MINNESOTA ASSOCIATION FOR children's mental health

A Guide to Infant & Early Childhood Mental Health

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by the Minnesota Association for Children's Mental Health
Infant & Early Childhood Division

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About the Minnesota Association for Children's Mental Health

Since 1989, the Minnesota Association for Children's Mental Health (MACMH) has been providing education and resources to families, professionals and youth across Minnesota and beyond.

MACMH's Infant & Early Childhood Division is grounded in the knowledge that the earliest years are critical in shaping lifelong health and wellbeing. Through our work, we build a multidisciplinary workforce equipped to address the unique needs of children, prenatal to age 6, and their families.

MACMH is a 501(c)(3) nonprofit organization.

A Guide to Infant & Early Childhood Mental Health

Prepared and published by
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As we set out to update the original Minnesota Association for Children's Mental Health (MACMH) publication, A Guide to Early Childhood Mental Health, we quickly realized that this would be a major undertaking, in large part because of the advancements in the field of infant mental health. When the Guide was originally published in 2006, there was not yet an Infant and Early Childhood Mental Health (IECMH) Division of MACMH. Since its establishment in 2007, the IECMH division has been a member of the Alliance for the Advancement of Infant Mental Health and is the only infant mental health organization integrated into a children's mental health organization serving children and their families, prenatal to adulthood.

We are grateful to Deborah Saxhaug, the retired Founder and Executive Director of MACMH, for her support for this project and to the continued support of Brandon Jones, current Executive Director. Lauren Moberg, the Infant & Early Childhood Division Director, has offered her untiring time, support and expertise. Lauren, along with Arielle Handevidt of the Northside Achievement Zone and Emily Richardson, MACMH's Director of Communications, were committed to ensuring that the language of the Guide was as inclusive as possible, a learning experience for us all. April J. Tighe, MACHM's Graphic Designer, provided her essential expertise. And MACMH's Grace Carey provided thorough proofing support. We are grateful to you all.

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Finally, we want to express our gratitude to the multidisciplinary IECMH professionals who are committed to promoting the wellbeing of young children, their caregivers and families. We hope that this guide will be a useful resource in the important work that they do.

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About This Guide

About this Guide

Welcome to ***A Guide to Infant and Early Childhood Mental Health***, originally published in 2006 as ***A Guide to Early Childhood Mental Health***. This revised and updated version reflects recent advances in the multidisciplinary field of Infant and Early Childhood Mental Health (IECMH) and will focus on infants and young children, beginning prenatally and extending to six years of age. In keeping with IECMH principles, we also focus on the relationships between children, their parents, caregivers and the professionals who work with them. In this guide we emphasize the promotion of young children's healthy mental health during these critical early years of brain development and the prevention of mental health difficulties. This guide is written for the multidisciplinary practitioners who work with infants, toddlers and preschoolers, and their caregivers and families. This includes providers of early care and education in settings such as Head Start, childcare, early childhood education, medical settings, early childhood special education and intervention, home visiting programs, and early childhood family education. We hope that parents also find this guide to be a practical resource.

This guide presents information on:

1. the importance of healthy social and emotional development (infant and early childhood mental health) as the foundation of lifelong mental health, social interaction and learning;

2. the influences on the development of healthy mental health, including relationships, brain development and environmental influences;

3. the most common concerns and disorders of early childhood; and

4. strategies and resources to facilitate parents' and caregivers' effective response to the children in their care to promote their mental health.

There are 11 chapters in this guide. Chapters 1 through 5 present a framework for understanding young children's development and behavior as viewed through four lenses: the developmental lens, the attachment lens, the stress and trauma lens and the culture lens.

Chapters 6 through 11 explore more specific topics including regulation; partnering with children's parents and caregivers; addressing common concerns, such as sleep, gender identity, and toileting; identifying when to be concerned, referral for assessment and intervention, and promoting children's resilience.

A reference list follows each chapter and the bibliography is included at the end of the Guide.

Strategies are integrated throughout the guide. For example, there is a section on tantrums in Chapter 8, Common Concerns. Tantrums are also mentioned in Chapter 2, The Developmental Lens, and Chapter 4, The Stress and Trauma Lens, as they all are interrelated.

When words are ***italicized*** and ***bolded***, they are defined in the glossary at the end of the guide. The appendices include handouts which readers are welcome to photocopy and distribute as well as informational sheets on common early childhood mental health diagnoses.

Following are definitions of terms we frequently use throughout the guide:

+ The term ***parent*** refers to the adults with the primary legal, parental and/or caregiving responsibilities of a child. This could include a mother, father, non-binary parent, foster parent, kinship (family member caring for a child) step- or adoptive parent and a non-custodial parent.
+ The term ***caregiver*** generally refers to all of the adults invested in the development and care of a child, other than the child's parents.
+ The term ***practitioner*** refers to anyone working with infants, young children and their families regardless of discipline. This may overlap with caregiver.
+ ***Infant*** will refer to children from birth through seventeen months; ***toddler*** refers to a child eighteen months to thirty-six months of age; and ***preschooler*** is a child from three through five years of age (thirty-six to seventy-two months). We will use ***child*** when the material applies to the age range of infant to preschool.
+ When we refer to a child, parent or caregiver, we will use the pronouns ***they*** or ***their***, unless we feel that designating the gender is important to understanding the text. This is done intentionally to avoid implying gender bias where we intend none and in acknowledgment that gender is on a spectrum, which includes many gender identities.
+ In this manual, the terms ***behavior problem*** or ***challenging behavior*** are interpreted as behaviors that challenge adults. Differentiating between a child's challenging behavior and behaviors that challenge adults is a critical distinction for a couple of reasons:
  - ***Challenging behavior*** is a subjective term. For example, we adults can have a broad range of how high an activity level we can tolerate in children.

- ***Gender***, ***culture*** (the child's and our own), ***age***, ***context*** and other factors influence our expectations of what we consider to be "appropriate" behavior in children.
- Behavior that is identified as "***challenging***" or "***a problem***" in a classroom setting may be considered acceptable at home and vice versa.

+ Behavior is a form of communication for young children. Children want to do well and when they act in ways that challenge adults, they are letting us know that they need adult help to regulate or do things differently. As adults, it is our job to figure out what they need.

Finally, most of this guide was written during the significant events of 2020-22, including the Covid-19 pandemic and its economic fallout, the racial unrest following the murder of George Floyd, and the divisive politics in our country. While we do not address these things directly, we want to acknowledge the increased stress experienced by families, caregivers and young children during this time and hope this guide will be a useful resource.

Chapter 1

Infant and Early Childhood Mental Health: The Beginning

Infant and Early Childhood Mental Health: The Beginning

"Sound mental health provides an essential foundation of stability that supports all aspects of human development — from the formation of friendships and the ability to cope with adversity to the achievement of success in school, work and community life."[1]
— Center on the Developing Child

The field of infant and early childhood mental health (IECMH) has come a long way since Selma Fraiberg first used the term in the 1970s. We understand so much more about infants and young children today. The wealth of research on the developing brain, including the recognition of development as the interaction of our genetic potential and our experiences, has changed the way we think about the needs of young children and their caregivers. The research tells us that the foundation for healthy mental health begins prenatally and is the foundation for all learning to follow. Because of the plasticity of the developing brain during this rapid rate of brain development, infants and young children are both the most vulnerable to negative experiences and impacted in response to positive experiences.

Let's start by defining Infant and Early Childhood Mental Health. Below is the definition which will be used in this guide:[1]

Infant and early childhood mental health is the developing capacity of the child from birth to age 6 years to:

+ form close and secure interpersonal relationships
+ experience, regulate and express their emotions
+ explore their environment and learn

all in the context of family, community and cultural expectations for young children.

Infant and early childhood mental health is synonymous with social and emotional development.[2]

An essential component of this definition is the recognition of the role of the family, the community surrounding the family and the influence of culture on the developing child.

Acquiring social and emotional competence is the primary developmental task of early childhood because it impacts all other developmental domains — physical growth, language development and cognitive skills — and lays the foundation for later development.[3]
— Harper-Browne

Why use a potentially stigmatizing term like ***mental health*** to describe healthy development if the term ***infant mental health*** is synonymous with social and emotional development? It is important to acknowledge the link between healthy social and emotional development and mental health across the lifespan. The basic principles of IECMH inform us about the optimal components of a foundation for mental health, acknowledging the interaction between the developing individual and their experiences that contributes to risk or resilience. Much of the focus of IECMH is on promotion of "healthy" mental health; therefore, it is important to continue to use this term.

Beginning in the 1950s, John Bowlby and Mary Ainsworth's foundational work in attachment theory was a precursor to the establishment of infant mental health as a field. Building on this work, Selma Fraiberg, at the University of Michigan in the 1970s combined knowledge of child development with psychoanalytic theory and a commitment to a multidisciplinary framework. Her seminal article, "Ghosts in the Nursery," described the intergenerational transmission of trauma and is based on the notion that the presence of the baby arouses strong feelings in the parent, often related to unresolved and

unconscious issues.[4] She developed a psychoanalytic home visiting model providing treatment of parent-child relationships as a port of entry for healing. Renee Spitz, who studied institutionalized children in the 1940s, is also considered a pioneer of the scientific study of infancy with his work on the primacy of caregiver-child relationships for optimal development.

We know that significant mental health problems can exist in very young children and present very differently than they do in older children or adults. For example, hyperactivity in young children can be a response to high levels of stress or trauma and/or a symptom of anxiety or depression, rather than a primary disorder of attention-deficit hyperactivity disorder (ADHD). High levels of activity can also suggest a specific developmental delay in the area of regulation, suggesting the need for a ***regulating partner*** beyond what might be expected for that age. Estimates vary on the incidence of clinically significant and impairing mental health problems for children under 5 years of age, ranging between 8-10 percent[5] up to 17 percent.[1] Early social, emotional and relationship problems can contribute to and/or result from problematic parent-child relationships and family functioning, impaired social interactions and difficulty participating in early care and education settings.

Mental health difficulties in early childhood warrant special consideration for several reasons. First and foremost, developmental domains in young children are interrelated and difficulties in the areas of social and emotional development/mental health can interfere with the healthy development of the brain, negatively impacting emerging capacities for relationships and learning. Development and learning in young children occur within the context of relationships, and therefore children are affected, either negatively or positively, by the relationships and environmental influences around them. Development is a dynamic process, meaning that it is constantly changing. It can be difficult to distinguish typical developmental variations from more significant or more persistent variations or delays. It is essential that professionals who work with infants, young children and their families and caregivers know the signs of mental health problems and that mental health difficulties in young children be treated in the context of their families, caregivers, cultural and community environments.

Guiding Principles of Infant and Early Childhood Mental Health

The following are nine evidence-based guiding principles, adopted by the Minnesota Association for Children's Mental Health — Infant and Early Childhood Division, to inform practice and policy:[6]

1. The brain is developing rapidly in the first years of life. All domains of development are interdependent, creating the foundation for all subsequent development, including lifelong learning, behavior and physical and mental health. Because brain development stabilizes with age, "it's easier and more effective to influence a baby's developing brain architecture than to rewire parts of its circuitry in the adult years."[3]

2. Development is the product of the interaction of genes and all experiences, beginning prenatally. From birth, children are active participants in their own development as they learn to select, engage and interpret experiences based on their earliest experiences. This reciprocal process establishes the trajectory for future development. It is early caregiving relationships, and the systems which surround them, that provide the basic structure within which all development unfolds.[5]

3. Relationships are the catalyst and the context for all early learning. While family members are the most important and influential relationships, children's relationships with other caregivers also influence developmental outcomes. Therefore, promotion, prevention and intervention services for young children's healthy development must be multi-generational and sensitive to families' and caregivers' values and culture.[7]

4. The field of IECMH is inherently intergenerational. Pregnancy and the birth of a child are a powerful port of entry for promotion, prevention and intervention services for young children and their families because of the neurophysiological and psychological changes associated with this period of life. Programs which address the needs of the parent/caregiver, the child and the relationship between them have been shown to significantly enhance early experiences with positive developmental outcomes.[8]

5. Early intervention for children whose development is at risk has been shown to shift the balance from risk to resilience. While the earliest years of a child's life are a time of robust development, they are also a time of profound vulnerability. Development can be seriously

affected not only by delay or disability, but also by environmental influences. These influences may include poverty, parental mental illness, parental substance use, parental history of trauma and their experience of being parented, family violence, child abuse and neglect, loss of a caregiver, racism and poor-quality childcare. Policy and practice must acknowledge and address all these influences to ensure optimal developmental outcomes for all children.[7]

6. Self-awareness leads to better services for children and families.[9] Working with young children and their families inherently arouses strong feelings and reactions in most adults. This is built into our biology, given the prolonged dependency of children on adults. Therefore, the capacity for adults to reflect on their own feelings, implicit biases, reactions and behaviors — as well as those of others — is among the essential competencies for infant and early childhood professionals. This complex work is best accomplished with supports that include reflective consultation/supervision.

7. The multidisciplinary nature of the field of infant and early childhood mental health is one of its defining characteristics. This has to do with the interrelatedness of development and the many factors which influence it, including genetics, biology, relationships and environments. Any practitioner who touches the lives of infants, young children and their caregivers — whether through early care and education, medical care, early intervention, social services or mental health — has a role to play in promoting infant and early childhood mental health by attending to the parent-child relationship.[10]

8. Working with young children, their families and caregivers requires a specialized set of competencies, firmly grounded in the unique developmental and relational needs of the earliest years. Infant and early childhood professionals represent a variety of disciplines.[11,12] A professional development system, grounded in evidence-based core competencies necessary to work with children prenatal to 6, their families and caregivers, should be integrated across all disciplines. This should include skills in identifying and responding to both adults' and children's developmental and relational needs. An example of such a competency-based professional development system is the Endorsement for Culturally Sensitive, Relationship-focused Practice Promoting Infant and Early Childhood Mental Health® promoted by the Alliance for the Advancement of Infant Mental Health.

Examples of a Multidisciplinary Approach to Infant and Early Childhood Mental Health

+ An infant is very fussy and appears to have sensory sensitivities, reacting negatively to their parents' efforts to soothe them by traditional touch and comfort measures. The first-time mother is feeling a profound sense of failure about her ability to meet her baby's needs, which is a complete contradiction to her expectations of becoming a mother. This distress in the parent-child relationship has the potential to send the baby's developmental trajectory off course. The primary medical provider recognizes the need for referral to early intervention/occupational therapy with practitioners skilled in addressing the baby's sensory sensitivities and promoting the parent-child relationship. The parents learn effective and mutually satisfying strategies for soothing their baby.
+ A new mother, at her post-partum medical exam, is showing symptoms of post-partum depression. The nurse practitioner considers how best to treat the parent's depression because they knows the impact of parental depression on the well-being of the infant. They also assist the parent in identifying other supportive adults who can offer responsive care to the baby during recovery.
+ An early care and education teacher recognizes that the separations between a parent and toddler at drop-off have become increasingly difficult. The parent appears extremely stressed and often hands their toddler to the teacher very abruptly, leaving the child to cry for an extended period of time. This requires the teacher's prolonged attention and upsets the other children in the room. The teacher feels protective of the toddler and somewhat resentful of the parent. However, the teacher is able to override this annoyance and become curious about what might be causing the parent's stress. After discussing this with the center's mental health consultant, the teacher invites the parent to a meeting and expresses concern for both parent and child, asking how to be helpful to them. The parent reports feeling tremendous financial pressures and fears of losing their job if they are late to work. Together the parent and teacher develop a plan to promote more successful separations, which eases the stress on both parent and child and facilitates a healthier relationship between them.

9. Programs and services for very young children and their families should be organized within cohesive systems to promote healthy developmental outcomes. These systems must coordinate and align all the components that make up a comprehensive early childhood system. This should include early learning guidelines and quality improvement initiatives. This is necessary to ensure the availability and access to high quality, affordable, integrated services. Even service providers who identify adults as their clients — such as substance use disorder or legal professionals — should consider the needs of the children as they are working with the parents. [13]

Foundational Strategies to Promote Infant and Early Childhood Mental Health

In this first chapter, we introduce some of the most foundational strategies that promote healthy mental health in everyday moments. When you use these strategies, you support the growth and learning in the infant, caregivers and the relationships surrounding them:

1. Be curious

2. Take multiple perspectives

3. Use the four lenses to understand children and adults

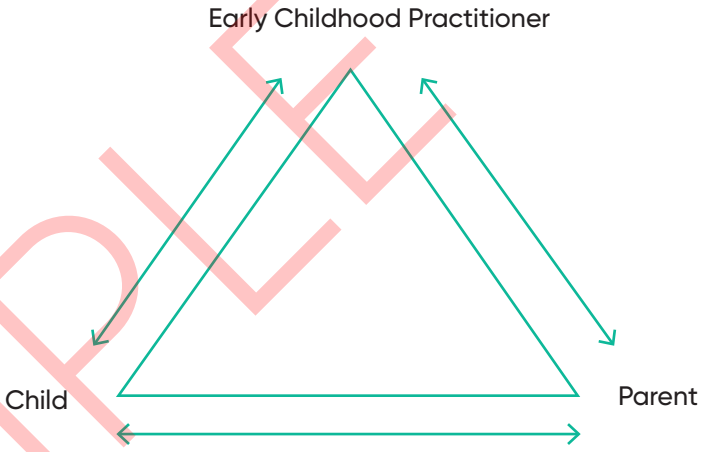
To illustrate these essential strategies, let's start with a story

> *Michael is a 3-year-old* recently enrolled in the preschool room of a childcare center. By the end of his first week there, his teacher is exhausted by his high activity level and his difficulty listening to directions and following routines. He takes other children's toys but does not settle on anything for more than a few minutes. When the teacher expresses her concerns to Michael's mother, she states that Michael doesn't show any of these behaviors at home.

Michael's story is probably familiar to anyone working with young children. He is the child who challenges parents and teachers alike; we are concerned about him and we are frustrated by him. How are we to understand Michael so that we can help him? Is this a behavior problem or a regulation problem? Why does this matter and how might it direct our interventions?

Strategy One: Be Curious

Because we know that young children's behavior is a form of communication, Michael's behaviors bring up a number of questions. First of all, what's it like to *be* Michael? What does his behavior feel like on the inside? What is Michael trying to communicate with his behavior? Is this a behavior problem or a regulation problem? Often, an adult's first response is, "He's just doing that for attention." If we reflect further and ask ourselves — "Why does he need this kind of attention and why is he using these strategies?" — we may be able to find answers that guide our strategies for addressing Michael's behavior. Wondering about the meaning of behaviors is an essential first strategy.



Strategy Two: Take Multiple Perspectives

Taking the perspectives of everyone involved in a situation can help us better understand the children and families with whom we interact as well as better understand ourselves. Michael, the early childhood practitioner and the parent are in relationships represented by the graphic above. Each person in the three corners of the pyramid has their own experience and perspective (Carol Siegel).

In the scenario of Michael, the following questions may be useful in guiding our interactions:

+ Michael: What is it like to be Michael? What might he be feeling/thinking?
+ Michael's parents: What is it like to be Michael's parent(s)? What might they be feeling/thinking?
+ Early Childhood Practitioner: What's it like to be ME, as someone interacting with Michael and his family?
  What does this child need from me right now?
  What does this parent need from me?
  How does this family perceive me given their experiences?

The answers to these questions are typically our best guess or hypothesis as we don't actually know, but they can give us important information or insight that can inform our interactions and interventions. For example, let's look closer at what each person in the pyramid may feel:

+ Michael: *I'm feeling overwhelmed. I don't know how it works here. Where's my mom? There are so many toys and kids here that I don't know where to start!*
+ Michael's parents: *What does this teacher think of me? Do they think something's wrong with my son? I am completely overwhelmed by my life right now. I could lose my job if the childcare has problems with my son.*
+ Early Childhood Practitioner: *I'm feeling frustrated that this child's needs are negatively impacting my classroom. I don't know how to help this child. I feel incompetent.*

Further questions increase the complexity but give a more complete picture of the entire situation. An early childhood practitioner may also ask:

How can I promote the quality of the relationships between myself and Michael, myself and Michael's parent, Michael and his parent, and Michael and the other children? What is the meaning of my role to the family? An expert who should know what to do? A person in a position of power/judgment? Someone who is going to get in their business? This will depend, at least in part, on the family's previous experiences with professionals and their thoughts about mental health.

Our hypotheses to these questions can offer us important information and a deeper understanding about what might be contributing to Michael's behavior and his parent's response to our concerns. For example, what if we learned that Michael's parent has recently started a new job and Michael has never been away from them? Both of them are likely to be feeling very stressed and overwhelmed. As a teacher, we might be able to interpret their behavior as a reflection of this stress, rather than as a behavior problem for Michael and a lack of caring on the part of Michael's parent. We might take a very different approach in our interactions with them.

Using this perspective pyramid to think through challenging situations, especially when we feel stuck, can offer us additional insight, and impact our thinking and interventions. It can be helpful to answer the questions from the voice of each person as shown here in the previous examples.

Strategy Three: Use Four Lenses to Understand Children and Adults

There are four lenses that can help us understand children's behavior and what they need from us:

+ The Developmental Lens
+ The Attachment Lens
+ The Stress and Trauma Lens
+ The Culture Lens

In this chapter, we will briefly describe each lens and their use in understanding children and families. Each lens has a defining question(s) to gain a deeper understanding of the concept. In succeeding chapters, each lens will be covered in more detail.

The Developmental Lens

Understanding where children are developmentally is necessary when setting appropriate expectations for their behavior. For example, we would have very different expectations for how well an 18-month-old can regulate their emotions than we would a typical 3-year-old. A 10-month-old who continually drops food off of their highchair and watches for their caregiver's reaction may be frustrating to care for in the moment. However, as an infant, it is highly likely that they are practicing cause and effect and social back-and-forth. If this were an otherwise typically developing 3-year-old, we might interpret the meaning of the behavior very differently. Understanding the process and range of typical development helps us set achievable expectations and goals for young children.

Start with these two questions:

+ How old is this child?
+ How old does the child seem when I am interacting with them, especially when they are stressed?

Michael, from our earlier example, may be chronologically 3 years old, but his ability to regulate his emotions in

his classroom appears to be much more like a younger toddler. There could be a number of reasons for this, including:

+ Children very often regress when they are stressed. Knowing this, we can adjust our expectations of what this child is able to do in the moment.
+ A child may not have had the experiences that support their development in a particular area; for example, Michael may have little or no experience with structured environments and routines or opportunities to interact with same-aged peers.
+ A child's difficulty with regulation and social-emotional skills might reflect an actual specific developmental delay in this area or perhaps a more global delay in development.

There are a number of factors which may be contributing to Michael's behaviors, including the stress of separating from his parent, being overwhelmed by the routines of the classroom or difficulty processing all the sensory stimuli in the classroom environment.

The Attachment Lens

Research tells us that all early learning occurs within the context of relationships.[14] This lens can help us understand what a child expects from relationships based on their previous experiences. When looking at the attachment lens, the question to ask is:

Based on the way this child interacts with me, what do they seem to expect from relationships?

Children show us what they expect from relationships by their behavior. Here are behaviors adults may observe:

+ The child who is able to ask/signal for and accept help from adults does so because their experience tells them that "*Adults help kids*" and "*I am worthy of help and support.*"
+ The child who doesn't ask for or doesn't seem to expect help or comfort from adults may have learned that needing help leads to rejection. They may even reject attempts of adults to help. This is the child who is often easy to overlook in a group of children because they seem to "stay under the radar."
+ The child who is clingy may be worried and stressed and/or may not feel they can count on adults to be there when they need them.
+ The child who relies on negative behavior to get a response from adults may have learned that this is the most effective way of getting on adults' radar. This child may have few positive strategies for getting the attention they need because, based on their experiences, the positive strategies haven't worked.

Michael may have reacted to the stress his parent is feeling with anxiety and fear which could have led to his high activity level. Adults around him may react with impatience and frustration. The attention he receives wouldn't help him regulate his anxiety. Instead, it may heighten it. In Chapter 3, we discuss attachment patterns that emerge from early experience that can help us understand what children expect from relationships and what they need from us.

The Stress and Trauma Lens

The surge of research on brain development and the neurobiology of stress in the last 25 years has given us much greater insight into how high levels of stress and/or trauma adversely affect the developing brain.[15] One of the most well-documented effects is the negative impact of trauma/toxic stress on the ability to regulate our level of arousal, our emotions and our attention. This directly influences our capacity to learn, explore and socialize.

We have all had the experience of not being our best selves when we are stressed. When our ***survival brain*** is activated by stress or threat, we have less access to our ***thinking brain***. This can affect our judgment and our ability to regulate and express our emotions. Typically, this high stress is a temporary experience and we return to a more functional state of regulation. However, when high levels of stress are frequent or chronic in early childhood, the negative impact on the rapid rate of brain can be long-lasting. The brain becomes "wired" at this higher state of arousal, thus interfering with other kinds of learning.

The stress and trauma lens is a way to make sense of young children's reactions that may seem confusing. For example, a young child may startle easily or have very strong, seemingly disproportionate reactions — such as fear, aggression and dysregulation — to adult requests that don't make sense to us as parents, teachers or caregivers. These may be clues that the child is very stressed and/or may have experienced trauma and is hyper-alert and reactive. Understanding this, we can figure out ways to change the environment or respond in ways that are helpful, even though we may not know what the specific trauma is. When using the stress and trauma lens, we ask the question:

"What Happened to You?" Versus "What is Wrong with You?"

Michael's high activity level may be a symptom of a high level of stress. This could be an intense reaction to the transition of starting a new classroom. Or perhaps this indicates a more chronically high state of arousal because of Michael's experiences of a very stressed home environment, a medical trauma or exposure to community or domestic violence. This kind of wondering can lead us to a more empathic approach and increased understanding of a child that may offer us a more effective direction for intervention.

The Culture Lens

Culture is a powerful lens through which we see and interpret the world around us. This is true for all of us whether we are practitioners, parents or caregivers. When using the culture lens, it is helpful to ask ourselves the following question:

How does culture (my own, the child's and their parents') inform our beliefs and reactions?

> **Zero to Three defines culture as follows:** Culture is a shared system of meaning, which includes values, beliefs and assumptions expressed in daily interactions of individuals within a group through a definite pattern of language, behavior, customs, attitudes and practices.[16]
> — *Maschinot*

This definition does not refer only to race, religion and ethnicity. It also includes shared systems of meaning related to gender, age (adolescent culture!), values, sexual orientation, economic status, education/employment, ability, neurodiversity, geographic location and so on. We could also define culture as what each of us learned within our families or within the settings in which we grew up. This means that each family has their own unique culture. Culture is a very dynamic concept that is continually being transformed and reshaped by the people who share it. For example, a family who has relocated from a rural setting to an urban setting or a new country will need to adapt to the new setting. This will require some shifting and adjustments to their family culture, such as how much freedom children have to explore outdoors or learning to use public transportation. The same is true for organizations and institutions such as a childcare center or school. Each has its own culture of shared history, values, and beliefs, but it's important the organizations and institutions are open to adapting that culture in response to the needs of families.

It is necessary to apply the culture lens to ourselves as well as to the families whose children we work with in order to understand the beliefs, reactions and behaviors of ourselves and others. This is particularly true for childrearing practices; how does each of us define what constitutes "good parenting?" Our cultural worldview may be outside our conscious awareness, partly because we are likely to experience our worldview as "undeniable reality," especially if we are European-American (often considered the "majority" culture in the United States). We may find ourselves making assumptions, based on our worldview, that are not shared by everyone. How "good parenting" is defined may have many different definitions across cultures. For example, does this child's family value independence as typified by typical Western cultural practices of having young children sleep separately from caregivers and learning to feed themselves by toddlerhood? Many of the world's cultures place more value on ***interdependence*** which is reflected in childrearing practices that include co-sleeping and feeding children into their preschool years.

There are a wide range of beliefs and values that form our expectations for young children's behavior. This may include our perceptions of what level of activity is acceptable/valued in young children or what emotions are acceptable in young children and what are acceptable ways to express them. When a child attends an early childhood environment, the task of merging their home culture with their school culture may be daunting, and even a bit unsettling. There may be significant differences in these expectations between a child's family culture and a child's classroom setting. For example, perhaps Michael comes from a family whose experiences with discrimination have been such that they feel it is important to encourage Michael to be assertive and take care of himself. Or perhaps Michael's family culture does not believe in setting limits on young children's behavior until they are older. Using this lens may contribute to our understanding of Michael's approach to exploring and interacting in the classroom.

This chapter lays a framework for understanding young children's development and behavior using three strategies:

1. Be curious
2. Take multiple perspectives
3. Use four lenses to understand children and adults.

The four lenses approach offers additional information so we can better promote their well-being and healthy development. This involves using four lenses – developmental, attachment, stress and trauma, and culture – and asking the following questions:

+ How old is this child? How old do they seem when I am interacting with them, especially when they are stressed?
+ What does this child seem to expect from relationships?
+ What happened to this child? versus What's wrong with this child?
+ How might my own cultural lens and that of this child and/or family inform our beliefs and reactions?

In the following four chapters, we will go more in depth on each of these four lenses and how they impact a child's social-emotional development.

Questions for Reflection:

1. In what ways do you promote healthy mental health for young children, their families and caregivers?
2. How might you use the four lenses approach to understand the children in your care?

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Fact Sheets

Introduction to the Fact Sheets

The fact sheets offered here describe some of the more common mental health disorders in infants and young children. Diagnostic classifications are intended to provide descriptions of symptoms that allow practitioners to able to communicate and to facilitate identification of appropriate resources and services. It is essential that any assessment and diagnostic classification of young children must keep in mind that all infants/young children have their own developmental progression and have individual differences in their motor, sensory, language, cognitive, emotional and interaction patterns. Acknowledging that infants/young children develop within the context of relationships is another foundation of assessment and diagnostic classification.[127] Diagnoses of infants/young children are best made over time and across multiple settings in order to capture variations in adaptation and development within different contexts, relationships and occasions. Diagnosing an infant/young child must also take into consideration the family's cultural values and practices as well as other sources of diversity.

Assessment and diagnostic classification should only be done by a qualified licensed professional. However, any of us working with young children and their families may have concerns about a child and/or be the person to whom the parents turn for guidance. The fact sheets are intended to provide a brief overview of the more common mental health disorders, common symptoms and behaviors associated with the disorders, general strategies and resources. The fact sheets have been updated using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5™), updated in 2016. The DC:0-5 is expanded to include birth through 5 years of age.

Fact sheets for the following diagnoses, categorized to be consistent with the DC:0-5, are included:

+ Anxiety Disorders
+ Attachment Disruption
+ Attention Deficit Hyperactivity Disorder and Overactivity Disorder of Toddlerhood
+ Autism Spectrum Disorder and Early Atypical Autism Disorder
+ Depressive Disorder of Early Childhood
+ Disorder of Dysregulated Anger and Aggression of Early Childhood
+ Post-Traumatic Stress Disorder
+ Sensory Processing Disorders

It can be challenging at times to differentiate symptoms and behaviors of mental health disorders from children's normal developmental patterns. For example, some toddlers respond to sensory overstimulation by flapping their hands or other repetitive activities, symptoms often associated with Autism Spectrum Disorder. A child may exhibit challenging behaviors in one setting and not another which requires that we consider the behavior as the child's adaptation to a specific context rather than assuming the behavior represents pathology. We also perceive behaviors differently depending on the age or developmental level of a child; for example, we are likely to be much more concerned about the frequent tantrums of a 5-year-old than we are of an 18-month-old, depending on the type and severity of the behavior.

Documenting Your Concerns

When you have concerns about a child, it can be extremely helpful to document your concerns in order to have accurate information when you share your concerns with parents or others. It is helpful to record the intensity and frequency of any behavioral difficulties in as much detail as possible. Also documenting the situations in which the concerning behaviors occur and help identify specific triggers and/or patterns. Specific descriptions are most helpful. For example, rather than stating that "Billy doesn't remember the rules at Circle Time," it is more helpful to be descriptive. For example, "Billy frequently stands up and moves about the room during Circle Time, interrupting others and has difficulty responding to the teacher's requests. This seems to occur most often at the beginning of the week." It is also good to record what happened before and after

the disruptive or uncharacteristic behavior. The change or pattern of children's behaviors may be explained by social situations happening in the classroom (e.g., the absence of a favorite teacher) or by something that the child is experiencing at home. With clear documentation of when the behaviors/concerns are occurring it is much easier to discover what factors may be contributing to the child's difficulty. Chapters 7 and 8 offer suggestions for communicating concerns with parents.

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Anxiety Disorders

About the Diagnosis

Infants and young children can experience clinically significant anxiety disorders which can negatively impact their development and functioning as well as that of their family. However, diagnosis can be challenging because very young children are unable to verbalize their internal states such as worry. Assessment relies on caregivers' descriptions of infant's/young child's behaviors and observable distress, as young children may be unable to verbally express their feelings. Adults often assume that young children can control their anxiety and the associated behaviors and will outgrow the symptoms.

All children experience anxiety at times. It is important to differentiate between developmentally appropriate anxiety and developmentally inappropriate, excessive anxiety. For example, distress at separation from primary caregivers is common between 8 and 24 months of age, peaking between 10 and 18 months. Children's normal fears and anxieties peak at around 3 years of age (loud noises, storms, monsters, strangers, dark) but are transient and do not derail a child's development.

There are specific criteria that distinguish an anxiety disorder from more typical developmental or temperamental anxieties and fears.[128] The anxiety symptoms must:

1. Cause the infant/young child intense distress that is developmentally inappropriate;
2. Be uncontrollable, at least some of the time, even with reassurance and repetition;
3. Persist for at least a month;
4. Impair the infant's/young child's or the family's functioning; and
5. Interfere with the infant's/young child's expected development.

The three most common anxiety disorders in young children are Separation Anxiety, Generalized Anxiety Disorder and Social Phobia Disorder. The major difference between them is the nature of the perceived threat that causes the anxiety, (e.g., separation from a parent, worries about events in the past or future, worries about interaction with others).

Symptoms and Signs

+ Inconsolable distress (e.g., crying, panic);
+ Clinging, hiding;
+ Reactive tantrums or other dysregulated behavior;
+ Excessive inhibition or reluctance to try new things (over and above what can be accounted for by a cautious or slow to warm up temperament).
+ Physical symptoms, such as increased heart rate, sweating, stomach aches, headaches;
+ Avoidance of experiences that trigger anxiety, (e.g., separation, meeting new people);
+ Need for constant reassurance;
+ Constant fears about the safety of self/others;
+ Sleeplessness, nightmares

Strategies to Support the Child and Family

+ The goal is not to eliminate anxiety or its sources, but to give children the skills to manage their anxiety.
+ Remember that anxiety can put us into "survival mode" which in children can present as dysregulated behavior that they may not be able to control without help. Always consider the underlying meaning of the behavior before choosing how to respond.
+ Anxiety can be contagious, so check your own regulation level before moving in to help the child/parent. In a classroom setting, other children may also need reassurance such as, Your friend is missing his mom. The teachers are helping.
+ Provide a predictable structure, relationships, rules and environment. When the child knows what is coming next and what is expected of them during transitions and activities, they can feel more confident and feel like they have mastery or a sense of control in their environment.
+ Be a "regulating partner" for the child and family, providing reassurance and support. Let them know they are not alone.
+ Acknowledge a child's fears or worries and talk about them so they know they are not alone in managing them. We don't want to dismiss the fear or amplify it. Our message should be, "I know you're scared and that's okay; I'm here to help you through this."
+ Partner with parents/caregivers as a regulating partner for them as well. It can be very challenging to understand and/or help a child cope with their fears.
+ Encourage small steps in helping a child overcome a fear; do not force a child.
+ Teach relaxation techniques to preschool-aged children, such as deep breathing. This can empower them to be "the boss of their worries."
+ Notice and celebrate when a child calms down; for example, You were really worried when Mom had to go. Look how you calmed your body down!
+ If the anxiety persists and/or is interfering with the child's development and the family's functioning, consider referral to an IECMH professional.

Resources to Facilitate Healthy Parent-Child Separations:

+ Daniel Tiger Grown-Ups Come Back song: https://www.youtube.com/watch?v=iVcFOUYIvWs
+ Books
  You Go Away (for toddlers)
  The Kissing Hand
  The Invisible String
  Llama Llama Misses Mama
+ www.inclusivechildcare.org
+ www.childmind.org

Strategies for Separation Anxiety

+ Help the parents understand that parent-child separation is a process that occurs in stages.
+ Offer parents and children plenty of time to become accustomed to you and your setting before expecting them to separate.
+ Start with short separations and increase over time.
+ Acknowledge and reassure parents that their discomfort is natural and to be expected and that you are there to help.
+ Ask the parent what would be most helpful to their child and to them in this process.
+ Offer to call the parent if the child is unable to settle (and follow through so the parent knows you can be trusted).
+ Let parents know about the typical difficulty of separation for children after about six months of age and reassure parents that you will be honest with them about how the child is doing.
+ Let the parent know they have been missed. Avoid judging a parent's ease or difficulty with separation.
+ Coach parents to always say goodbye to the child, even though it may result in tears. Explain that even though this may be difficult, saying goodbye helps a child trust the caregiver by creating predictability.
+ Have the parent leave a transitional object (e.g., parent's scarf or shirt), which can be comforting to both caregiver and child.
+ Goodbye rituals can include going to a window to wave goodbye, singing a special song with the parent and/or teacher, talking about what they will do during the day or after pick up.
+ For some young children, a visual reminder can be helpful. Teachers can create a simple daily schedule for the child that includes pictures of them with their caregiver at drop off and pick up. The teacher can review what the child will do during the day and when their caregiver will return.
+ Some children may like to select a book or toy from the classroom to show to their caregiver at pick up, to give them a tangible reminder of a plan to look forward to.

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Handouts

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Organizing/Regulating Language for Stressed Young Children

Language—how we speak to children—is a powerful organizing tool to help children regulate their feelings, state of arousal, attention and behavior. This includes our words, our tone of voice and our body language. Having a repertoire of phrases readily available to us can also organize us to feel better equipped to address the challenges we encounter in our work. It lets children know you can be trusted to help them and keep them safe.

This is how we ___ in our school/family/home. I'll help you.

Message: This is a consistent, predictable place.
Grown-ups are here to help kids.
You can ask for help.
It's okay to let grown-ups be in charge—you can trust us to keep you safe here.
Grown-ups help kids manage their Big Feelings.

In two more minutes, it will be time to stop___ so we can go ___.

Message: The world is a safe, predictable place.
Start thinking about getting your coping skills ready to make a transition.
This is what will happen next.

I am going to pick you up, change your diaper, wipe your nose, etc. (especially related to the child's body).

Message: The world is a safe, predictable place.
You have control over your body.
Start thinking about getting your coping skills ready.

I know you know how to put your shoes on, but sometimes everyone needs a little help—how about if I put one on and you put one on?

Message: Adults take care of kids.
I know you are competent.
It's okay to ask for help.
You can get your needs met.
It doesn't have to be my way or your way.
We can negotiate.

This is hard, but I will help you.

Message: I understand that it's hard to do things a different way or have Big Feelings, etc.
I can hold/tolerate all your Big Feelings (and I will help you learn to do that too).
This is a place where grown-ups help kids.
You are worthy of help.

At our school/house/family, we don't ___ (use scary words, hit, etc.); we ___ (can say ___, use words).

Message: This is a consistent, predictable place.
I will show you a different way to do things
I will help you shift gears because that's hard when you are having Big Feelings.
I won't judge you.
I'll et you know what behavior is or isn't okay here.

I'm going to stop you because ___.

Message: Grown-ups are in charge and we will keep you and others safe.
We are here to help you.
Our limits and expectations are clear, consistent and predictable.
You won't be rejected if you make a mistake.

Next time, you can ___.

Message: I believe you are competent and want to do things well.
You don't have to feel ashamed because there will be a next time to show me you CAN do it.

We had Big Feelings about that! You were mad and I was mad. See my face? I'm all done being mad. Are you all done being mad?

Message: Big Feelings have an end.
Your behavior can't derail our relationship.
Our relationship is still good.

I'm wondering if you're feeling ___.

Message: I understand your feelings and will help you through this.
This feeling has a name and knowing that can give you power over the feeling.

Lots of kids feel ___ when ___.

Message: Your feelings are normal and make sense to me – you are okay.
There is a reason for your feeling (connecting the dots between events and feelings)

I was thinking about you.

Message: I hold you in my mind even when I am not with you because you are special.

I like the way you___

Message: I notice the good things you are, say and do.
You are a competent and special person.

You did it! and/or You are working so hard!

Message: I admire the process of your work (not the product).
I want you to be proud for yourself, not to please me.

And when words don't work...

Children who are really upset (tantrumming, frightened, distressed) may not be able to process words in the moment. They need to know that they (and their feelings) are okay and that the adult can handle their Big Feelings. Our physical presence and our body language become especially important – staying close by, singing softly, holding, rocking. Words can come later. If we stay calm when a child is upset, they learn that:

+ *I won't be abandoned during difficult times.*
+ *Momentary rage doesn't result in rejection.*
+ *Feelings can be contained and not derail the competence of my caregiver.*
+ *Adults can be trusted to help kids feel better.*
+ *Calm comes after the storm.*

Reference

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