.com.au
- Final numbers: 1,087
- Number of Countries represented: 61 countries
- Information about the program see enclosed infographics and table.

ALL AVAILABLE TO VIEW ON-DEMAND



"I look forward to continue checking out the wonderful presentations in the next 6 months!"



"Very impressed with how the virtual program worked so smoothly"

**Australian & WAIMH
Affiliate Congress Institutes**



I am attending



WAIMH2021

17th World Congress
Brisbane Australia | 22-26 June 2021

*Creating stories in Infant Mental Health:
research, recovery and regeneration*

www.waimh2021.org

#WAIMH2021 #WAIMH #IMH



Table 1. Information about WAIMH 2021 Congress. Date 19th August, 2021.

WAIMH 2021 Congress presentations: 15 concurrent sessions		
	2020 F2F Program	2021 Hybrid Program
Submitted Abstracts	756	
Accepted Abstracts	724	
Rejected Abstracts	17	
Presentations Scheduled In Program		
Congress Institutes	2	2
Keynote Speakers	4	4
Presidential Symposium	1	1
Masterclasses	24	24
State of the Art Lectures	3	3
Invited Symposia	3	2
Brief Oral Presentations	293	186
Symposiums	62	49
Workshops	86	55
Video Presentations	8	7
Arts Program	6	
Poster Workshop	8	
Posters	230	147
Bi-National Sessions		8
Special Sessions		2
Total	630	490
Withdrawn	57 (prior to postponement)	299 total (after postponement)

WePlay Denver: Introducing a Flexible, Caregiver-Led Parent-Child Group

By Lauren Gross, M.A.*, Kelly Lavin, Ph.D.*, Kayce Moormeier, Esha Pahwa, M.A., Mariana Cerqueira, M.D., Mpsy, Tracy Moran Vozar, Ph.D., IMH-E® (IV-R/F) (*equal contributions)

Abstract

This article introduces and describes WePlay Denver, a culturally responsive, community-engaged, and evidence-informed parent-child play and support group. WePlay Denver offers groups in both English and Spanish within the local community. This article describes WePlay's approach, how the program pivoted to launch their first virtual groups, and shares the program's strengths, limitations, and future directions that may be applied to other early childhood and parenting support groups.



Photo: Adobe Stock.

Introduction

WePlay Denver (WePlay) is a facilitated play, support, and psychoeducation program with mental health components for caregivers with young children between the ages of 6 - 36 months. WePlay was inspired by the parent-child support group of the same name at the Chicago Children's Museum. WePlay is a caregiver-infant group model identified as a cooperative learning environment and therapeutic playgroup where participants can build their knowledge and parenting toolkit through the facilitated program content, parent-child interactions, and peer-to-peer reflections. The different dynamics and social layers between the caregiver and their child, one caregiver to another, one child to another, and the program facilitators to the participants, gives the cohort collective ownership of each session.

Using Chicago's model of a theme-based, multi-session cohort as a launchpad, Dr. Tracy Vozar, from the University of Denver's Graduate School of Professional Psychology (GSPP) and Sarah Brenkert, from the Children's Museum of Denver at Marsico Campus (CMD), developed the initial WePlay Denver model. The resulting program highlights the strengths of both institutions and mental health and child development backgrounds. CMD brought the value of engagement,

relationships, and development through play-based educational experiences. GSPP incorporated their expertise with mental health, caregiver-child relationships, community support, and early childhood development. The program developers' collective purpose was to offer caregivers a space for connection and respite from the challenges of parenting. Their intention was for parents to feel motivated and equipped to better connect with and support their children, leading to enhanced outcomes for both adults and children. To achieve these goals, WePlay adopted a community-engaged, culturally responsive, and evidence-informed approach, which represent the three foundational pillars of the program.

Pillar I: WePlay is Community-Engaged

WePlay was designed by and for the community with a commitment to utilizing a flexible caregiver-driven approach, increasing the accessibility of services and building strong community partnerships. During the early stages of content development, the WePlay team scheduled a series of focus groups. By inviting community voices to the planning table, the team hoped to learn more about individual's interests, successes, and challenges of parenting. Focus group participants were primarily

recruited from MotherWise, a Denver-based community organization that connects family-centered and health-focused resources to young, low-income families in Colorado (Baumgartner & Paulsell, 2019). Through this existing partnership between MotherWise, GSPP, and CMD, WePlay team members were able to attend English-speaking and Spanish-speaking community events hosted by MotherWise and connect with prospective families. Those who expressed interest in being part of the focus group, and/or in the pilot WePlay cohort, provided their contact information. CMD hosted separate English-language and Spanish-language focus groups between March and September of 2019. During the English-language focus groups, 6 parents attended; 5 of which identified as mothers and 1 as a father, all ranging in age from their 20's to 40's. During the Spanish-language focus groups, 2 parents attended; both identified as mothers and members of the Latinx community, ranging in age from 20s to 30s. The team provided food, transportation, a gift for the child, free admission to CMD, and on-site supervision of children present during the focus group to enhance participation.

The scope and sequence of WePlay Denver groups were built off of the preferences and interests expressed within the focus groups and from

conversations with community partner organizations. Some of the main themes to develop and directly inform the content of WePlay included helping children socialize, meeting other parents, reducing stress, understanding early childhood development, managing our own emotions, and creating opportunities to play. Participants wanted to hold WePlay groups in a community space like CMD that would help them feel comfortable and welcomed in a therapeutic playgroup. They also expressed interest in focusing the group's educational and developmental content on younger children, ranging from early crawlers to early walkers, which resulted in the WePlay planning team selecting the 6 months to 15 months age range for the pilot group. On a case-by-case basis, children that were outside of the age range were considered for participation in the pilot cohort (e.g., two families who participated in the focus groups with children that were slightly outside of the age range were included in the pilot cohort).

The team also noticed differences in the hopes and interests between the English-language and Spanish-language focus groups, validating the team's inclination to develop content to suit the community, cultural, and engagement needs of each cohort within the program. For example, themes of interest in the English-language group included ways to play and engage with very young children and child development. In the Spanish-language group, families were more interested in support around transitioning back to work as new parents as well as English-language support. These differences were incorporated into the initial WePlay sessions. Recruitment for focus groups, and particularly the Spanish-language group, was limited, therefore, plans were developed to ask potential participants for their input on group content during the initial recruitment discussion.

As the WePlay planning team built out the scope and sequence for the program's pilot cohort, the intended audience was informed by the feedback gathered from the focus groups, the age range, and the developmental stage of the participating infants (i.e., 7-17 months). The program content was designed to include age-appropriate and responsive play, caregiver support, engaging materials and activities, enriching take-home

materials, and continuous activities beyond the program's sessions. The pilot's format evolved into a 6-week series, with each 90-minute session focusing on a specific type of play and a developmentally informed psychoeducational topic, with paired take-home materials and resources to continue the learning beyond the walls of CMD. In addition, based on focus group input and support from grant funding, all participants accessed WePlay services for free, received access to transportation, snacks for both the caregiver and child during each session, and a year-long family membership to CMD. All of these factors are used as incentives for recruitment and retention to encourage weekly participation from the families. The team found that these factors, particularly the access to free transportation and free CMD admission for their family members during WePlay sessions, were successful in motivating participants' attendance. Using the early feedback from focus groups and ongoing feedback from cohort participants, the WePlay planning team continued to prioritize factors that would help reduce logistical barriers and stressful aspects that may discourage participants from attending.

GSPP and CMD recognize the presence of implicit bias, including socio-economic bias, in the planning and facilitation of these groups is the result of operating as a small team; the knowledge, research, perspectives, and life experiences are therefore limited to those within the group. The awareness of implicit bias, paired with a strong investment in creating a continuous and cooperative learning environment for all, motivates the WePlay team to remain evidence-based and be responsive to the varying needs or interests from one cohort to the next. As a way to help minimize socio-economic bias, for example, the WePlay team offers the same incentives for all participants, regardless of their income status. In addition, WePlay is aware that the incentives participants receive may impact responses in interviews and on questionnaires, thus reflecting more positive and favorable program findings. In an effort to minimize positive responding due to incentives, all group members received incentives before completing the final surveys and feedback interviews and interviews were conducted by a team member new to the group members. While incentives may have impacted participants' responses, WePlay team

members were intentional and found success in welcoming feedback from families in an effort to improve future groups.

Flexible caregiver-driven approach.

Through this pilot experience, the team saw early success with the flexible, caregiver-driven approach. Facilitators from GSPP and CMD teams are present during each group session and work to invite participants to ask questions and engage in discussion. This open dialogue format contributed to the warm and inviting nature of the program. Making the content relatable for the whole group and inviting participants to bring their own experiences into the conversation created a sense of authenticity that likely would not have been achieved otherwise. It also helped to dispel parental concerns, worries, and to normalize behaviors displayed by their child. For example, through group dialogue, parents heard from other parents and facilitators that the concerning behaviors their child was exhibiting (e.g., mild aggression towards peers or siblings, difficulties sharing) were common with the other children in the group and during their developmental period. In groups, parents and facilitators shared helpful approaches to address challenging behaviors and ways to scaffold positive behavior (e.g., quotes from participants illustrating this are included below).

As a result of the personal experiences shared by other caregivers and the informed perspectives shared by WePlay team members, many participants felt empowered to embrace new information to address unhelpful advice and criticisms from family members. For example, a parent was being criticized by family members for picking up her infant when he desired, suggesting that she was spoiling him. After discussing with the group and sharing anecdotal and research evidence that you cannot spoil a baby, the parent felt heard and supported. She asked, "Can I film you saying this for Facebook?", and laughed.

Every week, new topics of interest and ideas generated by group members were discussed by the WePlay team and new materials were generated to be responsive to group members' interests. In addition, facilitators queried group members regularly during groups to ask if there were additional topics or types of play that they would like covered. For example, one family was struggling with

toilet training and asked that this topic be discussed during the group. In response, both group members and facilitators listened to the parent's questions and struggles, provided useful strategies, and followed up with resources. During the next session, the parent described the group's assistance and attention to the toilet training topic to be very helpful, both in terms of the child's progress and parent-child relationship.

The WePlay team strongly believes that this flexible, caregiver-driven approach, resulted in steady attendance and retention. This overall format felt strong and responsive towards the caregivers in the initial groups, so the team felt encouraged to carry the collaborative approach forward into subsequent cohorts.

Accessibility.

WePlay also emphasized accessibility. All participants were offered either free rides to and from CMD or free parking. In addition, because some participating families also had older children, CMD offered free admission to siblings and other family members during and after WePlay sessions to minimize the need for additional childcare.

During the COVID-19 pandemic, WePlay moved its programming online. The team created a website that provided access to online resources, including videos demonstrating play activities and discussing psychoeducational topics. The website also included information about accessing mental health care during the pandemic, tips on how to talk about the virus with young children, and links to other online activities for families, such as live music time and virtual dance parties. The team also reached out to WePlay families that had either been a part of the recruitment contact list or past participants. The respondents generously offered their insight related to learning topics, the value of play, what sort of resources they needed, which digital platforms they preferred, and more. This information helped the team to validate, reshape, or create ideas for this new era of WePlay including topics that were specific to the events of 2020, such as COVID-19, discussing racial justice with children, and mindfulness.

In fall 2020, WePlay held its first virtual groups. Prior to sessions, the team delivered the physical materials used in the WePlay program to the participants' homes for use during the online sessions. The kits featured open-ended toys and objects that support multiple levels of developmentally-appropriate play, such

as juggling scarves, egg shakers, plastic cups and bowls, sensory balls, and more. Kits also included bilingual board books, printed infographics, snacks, gift cards for groceries or home goods, and a free family membership to CMD. The intended goal of providing these interactives was to share different ways to activate play-based learning using multi-functional items or everyday objects, ultimately giving families autonomy in deciding how they want to use these materials. One family, for example, used the hand-made sponge balls and measuring cups from one session to make their bath times more playful. Another child used a plastic storage bin as a multipurpose bathtub and bed for her dolls. The use of everyday objects in these kits also helped to foster the creativity and reimagining of other everyday objects within families' living space. For example, if cups and bowls were included in the kit, it would be an opportunity to talk about channeling imaginative and creative play by using these objects as drums as well as encourage families to identify other household objects that could also be used as a musical instrument. This approach to play-based learning encourages positive development and interactions through simple and easy-to-replicate ideas diminishing barriers in accessing resources.

Virtual sessions were reduced to 60-minute experiences based on previous group members and facilitator feedback of how much time was feasible and enjoyable over Zoom with young children present. Separate virtual groups were held in both English and Spanish. In order to keep WePlay as accessible as possible, team members worked with families to troubleshoot any connectivity or technical issues before and at the start of sessions. Because this first-ever approach to virtual WePlay included primarily returning participants, the children in the initial virtual groups were between the ages of 6-32 months.

Community partnerships.

The WePlay program is also committed to fostering community partnerships. For example, one of WePlay's main referral sources is MotherWise Colorado, a local organization that provides free parenting workshops to empower women and families (Baumgartner & Paulsell, 2019). In addition to the central collaboration between GSPP and CMD, WePlay partners with the Denver

Botanic Gardens to provide families with access to unique child-friendly activities. In addition, WePlay partners with Rocky Mountain Human Services (RMHS), an agency that provides various supportive services for families and children including early intervention. Through the partnership with RMHS, families with children who have special needs have participated in WePlay. WePlay conducted its first virtual cohort with families recruited from RMHS and look forward to incorporating feedback received into future groups so that WePlay can continue to provide tailored and supportive services to families with special needs and developmental considerations. Finally, the WePlay program is committed to expanding access to mental healthcare for families with young children. WePlay provides an important port of entry for parents adapting to the stressors of parenting. The WePlay program has connected many participants with free or low-cost services from area clinicians that specialize in perinatal to five years, mental health.

Pillar II: WePlay is Culturally Responsive

A key foundation of the WePlay model is the importance of culture and language in the developing caregiver-child relationship. The cultural sensitivity of the WePlay model is particularly pertinent because it addresses the needs present within the population of Colorado. Approximately 12% of Colorado's population speaks Spanish (Colorado Health Institute, 2015) and 1.1 million Coloradans identify as Latinx (Latino Leadership Institute, 2017). Both nationally, and in Denver, very few mental health professionals are able to offer services in Spanish, which contributes to poor communication between Hispanic individuals and their health care providers (American Psychiatric Association, 2017). WePlay-Español facilitators and supervisors are culturally and linguistically sensitive clinicians trained in offering evidenced-based psychotherapy in Spanish and English. WePlay-Español accounts for different culture-specific core values (e.g.: *simpatía* and *respeto*) and stressors such as social mobility, adaptation problems to a new language, behavioral norms, and values of the new environment (Rogler et al., 1991, cited in Welsh, 2013). WePlay-Español facilitators aim to reduce acculturative stress from assimilation issues (Crockett et

al., 2007), thus promoting mental well-being (American Psychiatric Association, 2017) while supporting participants around childcare practices and normative developmental behaviors. By providing information, clarifying doubts, and answering questions, WePlay-Español helps to fill a gap for participants who may feel hesitant or unwilling to ask questions of their care providers for fear of appearing disrespectful.

WePlay values cultural responsiveness in several ways, perhaps most specifically by offering separate groups in two of the dominant languages in our community, English and Spanish, and by creating content based on the interests of each cohort. The cultural sensitivity addressed by this model is not limited to language. WePlay addresses the specific needs and interests of each group. As mentioned previously, the focus groups indicated notable differences in the needs and interests of the English and Spanish participants, which lead to different content in the subsequent groups. For example, in the English group, parents were more interested in learning about parenting skills, whereas in the Spanish group there was a higher interest in learning about how to keep the culture of origin while adapting to a new culture. In addition, the Spanish language group was more likely than the English language group to share their personal experiences, which often shifted focus in the Spanish language group to topics such as challenges in accessing medical care. WePlay-Español facilitators follow the lead of the participants when a new topic would arise and would share resources, if available. WePlay Español facilitators also take note of new topics to bring up

as possibilities for discussion in future cohorts.

In addition to understanding differences across the English and Spanish-speaking groups, it is important to highlight and consider the intra-group differences in WePlay-Español. For example, participants differed in how long they have been in the United States and their degree of acculturation and assimilation with American culture varied. Participants' also differed in their willingness to share lived experiences and details about their multifaceted cultures. Furthermore, although all members within a cohort spoke the same language, participants often spoke different dialects reflective of different countries or regions. Participants' range of abilities in speaking and understanding English was also reflective of these intra-group differences. A similar challenge expressed across WePlay-Español participants was how to adapt to American culture and parenting practices while also preserving their own culture and heritage. These shared experiences facilitated enriching discussions, regarding topics such as bilingualism and how to honor participants' ancestral cultures, and permeated the conversations in WePlay Español.

Pillar III: WePlay is Evidence-Informed

The WePlay program aims to support caregivers and their young children by sharing best practices from nationally recognized early childhood organizations (e.g., Zero to Three; Harvard University's Center on the Developing Child), as well as incorporating findings from empirical research regarding temperament

and differential susceptibility, addressing challenging behaviors, and strengthening attunement (e.g., Belsky et al., 2007; Troutman et al., 2012; Troutman, 2015; Troutman, 2016; Marvin et al., 2002) into the program's psychoeducation and resource materials. WePlay understands that in order to promote healthy child development, it is imperative to support caregivers' well-being and mental health (Mensah & Kiernan, 2010; Smith, 2004). Therefore, WePlay invites discussion of caregiver-focused topics such as social support and self-care practices. In addition, caregivers are introduced to empirically supported parenting strategies, such as skills and techniques from Integration of Working Models of Attachment - Parent Child Interaction Therapy (IoWA-PCIT; Troutman, 2011) as well as parenting resources from Zero to Three and other credible sources, that promote children's positive social and emotional development.

WePlay also applies findings from program evaluation research into the development and planning of groups. WePlay collects pre- and post-group data on several important indicators associated with positive outcomes for caregivers and children, including caregiver well-being, mental health, and parenting-related factors. More specifically, caregivers' depression and anxiety symptoms are assessed using the Edinburgh Postnatal Depression (Cox et al., 1987) and the Postpartum Worry Scales (Moran et al., 2014). In addition, caregivers' parenting self-efficacy, parenting stress, and self-compassion as assessed using the Assessment of Parenting Tool

Table 1. Demographic Data from in-person WePlay Groups.

	WePlay Denver (English)				WePlay Español
	Cohort 1	Cohort 2	Cohort 3	Total	Cohort 1
Number of Dyads	7	7	5	15	4
Avg age of caregiver (range)	30 years (22-40)	34.67 years (34-46)	31 years (29-35)	31.27 years (22-40)	31.8 years (26-35)
Avg age of child (range)	11.7 months (7.1-17.2)	9.6 months (6.2-14)	9.9 months (6.4-15.2)	10.7 months (6.2-17.2)	12 months (9-16)
Child Gender	3 female, 4 male	2 female, 1 male	1 female, 4 male	6 female, 9 male	1 female, 3 male
Hispanic/Latino Caregivers	6 (85.7%)	0 (0%)	1 (TBD%)	7 (TBD%)	4 (100%)
Hispanic/Latino Children	6 (85.7%)	0 (0%)	1 (TBD%)	6 (TBD%)	4 (100%)
Avg sessions attended (range)	4.6 (3-6)	5.3 (5-6)	5 (4-6)	4.9 (3-6)	4.5 (3-5)

Table 2. Demographic Data from Virtual WePlay Groups.

	WePlay Denver (English)		WePlay Español	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Number of Dyads	6	7*	7**	6
Avg age of caregiver (range)	32.5 years (29-37)	35.7 years (29-44)	33.2 years (27-38)	34.5 years (28-41)
Avg age of child (range)	22.3 months (16-32)	12.6 months (9-15)	23 months (16-36)	22.5 months (15-28)
Child Gender	4 female, 2 male	4 female, 3 male	1 female, 5 male	2 female, 4 male
Hispanic/Latino Caregivers	1 (16.7%)	0 (0%)	6 (100%)	6 (100%)
Hispanic/Latino Children	1 (16.7%)	1 (14.3%)	6 (100%)	6 (100%)
Avg sessions attended (range)	4.3 (2-6)	5 (2-6)	----	3.8 (2-6)
Percent of returning participant	100%	0%	50%	33%

Note. * One family had twin children, so there were 6 caregivers and 7 children

** Missing data from 1 participant. Only 6 dyads used for subsequent calculations.

Attendance data was not collected from WePlay Español Cohort 1.

(Moran et al., 2016), the Parenting Stress Index-Short Form (Abidin, 1995), and the Self-Compassion Scale-Short Form (Raes et al., 2011). Data collected for each English and Spanish cohort helps WePlay facilitators better understand how participation benefits caregivers and children as well as which areas WePlay may need to target with additional support. Demographic data of WePlay English and Español cohorts are included in Tables 1-2. Descriptive data from WePlay's pre-and post- group surveys will be analyzed in future dissemination efforts. In addition to reporting scales, caregivers are invited to participate in a brief 20- to 30-minute semi-structured post-group interview regarding their experiences in WePlay. Results from each cohort are reviewed by the team and integrated into the planning of future WePlay groups.

Qualitative data for all English language cohorts, in-person and virtually, were examined using a thematic analysis approach and analysis of data for Spanish language cohorts is planned for the coming year. Themes across interviews from in-person WePlay English groups (total n= 15 caregiver-child dyads, across 3 cohorts) highlighted how the psychoeducation components of the group helped caregivers learn about

parenting approaches, child development, and how to best meet their child's needs. Caregivers expressed how beneficial it was to learn from other caregivers with children of similar ages and how validating it was to share similar experiences with peers. Caregivers appreciated the focus on caregiver well-being in groups and learned how important it is to care for themselves as well as their children. Children enjoyed the groups and caregivers appreciated how groups offered opportunities for children to socialize with peers around their developmental stage. Children and caregivers also enjoyed WePlay materials and activities and continued to engage with them after the program concluded. Overall, the positive experiences during WePlay were evidenced by the number of caregivers requesting program extension and interest in re-joining future groups.

"Yes – especially old age stuff about you spoiling them or they are trying to manipulate. And I learned that you really can't do that. Reassuring that you are there and paying attention to their needs instead of closing up."

Caregiver from WePlay English In-

Person Group (When asked if they learned things from the group)

"I did. I learned that some of the challenging behaviors were typical for his age. It was helpful to know that it was not specific to him but just part of development. It wasn't that I was doing something wrong. And I learned some tips on how to manage his behavior as well as how I react to those challenging moments."

Caregiver from WePlay English In-Person Group (When asked if they learned things from the group)

Preliminary qualitative data (n = 6 caregiver-child dyads, all returning participants) from the English language WePlay virtual groups with children between 6-32 months of age suggested caregivers' appreciated weekly material deliveries, play activities, timely psychoeducation topics (e.g., toilet training, wearing face masks during the pandemic, dealing with tantrums, and raising anti-racist children), and hearing

fellow caregivers' perspectives on psychoeducation topics. Data also suggested that weekly reminders including Zoom information facilitated group attendance. In addition, while caregivers noted how great it was for their children to see other kids, it was sometimes challenging to engage children through virtual formats, as would be expected developmentally. Lastly, caregivers noted several recommendations to increase child engagement, provide additional opportunities for caregivers to request psychoeducation topics and expressed wishes to expand and grow WePlay to include more families and varying developmental ages.

"...I think there was room to ask about whatever was going on in your life so I appreciated that. For me, those were two things that were coming up and I talked to Tracy about them or other people in the group and they were really helpful with ideas so I like the ability to talk about whatever was going on in our life. I like the ability to bring up questions and talk about life..."

Caregiver from WePlay English Virtual Group

Furthermore, qualitative data from our virtual WePlay (English) cohort (n = 6 caregiver-child dyads) recruited through RMHS with children between 9-15 months of age suggested families appreciated the accessibility of virtual group formats, psychoeducation topics and play activities, receiving validation for parenting struggles, learning from other parents' experiences, having a space to connect with other families, as well as children seeing other children. Some families provided feedback that the timing of the group conflicted with their child's nap schedule. They also suggested that future groups could include examples as to how enriching activities may be incorporated into everyday activities. Furthermore, families expressed wanting more interactions with other parents but also acknowledged the inherent limitations of the virtual format. Lastly, families shared new play material ideas (e.g., household objects such as couch cushions).

Challenges

While WePlay's flexible and caregiver-led approach promotes tailoring of support and resources to directly meet the needs of the community, this non-manualized model is accompanied by several challenges regarding implementation fidelity, program evaluation, and grant funding.

WePlay does not use a manualized approach but rather integrates various theoretical perspectives to inform and guide the team's approach to groups. For example, psychoeducation topics and activities designed to strengthen caregiver-child attunement are conceptualized through an attachment theory perspective (Ainsworth, 1978), while content aimed to address disruptive and challenging behaviors derives from integrated behavioral and attachment frameworks (Troutman, 2015; Troutman, 2016). The importance of considering caregivers' and children's individual differences and goodness of fit inform our discussions on creating an environment that is responsive and sensitive to the temperamental and relational characteristics of participants (Chess & Thomas, 1991).

Using a non-manualized approach introduces challenges in implementing groups with fidelity. Because cohort groups are each unique and topics are informed by the members of each cohort, it is difficult to communicate the exact learning objectives of each group cohort session until WePlay is underway. WePlay's non-manualized approach also presents complications in program evaluation. Because caregivers in different cohorts are potentially being introduced to different psychoeducation topics and play activities, it is hard to determine which aspects of the groups are leading to various outcomes. Instead of identifying which specific topics and activities facilitate change, WePlay is curious to evaluate the holistic effectiveness of flexible caregiver-led groups in caregiver and caregiver-child relationship outcomes.

Lastly, because the majority of program funders and stakeholders favor a manualized approach that is strongly supported by empirical research, it is difficult to ensure WePlay's financial sustainability. Without funding, WePlay is unsupported in regard to dissemination, sustainability of services in current communities served, and in

expansion efforts of services outside of the Denver metro area. The team plans to utilize innovative programmatic evaluation techniques that showcase the value of flexible caregiver-led programs and promote funders' interest and engagement.

Strengths

A unique strength of the WePlay program is the collaboration across museum and academic staff. CMD team members bring knowledge of child development, play, and activities that are novel in academic mental health programming. Similarly, clinical psychology faculty, staff, and trainees bring expertise in social-emotional development, perinatal to five mental health, Latinx psychology, and parent-child relationship development that is novel to the CMD setting. The team as well as group members have found this unique collaboration to be an excellent fit for the specific goals of the WePlay program and participating families. The team members learn from one another, and the group members learn with a dynamic interdisciplinary group of facilitators. The content, breadth, and depth within the group has expanded as a result of the skills and knowledge each team member brings to WePlay. Further, for group members who might hesitate to join a group within a formal clinical setting, the museum setting, focus on play, and relationship-based curriculum are welcoming characteristics. On numerous occasions, the WePlay program has been the initial port of entry for engaging families in additional mental health services. Our team has also benefited from a train-the-trainer model wherein staff, students, and faculty who have led a prior group are shadowed by newer team members. In this way, new team members learn the WePlay model by actively participating in the groups, with the support of more experienced members. This training strategy facilitates program replication and expansion.

Given the newness of the WePlay approach and the various team members and knowledge areas combined in the model, the team put in place various feedback mechanisms among stakeholders. First, one of the team members shadowing a more experienced staff person would take notes during the group to be shared at the next team meeting. Team meetings occurred following group sessions and provided a space for reflection, shared

observations, noted strengths and challenges of the group, and potential areas for revision in future groups. The ever-evolving nature of the group's content meant an openness to new topics and activities. The adaptability to new content also meant that team members often had to think quickly and creatively during a session or plan to address a topic the following week after generating new content. Sometimes planned activities or topics were swapped for other, more pertinent topics such as when the topic of promoting sleep practices was not a pressing concern for the group but supporting and troubleshooting toilet training was.

Another unique strength of the WePlay program is the training opportunities it provides for students. Clinical psychology doctoral students were involved in all aspects of the approach from the initial planning, focus groups, and design of the broader WePlay curriculum. In addition, WePlay allows students to provide group support to parent-child dyads in a less clinical setting, providing students with a unique clinical experience. Similarly, WePlay provides students with the opportunity to be involved in an ongoing and malleable community-focused research project, where students connect with community partners, help collect and analyze data, and use participant feedback to modify the content and structure of future WePlay groups.

WePlay's model of incorporated mental health screening and referrals offers trainees the experience of providing both group psychoeducation and more intensive clinical services when needed. Due to the unique, community-based, and collaborative nature of WePlay, many trainees are excited to volunteer to participate. WePlay benefits from the trainees' excitement by having plenty of staff to facilitate groups and to co-create content. In addition, students (including three of the current authors) have been actively involved in associated presentations and publications describing the WePlay program, thereby promoting their overall professional development.

Previous research on parent-child playgroups has demonstrated positive effects in numerous areas. Studies have found that these types of groups not only provide parents with valuable information about parenting, they also allow participants to make friends,

build a peer support network, and foster a sense of community (Strange et al., 2014). Another study found that improvements in parent-child interactions were maintained up to 32-weeks after participating in a parent-child playgroup, suggesting that the positive impacts of groups are long-lasting (Westrupp et al., 2018). While quantitative data has not been analyzed, qualitative and anecdotal data suggests that WePlay participants enjoyed peer support, information from experts on child development, and learning new ways to connect with their children. Participants also reported that the WePlay program was particularly beneficial during experiences of isolation due to the COVID-19 Pandemic.

"...(Child's name) was born, I mean all of the babies are in the same age range, he was born last July. He's almost one so he was born into a pandemic world so I pictured the start, I pictured especially, I don't know, I think one of the best things you can do for the little ones is just put them together and let them learn from each other. I think that's one of the best things you can do for new moms as well. I pictured that being part of our daily life - going to libraries or even friend's houses or parks and that just couldn't do it or I didn't feel particularly comfortable until recently. So, I think that's just what I enjoyed most even though (child) couldn't be with the other babies playing with them directly. I can always tell that he was hearing others' voices which is so nurturing for him. He was able to play with so many new materials. Yeah, so it really just provided the space that was good for the babies and I think good for the moms too. So I really look forward to just that time of being together. And I think everyone would have preferred to be in person. I know that we would

have. But it was filling this gap that we have been missing in this first-year."

Caregiver from WePlay English Virtual Group

"I just wanted to say thank you. The groups were really amazing, and we were so, so honored to be a part of them. We get to learn so much and we get to, you know do something. It was so exciting like 'yay, every Tuesday we have this!'"

Caregiver from WePlay English Virtual Group

Future Directions

As WePlay grows and expands, the team plans to collaborate with Denver metro area libraries as well as other child service agencies, such as RMHS, to continue increasing access to the WePlay program. WePlay has also begun conversations about developing a mobile shuttle that will improve accessibility for WePlay and additional mental health programming to more remote areas of Colorado. In addition, WePlay will introduce a new approach to ensure all caregivers have the opportunity to share their interests and concerns that inform psychoeducation topics. WePlay will provide anonymous pre-group surveys so that caregivers can list topics for the psychoeducation component of the group and share any details they find important about their child and/or family.

Over time, the team has found that caregivers value the perspectives of their peers and that caregivers within cohorts typically share similar psychoeducation topic ideas. Therefore, despite similarities and differences in topics covered across cohorts, WePlay plans to create a "tool-kit" of psychoeducation topic resources that can increase fidelity regarding the content covered. The tool-kit will also be beneficial to others who wish to replicate or offer similar programs in their communities. Furthermore, WePlay will continue to tailor and develop content and materials for cohorts with

children across varying developmental stages and who have special developmental needs and considerations. Consistent with WePlay's program model, feedback from the program participants, community partners, and other WePlay stakeholders will be continually solicited and integrated into future program planning and development.

References

- Abidin, R. R. (1995). *Parenting Stress Index*, Third Edition: Professional Manual. Odessa, FL: Psychological Assessment Resources, inc.
- Ainsworth, M. D. S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, N.J. : New York: Lawrence Erlbaum Associates.
- American Psychiatric Association. (2017). *Mental Health Disparities: Hispanics and Latinos*. <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-Hispanic-Latino.pdf>
- Baumgartner, S., & Paulsell, D. (2019). *MotherWise: Implementation of a Healthy Marriage and Relationship Education Program for Pregnant and New Mothers*, OPRE Report # 2019-42, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.
- Belsky, J., Bakermans-Kranenburg, M. J., & van Ijzendoorn, M. H. (2007). For better or for worse: Differential susceptibility to environmental influences. *Current Directions in Psychological Science: A Journal of the American Psychological Society*, 16(6), 300-304. <https://doi.org/10.1111/j.1467-8721.2007.00525.x>
- Chess, S., & Thomas, A. (1991). Temperament and the concept of goodness of fit. In J. Strelau & A. Angleitner (Eds.), *Explorations in temperament: International perspectives on theory and measurement* (pp. 15-28). Plenum Press. https://doi.org/10.1007/978-1-4899-0643-4_2
- Colorado Health Institute (2015). *Speaking of Health: A Look at the Health of Colorado's Spanish Speakers*. Colorado Health Access Survey. Retrieved from www.coloradohealthinstitute.org
- Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *The British Journal of Psychiatry: The Journal of Mental Science*, 150, 782-786. <https://doi.org/10.1192/bjp.150.6.782>
- Latino Leadership Institute. (n.d.). *Latino Colorado*. Retrieved from <https://latinoslead.org/latino-research/>
- Marvin, R., Cooper, G., Hoffman, K., & Powell, B. (2002). The Circle of Security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment & Human Development*, 4(1), 107-124. <https://doi.org/10.1080/14616730252982491>
- Mensah, F. K., & Kiernan, K. E. (2010). Parents' mental health and children's cognitive and social development: families in England in the Millennium Cohort Study. *Social psychiatry and psychiatric epidemiology*, 45(11), 1023-1035. <https://doi.org/10.1007/s00127-009-0137-y>
- Moran, T. E., Polanin, J. R., & Wenzel, A. (2014). The Postpartum Worry Scale-Revised: An initial validation of a measure of postpartum worry. *Archives of Women's Mental Health*, 17(1), 41-48. <https://doi.org/10.1007/s00737-013-0380-9>
- Moran, T. E., Polanin, J. R., Evenson, A. L., Troutman, B. R., & Franklin, C. L. (2016). Initial validation of the Assessment of Parenting Tool: A task- and domain-level measure of parenting self-efficacy for parents of infants from birth to 24 months of age. *Infant Mental Health Journal*, 37(3), 222-234. <https://doi.org/10.1002/imhj.21567>
- Pew Research Center tabulations of the 2017 American Community Survey (1% IPUMS). <https://www.pewresearch.org/fact-tank/2019/09/16/key-facts-about-u-s-hispanics/>
- Raes, F., Pommier, E., Neff, K. D., & Van Gucht, D. (2011). Construction and factorial validation of a short form of the Self-Compassion Scale. *Clinical Psychology & Psychotherapy*, 18(3), 250-255. <https://doi.org/10.1002/cpp.702>
- Rogler, L. H., Cortes, D. E., & Malgady, R. G. (1991). Acculturation and mental health status among Hispanics: Convergence and new directions for research. *American Psychologist*, 46(6), 585-597. <https://doi.org/10.1037/0003-066X.46.6.585>
- Smith M. (2004). Parental mental health: Disruptions to parenting and outcomes for children. *Child & Family Social Work*, 9(1), 3-11.
- Strange, C., Fisher, C., Howat, P., & Wood, L. (2014). Fostering supportive community connections through mothers' groups and playgroups. *Journal of Advanced Nursing*, 70(12), 2835-2846.
- Troutman, B., Moran, T., Pelzel, K., Luze, G., & Lindgren, S. (2011). *Developing a blueprint for training Iowa providers in early childhood mental health*. Iowa Early Childhood Mental Health Professional Development Work Group.
- Troutman, B. (2015). *Integrating Behaviorism and Attachment Theory in Parent Coaching* (1st Ed.). Springer International Publishing <https://doi.org/10.1007/978-3-319-15239-4>
- Troutman, B. (2016). Integrating behaviorism and attachment theory in addressing disruptive behavior. *Journal of the American Academy of Child & Adolescent Psychiatry*, 55(10), S229. doi:10.1016/j.jaac.2016.09.396
- Troutman, B., Moran, T. E., Arndt, S., Johnson, R. F., & Chmieliwski, M. (2012). Development of parenting self-efficacy in mothers of infants with high negative emotionality. *Infant Mental Health Journal*, 33(1), 45-54. <https://doi.org/10.1002/imhj.20332>
- Westrupp, E. M., Bennett, C., Cullinane, M., Hackworth, N. J., Berthelsen, D., Reilly, S., Mensah, F. K., Gold, L., Bennetts, S. K., Levickis, P., & Nicholson, J. M. (2018). EHLS at School: school-age follow-up of the Early Home Learning Study cluster randomized controlled trial. *BMC pediatrics*, 18(1), 148. <https://doi.org/10.1186/s12887-018-1122-y>
- US Census Bureau. (2015). *Projections of the Size and Composition of the U.S. Population: 2014-2060*. Retrieved from <https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf>

The experience of Child and Adolescent Psychiatry residents at a COVID-19 Testing Centre

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In March 2020 the SARS-CoV-2 pandemic took over our thinking, transforming the way we live and know the world. The imminence of a disaster scenario, such as the one observed in European neighbouring countries like Italy and Spain, forced the Portuguese Government to declare the State of National Emergency with the implementation of exceptional measures, such as the closure of national borders, curfews and the closure of schools and non-essential trade.

At the hospital level, as Child and Adolescent Psychiatry (CAP) residents under training in Centro de Estudos do Bebê e da Criança, an early childhood unit affiliated with the main Portuguese paediatric hospital, we witnessed the imposition of restrictions that immediately forced the restructuring of non-urgent care activity, with telemedicine becoming the new way of providing non-urgent consultations (Martins Halpern et al., 2020).

With the desire to play a more active and direct role in the fight against the pandemic, despite continuing our infant mental health clinical activity as CAP residents, we voluntarily joined, in April and May 2020, a Testing Centre (TC) to carry out SARS-CoV-2 tests in one of



Photo: Adobe Stock.

the capital's reference hospitals for the care of adult COVID 19 patients. In this article, we propose a reflection on our work experience at a COVID 19 TC, in the middle of the pandemic, as a very challenging experience compared to our usual clinical practice.

CAP Residents in COVID 19 Testing Centre

The TC shifts were organised into periods of 4 hours, with one infectious disease resident or specialist and two residents from other specialities scheduled for each shift. Our work consisted of compiling a medical history directed to the presence of symptoms and relevant antecedents and carrying out the procedure of collecting oral and nasopharyngeal swabs to test for SARS-CoV-2.

We felt that this experience was inwardly enriching, not only because of the possibility of observing in loco very primary reactions of the tested population but also because it allowed us to be spectators of our own emotions, putting us in a position closer to the patients, in the shared experience of such a threatening external reality.

It is interesting to reflect on how our brief contact with the patients, limited to the time spent performing the test, allowed us to identify our

defensive movements of denial of reality, somatisation, expressions of anger and irritability, alongside the projection of fears and anxieties on the technicians ("quickly, I can no longer stand being here") and feelings of great vulnerability and gratitude, experiences that have contributed to our better understanding of the nature of human behaviour.

In us, fear, anguish and a sense of ambivalence about the future stood out, in an atmosphere of pandemic climate fearful of the invisible and still little known "enemy". These feelings placed us in a permanent state of alert, in the face of all the potential risks of contamination, and we were confronted with the need to comply with various routines and rituals related to the usage of personal protective equipment and to take extreme care in cleaning and disinfection. This allowed us to better perceive the importance that the predictability of routines represents for a greater internal sense of security, which is something that we so often work on in the cases we follow in our specialty.

As CAP residents, it was very challenging, and sometimes equally distressing, to experience the contrast between our usual clinical intervention, a practice that favours time, relationships, continuity of care, and

the demand for speed and objectivity of the work in the TC. However, in a place where steamed-up glasses made eye contact difficult and protective equipment left us undistinguishable, the power of the word took on, perhaps, a new significance. We felt that, despite the brevity of the contact, the possibility for the patients to find a professional available to listen to their fears and concerns, in an attitude of understanding and validating them, proved to be differentiating and reassuring.

We were impressed by the story of a young postpartum woman, born in Nepal, having lived in Portugal for only 5 months, who, in compliance with the first national protocol for postpartum women infected with the SARS-CoV-2 virus (DGS, 2020), was separated from her baby after birth. Already asymptomatic and without any support apart from her husband, who was also positive, she repeated the test for the eighth time in just eleven days, as two consecutive negative tests were required for her to finally meet her baby, who had remained in the maternity hospital since the birth.

We were concerned by the coldness of the contingency plans initially implemented, which we felt disregarded basic measures to promote maternal-foetal mental health. Being able to feel so closely the impact of these measures motivated us to file a complaint to the Ombudsman, as an initiative for the protection of children's mental health. At the same time, a study (Figueiredo et al, 2020) was being carried out in our unit that proved the negative impact of these and other measures on the mental health of pregnant women, the results of which contributed to the revision and modification of these practices. Later, a new standard was issued, which recommended the right for the mother to be accompanied by the father during childbirth, the right for the mother to remain close to her newborn and the right to breastfeed.

Closing reflection

We believe that our collaboration in the TC allowed, not only the reduction of the number of shifts of colleagues with other frontline functions but also a unique learning opportunity regarding the reorganisation of services and the role of mental health professionals in a disaster situation, including advocating for families and their baby's wellbeing while also acknowledging the environment of the pandemic.

It was with great pride that we witnessed the ability to adapt, solve problems, and share knowledge, regardless of each person's qualifications, which made it possible to organise in a short space of time the necessary response to meet the needs of the population, in a true ethical spirit of unity and mutual help.

References

- Martins Halpern, C., Alves, M., Pires, S., Caldeira da Silva, P. (2020). Covid-19 Confinement and Babies: Video-Call-Based Developmental and Mental Health Approach. *Perspectives in Infant Mental Health: The Voices of COVID-19*, 28 (3), 30-33.
- DGS. (2020) *Orientação sobre gravidez e parto*, from <https://covid19.min-saude.pt/dgs-publica-orientacao-sobre-gravidez-e-parto/>
- Figueiredo, P. R. et al. (2020). Covid-19 and Mental Health in Pregnancy: A Cross-sectional Study on Depression, Anxiety, and Stress among Portuguese Women. *Perspectives in Infant Mental Health: The Voices of COVID-19*, 28 (3) 6-9.

A Case Study of the Early Childhood Mental Health Therapeutic Consultation Protocol within a Specialty Multidisciplinary Pediatric Clinic for Adopted and Foster Care Children

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Ethics Statement:

The case study and descriptive pilot data provided were approved by the BLINDED Institutional Review Board. All participants provided consent for their data to be included in scientific research and their related products.

*All names presented in this publication have been changed for privacy.

Data Availability:

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Abstract

Experiences of maltreatment, caregiver transitions, and other forms of chronic stress in early childhood have been related to an increased likelihood of health and mental health disorders. Despite having a number of well-developed and validated therapeutic options for fostered and adopted children, families are often overwhelmed by their child's multiple health needs and have a difficult time accessing care. This case report describes a 2-year old female child in foster care who took part in a multidisciplinary program for fostered and adopted children ages 0 to 5 years old. This family's experience highlights that patients can receive streamlined evaluations, short-term therapeutic interventions, and long-term service recommendations by providing families with a single point of contact in an integrated care setting. This approach decreases the time burden placed on parents, increases the effectiveness in understanding and addressing a child's needs, and improves family and provider collaboration. Further, models of integrated care reduce the likelihood of misdiagnosis. Many symptoms of early childhood adversity and attachment disorders can present like other common mental (i.e., Autism Spectrum Disorder) and physical disorders (i.e., motor delays). Misdiagnosis can lead to recommendations that are ineffective or ultimately harmful to children with experiences of trauma. Given the range of general and mental health effects of multiple housing transitions, maltreatment, and/or neglect, this case underscores how a team approach is invaluable for promoting at-risk young children's wellbeing and development.

Keywords: Foster Care; Adoption; Mental Health; Early Childhood; Integrated Care

Introduction

Over 443,000 children were involved in the foster care system in the United States during 2017 (Child Trends Databank, 2019). Children under the age of five are the largest group within foster care (~41%, N = 183,959; Child Trends Databank, 2019). Almost all children involved in these systems have experienced multiple transitions, maltreatment, and/or neglect. Many have also experienced malnourishment, pre-and post-natal substance exposure, premature birth, and exposure to infectious diseases. Environmental stress, bodily harm, and illness in early childhood can carry consequences for physical and mental health functioning across the lifespan (Cicchetti & Handley, 2019; Malionsky-Rummel & Hansen, 1993; Smith & Thornberry, 1995; Vachon, Krueger, Rogosch, & Cicchetti, 2015; Anda et al., 2006). Given the medical complexity of foster children, multi-disciplinary care models, including medical providers, mental health specialists, public health nurses, social workers, and occupational therapists (OT), are essential.

The purpose of this paper is to highlight the experience of a 2-year old female in foster care with a program that integrates early childhood mental health therapeutic consultation with a unique multidisciplinary medicine program for fostered and adopted children. We will, 1) illuminate the need for new ways for fostered and adoptive children under five to engage with health, mental health and other services, and 2) highlight an early mental health therapeutic consultation protocol within a pediatric setting. Ultimately we aim to motivate the development of this and similar programs across the United States to better serve young children facing threats to their life long trajectories of mental and physical illness due to early experiences of adversity.

Early Childhood Mental Health Evaluation in an Interdisciplinary Pediatric Team

Multiple housing transitions, maltreatment and/or neglect can be related to a range of medical, developmental, and emotional symptoms, with treatments located outside of the sphere of early childhood psychological intervention. Early childhood experiences of abuse and neglect have been linked to cardiovascular concerns, sensory processing disorders, failure to thrive, and chronic infections associate with immune system dysfunction (Anda et al., 2006; Felitti et al., 1998). Malnutrition, often associated with experiences of neglect, can have a detrimental impact on a child's development trajectory if left unaddressed – including an increased risk for cardiovascular and metabolic disease in adulthood (Campbell et al., 2014), lower IQ scores in early adolescents (Liu et al., 2003), and micronutrient deficiencies that cause irreversible alterations to brain development (Monk et al., 2013).

While physicians in the United States are typically underprepared to address mental health ramifications of early childhood trauma, mental health providers similarly lack the training to fully conceptualize a child's necessary medical interventions for their physical health needs. Due to this increased medical complexity for children who have faced early adverse experiences, it is invaluable to have a team approach that addresses concerns and efficiently rules out multiple etiologies for symptoms.

Further, many mental health symptoms related to trauma or attachment disorders can present like other common early childhood disorders. This may be difficult for providers without specialized training in early childhood trauma and attachment disorders to accurately determine the appropriate diagnosis. Misdiagnosis can lead to recommendations that are ineffective or ultimately harmful to children with experiences of trauma. For example, Autism Spectrum Disorder (ASD), trauma-related disorders, and attachment disorders have a similar profile of symptoms in early childhood. This includes delayed speech, delayed social cueing, difficulties with attention, and self-harm behaviors. However, for



Photo: Adobe Stock.

children with experiences of neglect, clinicians would recommend trauma-informed treatments focused on building attachment relationships and stability. For children with ASD, more behavioral oriented approaches would be recommended to target the growth of specific social skills. An ASD diagnosis for children with a trauma-related or attachment disorder could further disturb the child's developmental trajectory by delaying appropriate services that focus on bolstering the child's relational needs.

Access to Care and Therapeutic Consultation

Early childhood interventions that address parent-child attachment for children who have experienced early trauma have shown efficacy in reducing children's negative behavioral and emotional outcomes (Reyes et al., 2017; Dozier et al., 2017; Cohen et al., 2000). However, a large number of children facing adversity do not ever receive the benefits of early interventions (Hartinger-Saunders et al., 2019). Specialty pediatric care settings that work with early mental health providers and their state's department of human services have the unique opportunity to dramatically increase the likelihood that children who are at risk are identified and receive evidence-based interventions. However, to our knowledge, there are no standardized protocols, on how to incorporate early mental health and relationship-based evaluations into pediatric specialty care. This paper aims to highlight the benefits of a cross-systems integrated

care model for addressing mental health concerns among young children in foster and adoptive care.

In the United States, foster care and adoption legislation is determined by the State. In Minnesota, children in foster care have a case review hearing 90 days after a child's removal from parental care. After the court reviews the parent's progress on their case plan, there may be a 6-month extension on the child's foster care placement. Once a child has been in foster care for 12 months, the court will file a petition to decide on a permanency plan. Children in foster care can be adopted when their birth parents sign a voluntary consent, after which they have a ten-day period to change their mind. Children may also be made available for adoption through a court procedure to end parent rights. Birth parents have 20 days to appeal the court's order.

Method

The Adoption Medicine Clinic (AMC) at the University of Minnesota has been evaluating internationally adopted children since 1986 and in the past decade has focused on providing more services for children who have been domestically adopted or are in foster care. Funded by a grant from the Minnesota Department of Human Services the clinic has incorporated specialists into pediatrician visits, including psychology, OT, pediatric/public health nurses, and genetic counseling to address the far-reaching effects of early childhood adversity on physical and psychological functioning.

In 2019, approximately 48% (N = 188) of the population seen by AMC were children 5 years old or younger and were noted to have high rates of behavioral and emotional difficulties. Throughout 2019 and the beginning of 2020, the program spent large amounts of time doing community outreach to create partnerships and referral pathways. The program encouraged social workers across the state to refer young children and their foster families to the AMC for integrated care. All data and the case review were collected via chart review and approved by the University of Minnesota Institutional Review Board. At the onset of visits to the AMC, foster parents were provided with consents by check-in staff to choose to include their clinical information in research.

Early Childhood Mental Health Therapeutic Consultation Program Description

The over-arching goal of integrating the Early Childhood Mental Health Evaluation Protocol into AMC was to identify young children who are at high risk for long term mental health difficulties and displacement from their current foster or adoptive home. The mental health portion of the evaluation protocol consists of three components by which children are screened for (1) prenatal and postnatal experiences of trauma, (2) current behavioral, social, cognitive, and emotional concerns, as well as (3) current service access. In addition to the evaluation, the service includes referrals and a tailored psychoeducational intervention.

The first component of the evaluation consists of collecting information on pre and post-natal experiences of adversity. Prenatal risk factors can include the biological parent's level of stress, access to prenatal care, prenatal substance use, and genetic liability for psychopathology. Postnatal risk factors for this population often include neglect, abuse, chronic mobility, food insecurity, and multiple separations or transitions from primary caregivers. We identify the duration and age of these experiences in order to integrate a developmental framework that considers how the developmental timing and duration of these experiences could affect functioning. The clinician utilizes a standardized traumatic event screening form to identify risk for post-traumatic stress

disorder as well as the Disturbances of Attachment Interview (Smyke & Zeenah, 1999) which inquiries about symptoms of Reactive Attachment Disorder and Disinhibited Social Approach Disorder (DC:0-5; Klaehn, 2018).

The second component of the evaluation is collecting information on the child's mental and behavioral health difficulties. Information is gathered via medical chart review, foster parent interview, and behavioral observations in the clinical setting. Providers review the child's previous psychological evaluations and diagnoses. Clinicians complete a foster parent interview assessing the child's developmental trajectory and the formation of their current attachment relationship using the Disturbances of Attachment Interview (Smyke & Zeenah, 1999).

Mental health providers then observe child behavior in the context of a medical and occupational therapy exam. The observation protocol is designed to help mental health providers identify children's difficulties in cueing distress elicited by the exam, using foster or adoptive parents for emotion regulation and support, as well as indiscriminate friendliness with unfamiliar medical staff. Mental health providers observe the parent-child relationship (Crowell, 2003; Cooper, Hoffman, Powell, & Marvin, 2011). The observation protocol captures a snapshot of how foster and/or adoptive parents attend to children's distress and how, they provide structure, guidance and direction to their children. Children lacking a caregiver with these skills are the most likely to experience high levels of maladjustment related to early experiences of risk. Consistent and responsive caregiving has been shown to act as a buffer between young children and their environment, preventing the negative consequences of stress on mental and physical health (Johnson et al., 2018; Measelle & Albrow, 2018; Liberman et al., 2004).

At the end of the exam, mental health providers review the foster parent and/or adoptive parents' concerns and goals for the child's mental health, and evaluate if there are any risks for these foster/adoptive parents requesting the child be removed from their current placements. Child placement instability has been related to a host of emotional, behavioral and developmental difficulties in children (Fisher et al., 2016). Unfortunately, many states have a high rate of foster care placement instability (U.S. Department of Health and Human

Services, 2014). Foster parents who are at risk for requesting that children be moved to a different placement often have young children with high medical, behavioral, and emotional needs. Research suggests that children with more trauma symptoms are at an increased risk for foster care displacement (Clark et al., 2020). During the interview, foster/adoptive parents at risk often highlighted feeling exhausted by the child's needs, feeling as if they do not have the skill set to help the child, and feeling like they don't have the resources to identify those skills. Through our work, we have found it to be really important and impactful to have a candid discussion with foster parents about any of these concerns. Many foster parents were very grateful to have a space to talk through these concerns without judgement.

The third component of the evaluation consists of reviewing the child and their foster/adoptive family's current service utilization and needs. This involves reviewing if full developmental assessments using the DC:0-5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood have been completed as well as what mental health services the families may be using. In evaluating current mental health services, we review families' satisfaction with those services as well as provide recommendations for evidence-based interventions and providers with whom those interventions can be accessed. Families then receive a brief educational therapeutic consultation, based on our conceptualization of the child's current functioning and history. Foster/adoptive parents are provided with information on how to best emotionally and behaviorally support children's development in the context of their early adverse experiences. Most foster/adoptive parents receive educational information based on the Circle of Security (Zanetti et al., 2011) as well as in the moment feedback during the end of the session based on the Attachment Biobehavioral Catch-Up protocol (Dozier et al., 2017). We also discuss ways young children signal distress and ways foster/adoptive can help buffer those responses.

Young children who are identified as high-risk for placement disruption or long-term mental health difficulties are referred for a full mental health evaluation (using the DC:0-5™) and trauma-informed as well as relationship-

centered evidence-based treatment. Children that need immediate intervention and care because their current level of dysfunction is a risk for their wellbeing receive rapid access to a one to three session brief intervention while they wait for longer-term therapeutic options to become available.

Rationale for a Case Study

We chose to highlight Anna's* participation in our program as a case study for multiple reasons. First, there is limited knowledge on the feasibility of integrated care consultation models for young children in foster care. We will highlight how a common point of contact can increase high-risk children's access to appropriate and timely early intervention services. Relatedly, we hope to use this case to highlight the medical complexity of these young foster care children and hope to support program and policy development. Third, many of these children are at risk for experiencing multiple foster-care placements. Multiple placements have been related to increased maladaptive functioning (Lloyd & Barth, 2011). We hope to use this case to highlight how providing consultations services, short term emergency care, and facilitating the prioritization and referrals to community services, integrated care settings like these may decrease the likelihood of multiple placements.

Case Background

Anna is a 2-year 8-month-old Black female who presented to the AMC. Anna was accompanied by her foster mother Rachel*, who was interested in gaining a better understanding of Anna's behaviors and wanted to learn additional techniques to help support her development. Rachel described Anna as bold, talkative, active, and loving. Rachel had an initial interest in adopting Anna, but had concerns about her ability to provide long term care due to Anna's many medical and emotional needs.

Based on a medical record review and foster/adoptive parent interview, Anna was prenatally exposed to marijuana, cocaine, and alcohol. Anna's biological mother experienced homelessness and engaged in sex work while pregnant. Anna's biological mother has a history of substance use, an anxiety disorder, and depression. Anna was born at 36 weeks gestation via cesarean section due to maternal preeclampsia. At birth Anna

weighed 3 lbs. and spent one week in the neo-natal intensive care unit due to her low birth weight. At birth, she had Δ 9-tetrahydrocannabinol (THC) in her system and was potentially exposed to a Sexually Transmitted Disease. As a young infant, Anna was reported to have spent time with various caregivers for extended periods of time while under her biological mother's care and experienced residential mobility. At 10 months, Anna had a documented emergency room visit after reportedly being dropped by her biological mother. At 11 months, she was removed from her biological mother's care due to concerns for neglect and placed with her current foster family. At placement, Anna was malnourished – weighing only 11 lbs. – and was diagnosed with failure to thrive. Since being placed with her foster parent, Rachel reported multiple ear infections but otherwise noted that Anna had appeared to be medically healthy. At the time of the AMC visit Anna was living with her two foster parents, her biological sister (1-year-old), and three foster siblings (9, 5, and 2 years old). Anna did not have any contact with her biological mother or father since being in foster care.

At the initial foster care placement, Anna displayed flat affect and was socially uninhibited. At the time of evaluation, Anna displayed extreme difficulties with separating from her foster parents, often refused food, and had no independent self-soothing behaviors. Anna and Rachel had previously engaged with play therapy, but Rachel reported that it seemed to make Anna's symptoms worse. Rachel noted high levels of intense meltdowns after play therapy sessions as well as regression in her toileting abilities. Due to these symptoms, they ceased services. Over the few months leading up to the appointment, Anna displayed high-intensity distress and anger at home and appeared inconsolable. In order to manage Anna's emotional and behavior needs, Rachel took 6 months off of work and sent Anna's 1-year old biological sister and foster siblings to daycare. This was a challenging experience financially and emotionally for Rachel and the other children. Additionally, there were concerns with sensory processing, speech development, and muscle reflex issues. Anna covered her ears during loud noises, displayed freezing behaviors in new or unfamiliar situations, and had a hard time with zippers and putting clothes on.

Implementing the Early Childhood Mental Health Therapeutic Consultation Protocol

Anna and her foster mother spent an hour with our multi-disciplinary team of occupational therapist, nurses, medical doctors and psychologists. All team members were present for the duration of the visit. Results of the medical exam noted generalized muscular weakness, vitamin D insufficiency, iron deficiency, and tonsillar hypertrophy. Anna was prescribed a series of vitamin supplements. The experience of traumatic stress and micro-nutritional deficit prenatally and in early childhood may cause an altered vitamin D metabolism in children (Terock et al., 2020). Further, iron deficiency – also related to micro-nutritional deficits – can worsen for children directly in proportion to the amount of rapid post-placement growth (Fugelstad et al., 2008). Both nutritional issues have been related to numerous long-lasting developmental and cognitive deficits (Doom et al. 2014; Terock et al., 2020).

Due to prenatal exposure to substances, the medical team assessed Anna for the facial features of prenatal alcohol exposure. Her facial feature measurements were not consistent with those seen in children with Fetal Alcohol Spectrum Disorder. The occupational therapy team noted a speech delay and slight sensory processing difficulties on their developmental screening. They recommended a full assessment with a speech language therapist.

In Visit Observations

The mental health team observed Anna's interactions with her primary caregiver, Rachel, and her emotional reactivity/regulation during novel situations. During the visit, Anna started by cuddling into her foster mother and was not interested in exploring the toys in the room. Throughout the hour Anna became increasingly more interested in the toys and displayed more positive emotions. Anna looked to her foster mother for support when she was unsure of toys or new people. Her mother provided comfort as well as acknowledged and validated her emotional expressions (both positive and negative). Anna appeared to experience her foster mother as an emergent secure attachment figure. However, Anna appears to have a difficult time relying on Rachel to

provide support when she became distressed. At those moments Anna would appear to freeze in the middle of the room. Anna appeared to become particularly distressed and cover her ears if she believed something would make a loud noise. Observations of Anna suggested that she was developmentally delayed in her fine motor movements, and speech. Anna also demonstrated potential delays in social-emotional development.

Mental Health Treatment and Therapeutic Outcomes

At the end of the initial visit, the mental health provider engaged in a short educational intervention, using augmented protocols from the circle of security program (Zanetti et al., 2011). We described the impact of children's trauma on development and highlighted the ways Anna's trauma was playing out in her relationship with Rachel. Trained Circle of Security providers (<https://www.circleofsecurityinternational.com/trainings/about-trainings/>) introduced the circle and being with Anna on the circle. The provider and Rachel practiced identifying when Anna was on the top or bottom of the circle over the course of the medical exam. The mental health team referred Anna to receive a full DC:0-5 screening from our team and engaged with two brief emergency intervention sessions to build Rachel's skills on identifying when Anna was experiencing distress and how to help soothe that distress. The team also assisted Rachel in setting up respite caregiving services. Anna was referred to and subsequently engaged in early childhood day-treatment therapy services. Rachel also engaged with a circle of security group through our partner community clinics. Outside of the mental health and medical interventions described above, Anna received OT services for her speech and sensory concerns. At a follow-up appointment approximately one year later with AMC, Anna was still placed with the same foster family. They reported that many of the interventions helped reduce Anna's symptoms and that they are hoping to move forward with adoption.

Piloting the Early Childhood Mental Health Evaluation Protocol

In the pilot of the evaluation protocol that Anna took part in at the AMC, there were 105 children like Anna seen by the clinic team in the span of ten months. Children ranged from 0.7 to 71 months of age and were 41.38 months on average. They were 43.3% female and 72% (n = 75) of the children were in foster care. There were thirty-one domestically adopted children and twenty children adopted internationally. Of those adopted internationally, fourteen had experiences of institutional care. On average children experienced 2.35 transitions, but this ranged from one transition to seven. Children were 10.61 months old on average at their first primary caregiver transition, and children were 24.49 months at their most recent transition. All children had experienced some form of neglect or abuse, with the most common experience being parental drug use (n = 49 parental drug use; n = 64 prenatal drug exposure; n = 43 prenatal alcohol exposure). Of the children seen at the clinic, 21 experienced physical abuse, 19 witnessed domestic violence, and 36 experienced neglect.

Approximately 68% (n = 71) of primary caregivers noted behavioral, social, or emotional concerns for their children at the onset of the visit. Concerns included failure to thrive, broad developmental delays, sleep difficulties, feeding difficulties, high amounts of emotional distress and difficulty soothing. Clinical observations noted that 24% (n = 25) of children exhibited maladaptive stress behaviors. However, the vast majority of children sought and received comfort from their caregivers effectively (n = 82; 79%). There were five children who exhibited significant levels of indiscriminate friendliness by clinician observation.

Only 32% (n = 23) of these children were accessing psychological services at the time of their visit, and 29% (n = 30) of all children had seen a neuropsychologist. Three of those receiving neuropsychological evaluations were based in DC:0-5 protocols (2016). DC:0-5 evaluations review the development and functioning of young children in the context of their relationship with caretakers and other environmental inputs such as traumatic events. Of the children who had caregiver reported

emotional and behavioral concerns or exhibited difficulties in the clinic, six were referred for an immediate consultation or brief therapeutic interventions with the early childhood mental health team.

At the time of this manuscript, four of those referrals have been fulfilled. Of the two whose referral has not been fulfilled, one lived out of state and the other is unknown. Further, twenty-six individuals were referred for a full mental health assessment with our team and eleven of those have been fulfilled. Many families traveled to the clinic from multiple hours away and either preferred to see a provider closer to them and/or we also recommended they could receive services from a member of the community closer to their homes. We recommended that forty-eight children (46.7%) receive a trauma-informed diagnostic assessment and pursue evidence-based therapeutic treatment.

Conclusions and Clinical Recommendations

We found that social, emotional, and behavioral concerns are highly prevalent and a central concern for foster care and adopted children (Measelle & Ablow, 2018; Shonkoff et al., 2012). These concerns often present in addition to the many medical symptoms that foster children are experiencing. Working with an interdisciplinary collaborative team can offer the opportunity for an efficient consideration of other etiologies for behavior and intervention programs to address sensory, physical, genetic, or neurodevelopmental issues. In Anna's case, she was able to benefit from all aspects of these interventions including medical interventions for micronutrient deficiencies, as well as OT services. Collaborative consultation programs lower the amount of time families spend going to appointments as well as the time demands on providers. This is particularly a positive for families who live in rural communities, who have to travel far distances to receive care. It is essential to not only provide recommendations but also explicitly state how families should prioritize these recommendations. Anna needed help to first address her emerging attachment relationship with Rachel in addition to her immediate medical concerns. Following these services, additional pediatric rehabilitation and

sensory-based interventions were effectively introduced.

Collaborative environments should create access points to care while also decreasing the strain of accessing care on families who are balancing the many needs of their children. Potential community mental health referrals should be located in a convenient location for families and operate under a developmental and trauma-informed lens and offer evidence-based treatment. Creating referral lines and professional relationships with community clinics that provide this care was an element central to this program's success.

However, we also found that for cases like Anna's it is essential to have opportunities for immediate longer therapeutic sessions with a mental health provider. Many families seeking our care are families currently in crisis where children are facing potential long-term harm to their developmental trajectory. This includes highly distressing child symptoms such as self-harm behaviors or those that are highly challenging for caregivers to manage and who are at risk for placement disruption due to these symptoms.

Integrated care settings that specialize in foster and adoptive care experiences in early childhood could greatly reduce the probability that children will sustain long term consequences of early childhood stress. This case study demonstrated the feasibility and need for these services. Future work should evaluate if access to multiple service providers in one meeting decreased the number of appointments for those children and if it increased knowledge, and access to appropriate therapeutic care for families. Further, studies should evaluate if access to therapeutic care reduces the child's likelihood of foster care displacement.

References

- Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C. H., Perry, B. D., Dube, R., & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience*, 256(3), 174-186.
- Campbell, F., Conti, G., & Heckman, J. (2014). Early childhood investments substantially boost adult health. *Newsletter - Science / Universität Stuttgart*, 343, 1478-1485.
- Child Trends (2019, May). *Foster Care*. <https://www.childtrends.org/?indicators=foster-care>
- Cicchetti, D., & Handley, E. D. (2019). Child maltreatment and the development of substance use and disorder. *Neurobiology of Stress*, 10, 100144. doi:10.1016/j.ynstr.2018.100144
- Clark, S. L., Palmer, A. N., Akin, B. A., Dunkerley, S., & Brook, J. (2020). Investigating the Relationship between Trauma Symptoms and Placement Instability. *Child Abuse & Neglect*, 108, 104660. doi:10.1016/j.chiabu.2020.104660
- Cohen, J. A., Mannarino, A.P., Berliner, L., & Deblinger, E. (2000). Trauma-Focused Cognitive Behavioral Therapy for Children and Adolescents. *Journal of Interpersonal Violence*, 15(11), 1202-1223. doi:10.1177/088626000015011007
- Crowell, J. A. (2003). Assessment of Attachment Security in a Clinical Setting: Observations of Parents and Children. *Journal of Developmental & Behavioral Pediatrics*, 24(3), 199-204. doi:10.1097/00004703-200306000-00012
- Doom, J. R., Gunnar, M. R., Georgieff, M. K., Kroupina, M. G., Frenn, K., Fuglestad, A. J., & Carlson, S. M. (2014). Beyond Stimulus Deprivation: Iron Deficiency and Cognitive Deficits in Postinstitutionalized Children. *Child Development*, 85(5), 1805-1812. doi:10.1111/cdev.12231
- Dozier, M., Bernard, K., Roben, C. K. (2017) Attachment and biobehavioral catch-up. In H. Steele & M. Steele (Eds.), *The Handbook of Attachment-based Interventions*. (27-49). The Guilford Press. New York
- Egger, H. L., & Angold, A. (2006). Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. *Journal of Child Psychology and Psychiatry*, 47(3-4), 313-337. doi:10.1111/j.1469-7610.2006.01618.x
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & 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.
- Fisher, P. A., Leve, L. D., Delker, B., Roos, L. E., & Cooper, B. (2016) A developmental psychopathology perspective on foster care research. In D. Cicchetti (Ed.), *Developmental psychopathology* 3rd ed., (pp. 513- 548). New York, NY: Wiley.
- Fuglestad, A. J., Lehmann, A. E., Kroupina, M. G., Petryk, A., Miller, B. S., Iverson, S. L., ... Georgieff, M. K. (2008). Iron deficiency in international adoptees from Eastern Europe. *Journal of Pediatrics*, 153, 272-277. doi:10.1016/j.jpeds.2008.02.048
- Gadow, K. D., Sprafkin, J., & Nolan, E. (2001). DSM-IV Symptoms in Community and Clinic Preschool Children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40(12), 1383-1392. doi:10.1097/00004583-200112000-00008
- Hartinger-Saunders, R. M., Jones, A. S., & Rittner, B. (2016). Improving Access to Trauma-Informed Adoption Services: Applying a Developmental Trauma Framework. *Journal of Child & Adolescent Trauma*, 12(1), 119-130. doi:10.1007/s40653-016-0104-1
- Johnson, A. B., Mliner, S. B., Depasquale, C. E., Troy, M., & Gunnar, M. R. (2018). Attachment security buffers the HPA axis of toddlers growing up in poverty or near poverty: Assessment during pediatric well-child exams with inoculations. *Psychoneuroendocrinology*, 95, 120-127. doi:10.1016/j.psyneuen.2018.05.030
- Klaehn, R. L. P. (2018). DC:0-5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. *Infant Mental Health Journal*, 39(4), 489-491. doi:10.1002/imhj.21714
- Lavigne, J. V., Gibbons, R.D., Christoffel, K. K., Arend, R., Rosenbaum, D., Binns, H., Dawson, N., Sobel, H., & Isaacs, C. (1996). Prevalence Rates and Correlates of Psychiatric Disorders among Preschool Children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(2), 204-214. doi:10.1097/00004583-199602000-00014
- Lieberman, A. F. (2004). Traumatic stress and quality of attachment: Reality and internalization in disorders of infant mental health. *Infant Mental Health Journal*, 25(4), 336-351. doi:10.1002/imhj.20009

- Liu, J., Raine, A., Venables, P., Dalais, C., & Mednick, S. (2003). Malnutrition at age 3 years and lower cognitive ability at age 11 years. *Archives of Pediatrics & Adolescent Medicine*, 157, 593-600.
- Lloyd, E. C., & Barth, R. P. (2011). Developmental outcomes after five years for foster children returned home, remaining in care, or adopted. *Children and Youth Services Review*, 33(8), 1383-1391.
- Malinosky-Rummell, R., & Hansen, D. J. (1993). Long-term consequences of childhood physical abuse. *Psychological Bulletin*, 114(1), 68-79. doi:10.1037/0033-2909.114.1.68
- Measelle, J. R., & Ablow, J. C. (2017). Contributions of early adversity to pro-inflammatory phenotype in infancy: the buffer provided by attachment security. *Attachment & Human Development*, 20(1), 1-23. doi:10.1080/14616734.2017.1362657
- Reyes, V., Stone, B. J., Dimmler, M. H., & Lieberman, A. F. (2017). Child-Parent Psychotherapy: An Evidence-Based Treatment for Infants and Young Children. *Evidence-Based Treatments for Trauma Related Disorders in Children and Adolescents*, 321-340. doi:10.1007/978-3-319-46138-0_15
- Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., McGuinn, L., Pascoe, J., Wood, D. L., Committee on Psychosocial Aspects of Child and Family Health and Committee on Early Childhood, Adoption, and Dependent Care. (2012). The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics*, 129(1), e232-e246. doi:10.1542/peds.2011-2663
- Smith, C., & Thornberry, T. P. (1995). The relationship between childhood maltreatment and adolescent involvement in delinquency. *Criminology*, 33(4), 451-481.
- Smyke, A. T., Zeanah C. (1999) Disturbances of attachment interview. *Unpublished manuscript*.
- Terock, J., Hannemann, A., Van der Auwera, S., Janowitz, D., Spitzer, C., Bonk, S., ... Grabe, H. J. (2020). Posttraumatic stress disorder is associated with reduced vitamin D levels and functional polymorphisms of the vitamin D binding-protein in a population-based sample. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, 96, 234-238. doi:10.1016/j.pnpbp.2019.109760
- U.S. Department of State. (2020, February). *Adoption Statistics*. https://travel.state.gov/content/travel/en/Intercountry-Adoption/adopt_ref/adoption-statistics1.html?wcmmode=disabled.
- U.S. Department of Health and Human Services (2014). *Preliminary estimates for FY 2013. Administration on children, youth and families, children's bureau*. Retrieved at www.acf.hhs.gov/programs/cb.
- Vachon, D. D., Krueger, R. F., Rogosch, F. A., & Cicchetti, D. (2015). Assessment of the harmful psychiatric and behavioral effects of different forms of child maltreatment. *JAMA psychiatry*, 72(11), 1135-1142.
- Zanetti, C. A., Powell, B., Cooper, G., & Hoffman, K. (2011). The circle of security intervention: Using the therapeutic relationship to ameliorate attachment security in disorganized dyads. In J. Solomon & C. George (Eds.), *Disorganized attachment and caregiving* (p. 318-342). The Guilford Press. New York

Contemplating Help-Seeking in Perinatal Psychological Distress: A review

By Minna Sorsa, RN, PhD, Tampere University, Finland

In a recent paper, Minna Sorsa, Jari Kylmä and Terese Bondas report findings of their study that details the existing state-of-art regarding mothering and help-seeking.

A socio-cultural lens on mental health

Mental health and help-seeking are significantly determined by social and cultural factors. The question about the meaning of the social relationships or an individual's opportunities to make informed choice are utterly different within the different global healthcare and social care system's resources.

Perinatal psychological distress

The authors used the concept "*perinatal psychological distress (PPD)*" as an umbrella term for depression, distress and anxiety, during the time of pregnancy and the 1st year in a child's life. Depression, stress or anxiety are experienced by 21%- 27% of the mothers (Obrochta, Chambers, & Bandoli 2020).

Socio-cultural help-seeking theories

Help-seeking theories conceptualize this period prior to accessing services as non-formal help-seeking from families, friends and network, as distinct from formal help-seeking in regard to officially funded and existing services (Rickwood & Thomas, 2012). Holly Hadfield and Anja Wittkowski found in their study of depressive mothers a stage of early help-seeking, when women seek informal support from friends, family, and the Internet; in this stage, women recognize that something is wrong, but they do not yet seek help (Hadfield & Wittkowski 2017). A challenge is that women may not seek help, even though perinatal services would have been developed and be available. Additionally, women may choose not to disclose their problems.



Photo: Adobe Stock.

Help-seeking as a decision-making process: An existential phenomenology approach

Help-seeking viewed as a decision-making process emphasizes the assumption that people are active and goal-directed and that they fulfill instrumental purposes by seeking help from somebody, such as for specific mental health concerns (Rickwood & Thomas, 2012). On the contrary, the authors used an approach of existential phenomenology (the philosopher Lauri Rauhala, 1983), who posited that experiences are labeled according to the meaning given to specific situations within the individual life situation. Further, they used meta-synthesis originating in meta-ethnography, as developed by Noblit and Hare (1988), and they followed the eMERGe guidelines, which provide recommendations for conducting and reporting of meta-ethnography (France et al, 2019).

Contemplating help-seeking

By integrating and synthesizing knowledge of women's experiences of contemplating seeking help for PPD the authors identified seven themes

and a metaphor in a lines-of-argument synthesis, showing that contemplating help-seeking is a multidimensional phenomenon.

Women with PPD may not recognize an illness, perceive a need, name a disorder, or search for suitable care providers.

Women may not view their life situation as a barrier to care, but rather try to manage their life situation in the best possible way.

Women wanted to be sensitive toward their family members: this might lead to a lack of open discussion in the family or women not wanting to upset family members.

Given that women seem to want to protect their loved ones and are sensitive to critique, the authors write, that societal stigma around mental illness may be especially harmful. Shame and guilt of mental ill health can be formed

by existing societal norms of being “supermoms”.

Therefore, it is essential to develop information and provide education for society around mental health-related questions and make such information available for women by pregnancy at the latest.

Mothers with PPD lacking shared experiences need an especially sensitive and appreciative manner of encouraging and enhancing reflection, possibly supporting the close relatives.

If the health care practitioners (HCPs) recognize the phase of contemplating help-seeking, HCPs can address women's concerns seriously prior to clients accessing services. Existing strategies and recommendations on perinatal mental health issues would benefit from the micro perspective, as women can only be helped by services if they themselves are willing to participate and share their lifeworld with those helping them in the services.

A clinical implication to improve practice, policy, and service user outcomes in health and other fields is that service providers should work with outreach and develop tools to connect with these mothers. Another suggestion is to improve training in mental health literacy prior to or during pregnancy. Also, the father perinatal distress should be considered of relevance, as the main actors within families are the loved ones. Identification of solutions at an earlier stage might improve the intake of formal support, since about half of the women experiencing PPD may not seek help without extra support.

Reflections

What does this mean for mothers with their babies, for babies and for the family of women in perinatal psychological distress?

How does this relate to the baby's wellbeing, parent-child relationships, and the family context?

“Infant mental health” refers to how well a child develops socially and emotionally from birth to three (Zero to Three 2021). Infants grow

in relationships with their carers. We know from research that perinatal psychological distress is associated with a number of poor outcomes for the mother, baby, and family. The parenting capacities, that may put infants at risk of adverse childhood experiences are experienced in everyday life situations within the family. Being very tired all the time, feeling overwhelmed by emotions and mood changes, such as dwelling in anxiety, being irritated, frustrated or angry may impact the way the mother connects with the new-born baby, and how parenting capacities can be used. As the everyday caring environment has an impact on infant mental health, it is of vital importance that the families have support available.

Infant mental health is ideally formed in caring attachment relationships, perinatal psychological distress may challenge the formation of relationships. Help-seeking theories in mental health (Rickwood & Thomas, 2012) have revealed, that women may try to first solve their problems by themselves or with the help of family. The meta-synthesis showed, that seeking help from official sources may be the next best choice.

Yet, scientifically sound services with a family-centred and infant-centred approach may not have the outreach tools that these families could utilise. The suggestion is to develop earlier service forms, which may include wider ecosystems of care, mental health literacy and cultural questions.

New families with perinatal psychological distress may not recognize themselves being at risk, or being in need of help. This is something that care providers may not know. Therefore the early help-seeking phase is utterly important and brings a development need to outreach, early, preventive and even health promotion pursuit and strategies. In order to prevent and treat the mental health problems of very young children and their families, outreach development is needed, which requires scientific studies, and implementation of knowledge of the best existing practices of care.

Can the real stories of everyday life be used as basis of best practices?

The review questions based on the micro-level, the individual perspective, lift up new questions. Could and should the real stories of everyday life be used as basis of best practices? It could be an aspect of interest as it is a way to explore the baby connection with the wider relationship network in everyday life. From the help-seeking perspective the micro-level may mean that tiny instances within the service may be the reasons for the family interpretation of their formation of relationships with the services. An utterly sensitive and appreciative approach will be required by staff so that families would not drop out of care even before they start using services.

The women in the meta-synthesis experienced ambiguity, shame and guilt, and a contrast to ideals of family life. Maternal mental health intersects with infant mental health, which has implications for services. A phase of connections, of starting to work, of engagement within the services, may be required prior to clinical interventions that have been demonstrated to address attachment security in this context (such as Child-Parent Psychotherapy) taking place.

A challenge may be that services may have a focus either on parental psychological distress, or the well-being of babies, whereas a family-centred approach yields even more problematic questions. The promotion and protection of babies occurs in their primary relationships in their families. Therefore a system of care that pays attention to parental mental health needs, as well as the risks posed by failing to bring care to families who are struggling is warranted. A wider systems approach addressing babies' needs for responsive and sensitive caregiving and secure relationships with primary caregivers is needed.

Challenges in the incorporation of best practices in the wider system of care, are formed by the intention to develop seamless practices. On the other hand, the comprehension of the steps the families take prior to accessing services are not well known. Developing these steps are supported by the aims of the requirements for the promotion of infant mental health:

"Dissemination of scientific knowledge about services for care, intervention and prevention of mental disorder, and impairment in infancy."

"The dissemination of evidence-based knowledge about ways to support the developmental transition to parenthood, as well as the healthy aspects of parenting and caregiving environments."
(WAIMH, 2021)

These aims support taking into account multiple perspectives in strategic planning, incorporating the family insider viewpoint, and everyday life practices.

These findings matter to infant mental health – to babies in their primary relationship/s in their family.

Since families will try to solve their problems at an earlier stage, perhaps each person, who connects with a family enduring perinatal psychological distress is important and a possibility with hope? The service providers are one step away from the everyday life of families, and thus effort is required to close the gap, so that families, the babies, supporting and protecting their relationships with their mums, in their family setting would be helped at an earlier stage, already during the contemplation stage of help-seeking. In many countries a natural place to start closing the gap are the well-baby clinics and the time of pregnancy.

Finally, as the perinatal period is a unique time during women's and infants' lives, the results raise further questions. For example,

1. How are women approached by professionals within health and social care services and programs?
2. What are the attitudes of staff, and how would they become aware of those? How do service providers engage with families?
3. What are the professionals' sensitivity skills?
4. How would such skills become the capacity of a wider health and social care service workforce?

Based on this research, I fully encourage infant mental health specialists to continue to rewrite the core skills to be used by any professional meeting with the families with perinatal psychological distress, so as to fully acknowledge families in their lived-experience of contemplating help seeking so as to better support them to engage in help-seeking as early as possible.

Review:

Contemplating Help-Seeking in Perinatal Psychological Distress—A Meta-Ethnography

By Minna Sorsa, Tampere, Finland, Jari Kylmä, Tampere University, Tampere, Finland, and Terese Bondas, University of Stavanger, Stavanger, Norway

Access the original article in International Journal of Environmental Research and Public Health: <https://www.mdpi.com/1660-4601/18/10/5226>

References

- France, E.F., Cunningham, M., Ring, N., Uny, I., Duncan, E.A.S., Jepson, R.G. et al. (2019). Improving reporting of meta-ethnography: The eMERGe reporting guidance. *Bmc Medical Research Methodology*, 19, doi:10.1186/s12874-018-0600-0.
- Hadfield, H., & Wittkowski, A. (2017). Women's Experiences of Seeking and Receiving Psychological and Psychosocial Interventions for Postpartum Depression: A Systematic Review and Thematic Synthesis of the Qualitative Literature. *Journal of Midwifery & Womens Health*, 62, 723–736, doi:10.1111/jmwh.12669.
- Noblit, G., & Hare, R. (1988). *Meta-Ethnography*. London, United Kingdom: Sage Publications Inc.
- Obrochta, C.A., Chambers, C., & Bandoli, G. (2020). Psychological distress in pregnancy and postpartum. *Women Birth*, 33, 583–591, doi:10.1016/j.wombi.2020.01.009.
- Rauhala, L. (1983). *Ihmiskäsitys ihmistyössä*. Jyväskylä, Finland: Gaudeamus.
- Rickwood, D., & Thomas, K. (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychology research and behavior management*, 5, 173–183, doi:10.2147/PRBM.S38707.

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Dr. (Anne) Denise Guy has been recognised in the Queen's Birthday Honours List



By IMHHAANZ Executive, New Zealand

Denise Guy is the immediate Past President of the Infant Mental Health Association Aotearoa New Zealand (IMHAANZ) and has recently been made an Officer of the New Zealand Order of Merit for services to infant mental health.

Dr. Denise Guy is a consultant Child Psychiatrist, a pioneer in the field of infant mental health (IMH), the social and emotional wellbeing of babies and young children from zero to four years. Working in this area for more than 35 years, Dr. Guy has supported the development of the IMH workforce across organisations including Naku Enei Tamariki, Whānau Āwhina Plunket, and Perinatal and IMH services in District Health Boards.

She supervises practitioners working with families and young children across areas including mental health, early intervention and early childhood education. And currently also holds teaching and advisory roles across the mental health sector.

Dr. Guy is founding Trustee of Incredible Families, which delivers programmes for parents and clinicians. From here she coordinates training in the 'Watch, Wait and Wonder Intervention', addressing problematic infant-parent relationships.

She is a founding member of IMHAANZ since 2006. As Vice President and President she developed two key initiatives, Facilitating Attuned Interactions (FAN), an internationally acclaimed model building relationships and reflective practice used by a variety of organisations, and Two Homes/Ngā Kainga e Rua which provides resources for the parents of babies and toddlers when they separate and/or live in two homes.

Message from the IMHAANZ Executive: Congratulations Denise! And thank you from all of us for your ongoing and incredibly valuable contribution to the field of infant mental health in Aotearoa New Zealand. This recognition is so very well deserved. Ngā mihi nui.

Dr. Julie Stone has been recognised in the Queen's Birthday Honours List



By Emma Toone, Australia

Dr Julie Stone of the Victorian Branch, Australian Association for Infant Mental Health (AAIMH VIC), was recently made a Member of the Order of Australia (AM) for significant service to child mental health, and to psychiatry.

Julie Stone is an infant, child and family psychiatrist with decades of experience working with and for infants and families in distress. She has worked extensively with peri-natal and child and adolescent mental health services and community-based organisations, in Australia and internationally. Julie has also taught in infant mental health, child psychotherapy and child psychiatry courses in Australia. Julie was previously awarded a Churchill Fellowship in 2000, and Australia's first Zero to Three Fellowship in 2002-2003, in recognition of her leadership and commitment to the field of infant mental health.

As a consultant, supervisor and mentor Dr Stone inspires practitioners to deepen their practice, think creatively and build leadership confidence. She has actively participated in and fostered the Victorian Branch Committee group of the Australian Association for Infant Mental Health, initiating the *Ann Morgan Prize*; facilitated the development of the Agnes Parent-Infant Unit in Gippsland, Victoria, drafting of *The Thinking Framework*; and supported the review and re-development of the Child & Adolescent Mental Health Service in Shepparton, Victoria.

Internationally, Dr Stone conceived and developed the Urthando *Doll Project* in Kwa-Zulu Natal, South Africa; consulted to the BRAC early childhood education programs throughout South Asia and psycho-social responses for displaced Rohingya children and families in Bangladesh; and lectured in the Tavistock Clinic Under 5's Short Course in the United Kingdom.

Photo: Dr Julie Stone (photo used by Perspective with permission from Dr Julie Stone)

Pedrina, Fernanda (2020): *Babys und Kleinkinder in Not. Psychopathologie und Behandlung*. Frankfurt am Main: Brandes & Apsel.

First publ. in: *Kinder- und Jugendlichen-Psychotherapie. Zeitschrift für Psychoanalyse und Tiefenpsychologie*, 2020/4, S. 534-536.

NOTE: Brandes & Apsel Verlag grants WAIMH Perspectives in Infant Mental Health to publish the English translation of the following book-review: Pedrina Fernanda 2020, *Babys und Kleinkinder in Not. Psychopathologie und Behandlung*. Frankfurt am Main (Brandes & Apsel), 2020, 346 S., 39.30 Eu, by Éva Hédervári-Heller, Berlin.

Pedrina, Fernanda (2020): *Babies and young children in distress. Psychopathology and treatment*.

With this book, Swiss psychoanalyst and specialist in child and adolescent psychiatry and psychotherapy Fernanda Pedrina has presented a comprehensive work describing psychological disorders in early childhood and their treatment. The current state of research in psychopathology and psychotherapeutic treatment of disorders in infancy and early childhood is analyzed in a differentiated and impressive manner. Topics rarely treated in the literature, such as cultural sensitivity or communicative musicality in connection with a verbal communication in early childhood, are equally discussed here and their usefulness in psychotherapeutic treatment is described.

In addition to the scientific reflection of the still relatively new field of treatment of early childhood psychopathology in the context of parent-infant/toddler psychotherapy, the author describes her own development as a psychotherapist in this field. Especially scientific work in the field of deprivation, attachment and infant research as well as the first psychotherapeutic treatments of families with infants and toddlers from the 1940s onwards had a particularly inspiring effect on the psychotherapeutic work of the author. The inclusion of the scientific findings of Rene Spitz, Donald Winnicott, Selma Fraiberg, John Bowlby, Daniel Stern, Hanus and Mechthild Papousek as well as Alicia Lieberman should be emphasized.

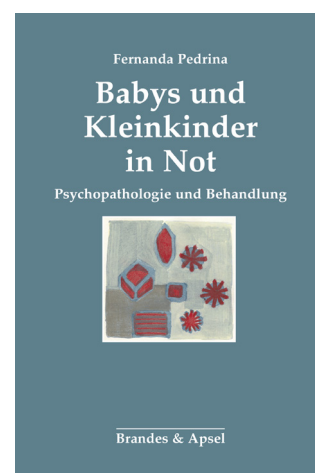
The book is divided into two parts: 1) a part with theoretical papers and 2) a

clinical part with descriptions of specific disturbance patterns in collaboration with three other co-authors (Maria Mögel, Monika Strauss and Pamela Walker).

In the first part, principles of psychotherapy in early childhood are explained on a broad theoretical basis and results from empirical research are presented. Concepts significant for understanding early childhood development such as intersubjectivity, early parent-child relationship and its disorders, symbolization and mentalization are addressed here. Theoretical discussions of parenting, child protection, migration, and culture provide an overview of the important issues that must be considered when families with infants and young children are in need. The author provides deep insights into clinical and socio-educational work, including research findings and practical experience from outpatient and inpatient treatment.

In the second part of the book, the author and three co-authors (from medical, psychological, and psychoanalytic fields of practice) address the disorder-specific findings and treatment approaches of the most common disorders according to the recently published DC:0-5 (Diagnostic Classification of Mental Health and Developmental Disorders of Early Childhood) descriptions (Zero to Three 2016). The clinical assessment according to DC:0-5 is complemented by disorder-specific interventions, to be applied in private counseling as well as in clinical and social-pedagogical professional settings in multidisciplinary collaborations with pediatric clinics or child protective services. The practice-oriented descriptions of each individual disorder are illustrated with case studies giving insight in the emotional and cognitive experience involved in therapy.

The author's therapeutic attitude and treatment approaches, which are based on psychoanalytic procedures, on her 40 years of clinical practice, as well as on the continuous study of research and clinical literature, are to be emphasized. A therapeutic attitude, which, in the sense of Winnicott, can be seen, among other things, in the appreciation of the patient, in an encounter at eye level, in creativity



or in the spontaneity of the therapeutic work, runs through all the case studies.

One of the basic treatment approaches in psychotherapeutic work with infants and toddlers is formulated by the author as follows: "The therapist must act spontaneously and is guided by the child's spontaneous gestures. In this situation, the attitude of improvisation (...) is inspiring and helpful: get on the pulse and play along, reflecting afterwards to become a better, improvising therapist with experience." (S. 34).

This excellent book is not only recommended for psychotherapists working with families with infants and toddlers, but also for professionals in the counseling and support of families with young children. The easy-to-understand and illustrative case studies from outpatient and inpatient treatments make this book a profitable and highly recommended read even for professionals who are less familiar with the theoretical concepts.

Reference

Zero to Three (2016). DC:0-5. Diagnostic classification of mental health and developmental disorders of infancy and early childhood. Washington D.C.: Zero to three.

Translated with www.DeepL.com/ Translator (free version) and adapted by Maria Mögel.



PERSPECTIVES IN INFANT MENTAL HEALTH

Perspectives in Infant Mental Health (formerly, The Signal) is a Professional Publication of the World Association for Infant Mental Health (WAIMH).

It provides a platform for WAIMH members, WAIMH Affiliate members, and allied infant mental health colleagues to share scientific articles, clinical case studies, articles describing innovative thinking, intervention approaches, research studies, and book reviews, to name a few. It also serves as a nexus for the establishment of a communication network, and informs members of upcoming events and conferences.

It is a free open access publication at www.waimh.org

During the past 50 years, infant mental health has emerged as a significant approach for the promotion, prevention, and treatment of social, emotional, relational, and physical wellbeing in infants and young children, in relationship with their parents and caregivers, in their families and communities.

Within this same time frame, the infant mental health movement has expanded to a global network of professionals from many disciplines. This infant mental health global network community of research, practice, and policy advocates, all share a common goal of enhancing the facilitating conditions that promote intergenerational wellbeing; including intergenerational mental health and wellbeing relationships, between infants and young children, parents, and other caregivers, in their communities.

The global reach of infant mental health demands attention to the cultural context in which a young child and family lives, as well as critical attention to issues that affect child development, child health, child mental health, parental mental health and early relationship development.

Invitation to contribute

We invite all members of WAIMH and WAIMH Affiliate members to contribute to Perspectives in Infant Mental Health.

Because WAIMH is a member-based organization, we invite each of you to think creatively and consider submitting an article that provides a "window on the world" of babies and their families –

In the spirit of sharing new perspectives, we welcome your manuscripts. Manuscripts are accepted throughout the year. Articles are reviewed by the Editors, all of whom are committed to identifying authors from around the world and assisting them to best prepare their papers for publication.



Full issue publication dates

Spring issue: April

Papers received by February 1 will be considered for inclusion in this issue.

Summer issue: August

Papers received by May 1 will be considered for inclusion in this issue.

Fall/Winter issue: December

Papers received by October 1 will be considered for inclusion in this issue.

Perspectives in Infant Mental Health Submission Guidelines

APA 7th Edition.

12-point font.

1.5 or double spaced.

Maximum 3000 words, including references.

All in-text citations, references, tables, and figures to be in APA 7th edition format.

Papers with tables and figures. Please submit the paper as a word-format document with separate files attached for each table and/or figure.

We welcome photos of babies and families.

All photos need to be sent in a separate file with a resolution of at least 72 pixels/inch.

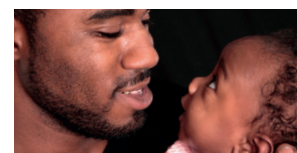
All photos need to include a permission statement from the author for WAIMH to publish the photo in Perspectives and also on WAIMH online social media platforms.

Further details:
www.waimh.org

Contact

To inquire about Perspectives in Infant Mental Health or to submit articles, please contact:

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Perspectives in Infant Mental Health: Special issue call for papers

Infant Mental Public Health Promotion and Policy: Prioritising infant mental health in public health – the why and the how

Call for expression of interest to contribute to this special issue.

We welcome interdisciplinary papers with a focus on infant mental health promotion and policy at all organisational levels with specific attention to, for example:

- Sustaining an intergenerational lens on IMH promotion and public health policy
- Barriers and enablers to IMH promotion and policy advocacy
- Approaches that work, how they work, in what context, with examples
- Context-specific case studies
- IMH and the Sustainable Development Goals (SDG's) 2030
- IMH and the social determinants of health
- Implementation of the Nurturing Care Framework 2018 (WHO)

All contributing authors will be invited to engage in a core set of reflective questions about:

- a) "how" change in the science to practice - policy translation process worked, was challenged and or compromised (no matter how small or grand), and
- b) Context-specific and possible context transferable IMH health promotion/ policy practices.

Timeline

- Call for brief abstracts (400 words) (June to December 8, 2021)
- Full paper submissions (December – February 1, 2022)
- Special issue publication: April 2022

Call for expressions of interest

400 word (max) abstract

Due date: December 8, 2021

Email header: Perspectives special issue IMH promotion and policy abstract

Email to: perspectives@waimh.org

Keep an eye on this webpage as we will add resources and links relevant to this forthcoming special issue.

Any general enquires about this special issue, please direct to:

Maree Foley (Editor-in-Chief Perspectives in Infant Mental Health) : email perspectives@waimh.org



WAIMH Office News: Join the WAIMH discussion channels available for members!

By Neea Aalto and Minna Sorsa, World Association for Infant Mental Health

The WAIMH Office has frequently received questions from members about how to network and communicate with other members in the WAIMH online community. Are you following WAIMH on Facebook, Twitter or LinkedIn? These are forums you may know quite well. Yet, there are other channels that are not so well known. The WAIMH website at Yourmembership actually has several options for members to use.

Join the General Discussion Group to network with other members

The General Discussion Group that the WAIMH Office has created offers a good channel for this. If you would like to join

the group, please click on the "Groups" tab in the members portal.

When you click on the link of the group, you will be taken to the Group Feed page. Once you have joined the group, you can, for example, send a message to all the group members by using the Message Center.

Other ways of networking and communicating in the General Discussion Group:

Posting to the Group Feed is a great way for members to start group discussions on topics of interest. You will need to have a moderator.

The Group Directory allows a member to search for other members within the group.

The Group Calendar displays group-specific events.

The Group Blogs are good for more informational topics, where you generally have one contributor and multiple people adding comments to the post(s).

The Group Forums are good for ongoing discussions and typically involve multiple contributors.

The Group Photo Gallery will direct members to the group photo gallery to view group photos.

If you have any more questions about the Groups or need any help, please don't hesitate to contact the WAIMH Office at [memberships\(at\)waimh.org](mailto:memberships(at)waimh.org)!

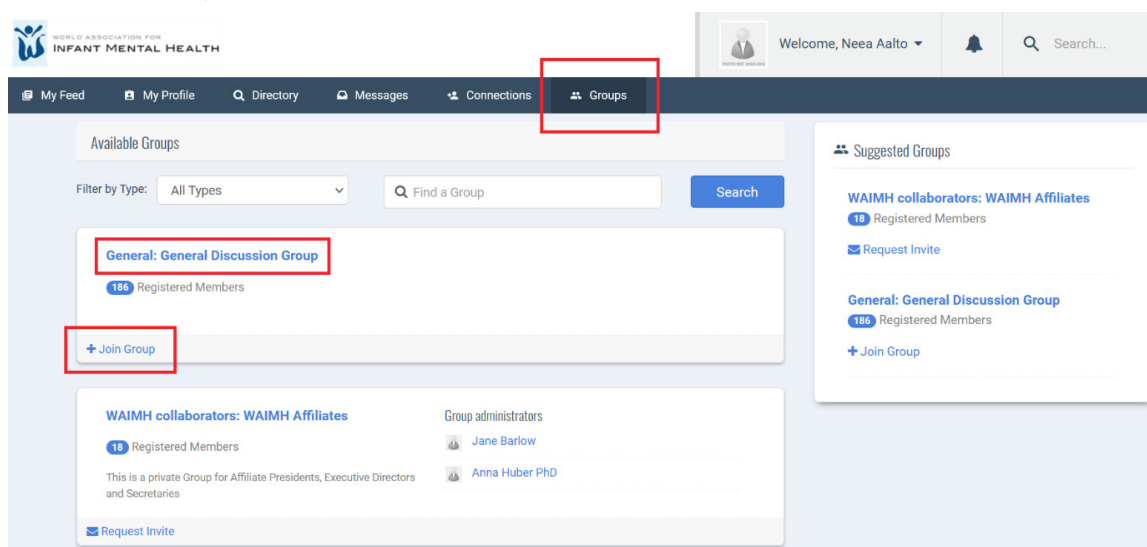


Photo 1. How to join the General Discussion Group in the members portal.

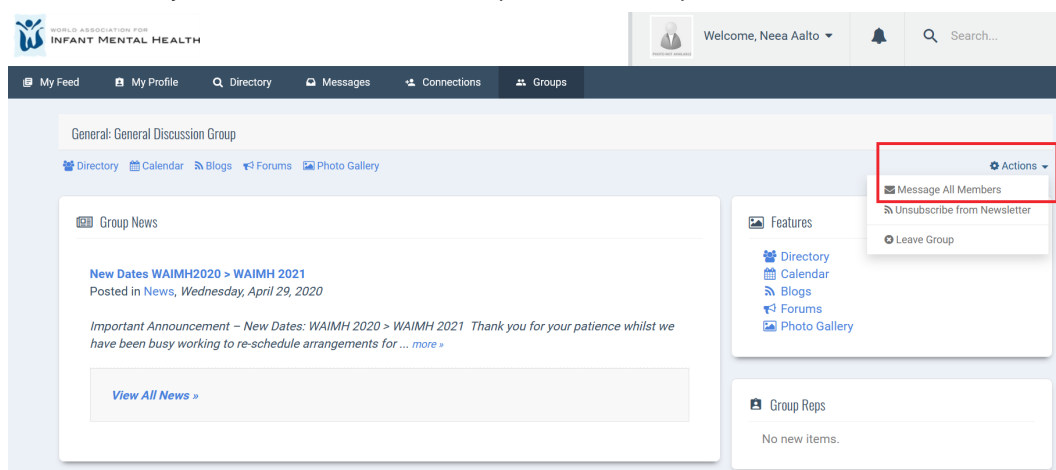


Photo 2. How to message all the members of the General Discussion Group.

WELCOME

**to the 18th World Congress of the World Association for Infant Mental Health
15-19 July 2023, Dublin, Ireland**

The Irish Association for Infant Mental Health (I-AIMH) is delighted to invite you to Save the Date to participate in the 18th World Congress of the World Association for Infant Mental Health (WAIMH). Scheduled for 15-19 July 2023, it will be held at the Convention Centre Dublin, situated in the heart of Ireland's beautiful capital city.

The COVID pandemic has brought significant changes across the world and also denied WAIMH members those much desired reunions. However, we are a strong, resilient international community, and as the Irish proverb goes, '*Ar scáth a chéile a mhaireann na daoine*': through the shelter of each other, people survive.

The Dublin Congress aims to provide an in-person stimulating and engaging environment for WAIMH delegates – it will be a truly memorable experience.

Following in the footsteps of previous WAIMH congresses, mutual exchanges that cross interdisciplinary boundaries will be at the heart of the 2023 programme.

We look forward to extending a warm invitation to our infant mental health colleagues across the world to share the latest scientific research, clinical experiences, scientific knowledge and cultural perspectives on a global scale.

Register your interest on the Congress website: www.WAIMH2023.org and we will make sure you are kept updated with the latest Congress news, programme information and links to submit abstracts and register.

Audrey Lonergan
President,
Irish Association for Infant Mental Health

Catherine Maguire
Chair, Local Organising Committee

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