Pathways to
Professional Development

Building Foundations in Infant
and Early Childhood Mental Health

Child Abuse and Neglect: Impact, Assessment and Responses that Support Children within their Caregiving System

Susan Chinitz, Psy.D. and Gerard Costa, Ph.D.

Pathways to Professional Development Building Foundations in Infant and Early Childhood Mental Health

Pathways to Professional Development was developed to build workforce competence and to prepare professionals working in the perinatal and birth to 5 periods

- 21 webinars focused on the foundations of Infant and Early Childhood Mental Health.
  - Provided live virtually
  - Recorded for viewing as LMS modules

- Diagnostic Classification of Mental Health And Developmental Disorders of Infancy and Early Childhood (DC:0-5) offered virtually and in-person.

  - View all offerings here→ https://www.ctacny.org/special-initiatives/pathways-to-professional-development/

The aim is to develop a well prepared and competent workforce trained to **identify** and address mental health concerns early, to **promote** awareness of mental health, to **prevent** long-term problems and to **intervene** to help children stay on developmental track.

Pathways to Professional Development Webinar Series

- **Module I:** Developmental and Psychodynamic Foundations of Infant and Early Childhood Mental Health – <u>6 Webinars</u>
- **Module II:** Assessment, Diagnosis, Formulation and Professional Development – <u>4 Webinars</u>
- **Module III:** Risk, Stress, Protection and Resilience – <u>2 Webinars</u>
- **Module IV:** Through the Lens of Family, Community and Culture – <u>2 Webinars</u>
- **Module V:** Specific Disorders: A Closer Look: <u>4 Webinars</u>
- **Module VI:** Helping in Infant and Early Childhood Mental Health – <u>3 Webinars</u>

Who we are

These trainings are funded by the New York State Office of Mental Health (OMH) and provided by the New York Center for Child Development (NYCCD) in collaboration with CTAC.

- **New York Center for Child Development** (NYCCD) has been a major provider of early childhood mental health services in New York with a long history of providing system-level expertise to inform policy and support the field of Early Childhood Mental Health through training and direct practice.
- **NYU McSilver Institute for Poverty Policy and Research** houses the Community and Managed Care Technical Assistance Centers (CTAC & MCTAC), Peer TAC, and the Center for Workforce Excellence (CWE). These TA centers offer clinic, business, and system transformation supports statewide to all behavioral healthcare providers across NYS.
  - **NYCCD and McSilver** also run the **NYC Early Childhood Mental Health Training and Technical Assistance Center(TTAC)** which offers ongoing training and technical assistance for those working during the perinatal period to age 5

https://ttacny.org/

Pathways to Professional Development Webinar Module 3 – Webinar 2 Overview

Child Abuse and Neglect: Impact, Assessment and Responses that Support Children within their Caregiving System

This presentation provides an overview of child abuse and neglect, beginning with prevalence data and the extraordinary risks of maltreatment in infancy and early childhood. Factors that increase risk for maltreatment, and the consequences of abuse and neglect on brain systems and early child development will be examined. Professional and ethical practices will be identified.

Child maltreatment occurs, and intervention by child protection services, including placement in foster care, is often necessary. Interventions result in both intended and unintended consequences which must be examined. Interventions must acknowledge the importance of children's attachment relationships, even with parents who have been abusive and neglectful. Evidence-backed interventions for families of young children will be described, which can help reduce the effects of abuse and the unintended effects of child protection intervention. Principles of infant and early childhood mental health, and practice guidelines that center the young child's experiences, and include the child's important caregivers, will be offered, in addition to resources for use with families.

Overview

- Starting Points
- Child Maltreatment – types, prevalence rates for infants and young children
- Infant and child mental health and the brain
- Relational interventions
- Foster care as an intervention
- Through the eyes of the child: Unintended consequences of placement in foster care
- Ways to minimize the adverse consequences of maltreatment and intervention
- Revised mandated reporter training in NYS
- What else early childhood/early childhood mental health practitioners can do to help
- Resources

Learning Objectives

- Identify and describe the types of child abuse and neglect and the prevalence data indicating the greatest risk to infants and very young children.
- Explain the consequences of child abuse and neglect on brain systems and early child development.
- Describe the unintended consequences of foster care as an intervention and practice guidelines, including evidence-backed interventions, that reduce the complex effects of maltreatment and child welfare system intervention.
- Review reporting requirements.

Starting Points

- Child maltreatment occurs, and state intervention is necessary.
- Interventions result in both intended and unintended consequences which must be examined.
- Interventions must acknowledge the importance of attachment relationships, even with parents who have been abusive and neglectful.
- All development, particularly brain development, is organized through the nature of relationships.

Acts of Commission and Omission

child abuse and neglect

noun

1. Any act or series of acts of commission or omission by a parent, caregiver, or another person in custodial role that results in harm, potential for harm, or threat of harm to a child.
2. A preventable act.

VetoViolence

Maltreated & Traumatized Young Children: The Potential Triple Threat to Their (Attachment) Development

1. Experience of neglect and abuse
2. In cases where a child is in out-of-home placement, the experience of separation, loss, and lack of a secure base despite a safe placement.
3. Experience of being lost: A child's unique needs are not addressed efficiently by the systems of child welfare, mental health, and early intervention.

Incidence, Types, and Risk Factors for Maltreatment

<u>Categories of maltreatment</u>

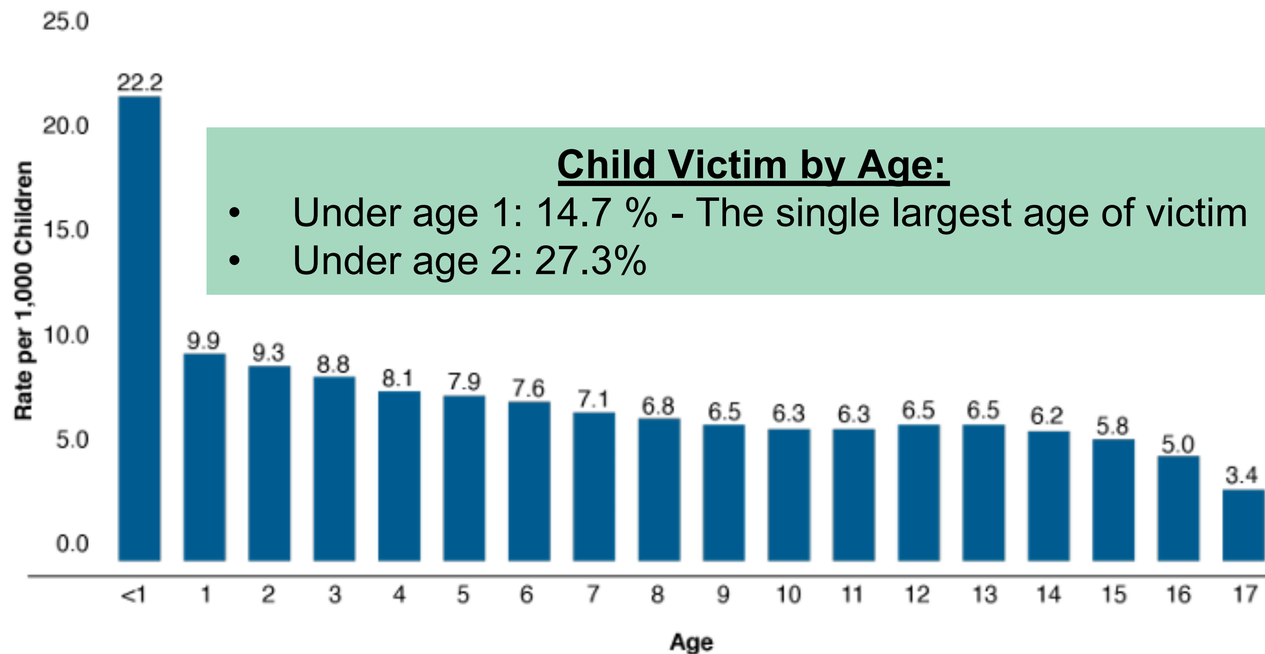
- Child neglect (75.3%)
- Medical neglect (2.2%)
- Physical abuse (17.2%)
- Sexual abuse (8.4%)
- Psychological maltreatment (6.2%)
- Other (6.9%)

Source: USDHHS, Child Maltreatment 2022

Incidence, Types, and Risk Factors for Maltreatment

Major Risk Factors for Physical Abuse:

- Living in conditions of poverty
- Single parenthood
- Lack of social support from a relative or other adult
- Social isolation from family, friends, or neighbors
- History of being abused or living in family situations characterized by family violence and/or conflict
- History of mental illness or substance abuse
- Parental difficulties with self-regulation and reflective capacity, often stemming from the factors above



Child Victim by Age:

- Under age 1: 14.7 % - The single largest age of victim
- Under age 2: 27.3%

Source: USDHHS, Child Maltreatment 2022

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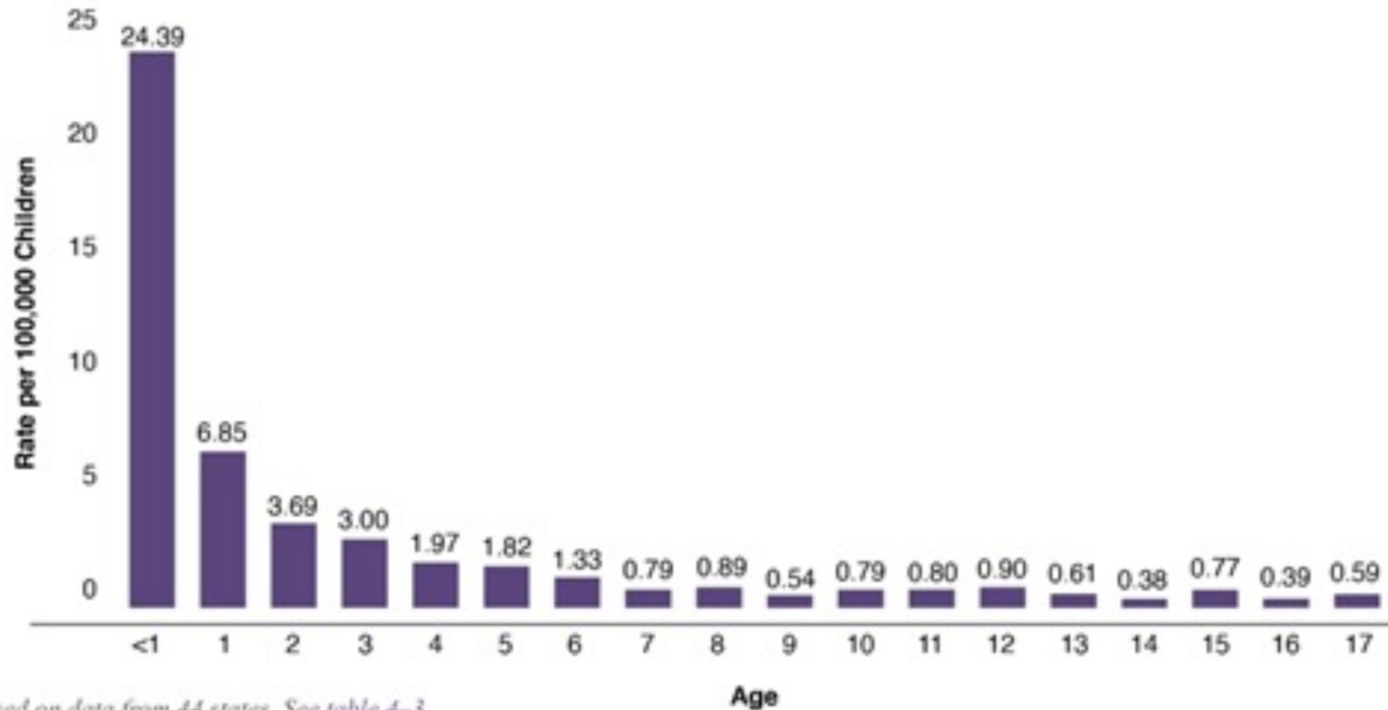
Exhibit 4–B Child Fatalities by Age, 2021

Children <1 year old died from abuse and neglect at more than three times the rate of children who were 1 year old.



Based on data from 44 states. See table 4–3.

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Neglect

Definition: Failure of a parent or other person with responsibility for the child to provide needed food, clothing, shelter, medical care or supervision to the degree that the child's health, safety, and well being are threatened with harm

Types of Neglect:

- Physical or supervisory neglect
- Psychological neglect
- Medical neglect
- Educational neglect
- Often co-occur

- The allegation that comprises the largest number of reports to the SCR and the largest category of indicated cases

- Often considered a less severe type of maltreatment

Impact of Neglect on Brain Development

- Researchers: Neglect is he absence of sufficient attention, responsiveness and protection that are appropriate to the age and needs of a child
- Healthy development can be threatened not only by bad things that happen to children (physical/sexual abuse) but also by the **absence** of experiences essential to their wellbeing

Dual threat to the integrity of the developing brain includes;

- The lack of serve and return interaction which builds the foundational and integrated neural circuits needed for cognitive and language development and all subsequent learning, and
- Because responsive relationships are developmentally expected and biologically essential, their absence during the earliest years activates the body stress response systems

Causes of Neglect

- Adult mental health impairments, including maternal depression and/or Post traumatic stress syndrome
- Adult substance use disorders
- Significant stresses associated with poverty, high levels of economic hardship causing elevated levels of parental stress, instability and preoccupation meeting family's basic needs
- There is a new and deeper understanding of the intersection of neglect and poverty, calling for a different response separate from engagement of the child welfare system

Consequences of Maltreatment

- Effects of maltreatment follow a **developmental cascade**, wherein negative events or behavior at one age lead to negative events or behavior at a subsequent age

PHYSICAL HEALTH AND BRAIN DEVELOPMENT

- Physical and emotional abuse, as well as neglect, may alter the course of early brain development by increasing harmful levels of cortisol
- MRI scans of maltreated children show evidence of reduced cerebral volume, larger ventricles, and smaller corpus callosum
- ACE studies have highlighted the impact of early adversity on a large number of health and mental health markers in adulthood through chronically activated stress systems and wear and tear on other body organs

Consequences of Maltreatment

- COGNITIVE DEVELOPMENT : Children with a history of maltreatment have deficits in language, IQ, and academic achievement
- Deficits in executive function including the regulation of attention
- EMOTION REGULATION AND PERCEPTION: Maltreated children develop atypical responses to emotional distress in other people

Consequences of Maltreatment

- SOCIAL RELATIONSHIPS: Seventy to 95 percent of maltreated infants have insecure or disorganized attachments
  - May have poor emotional regulation
  - May act aggressively
  - May withdraw from social interactions with peers
- Relational difficulties extend to others as they grow older

Emotional Concerns

- Negative representations of the self
- Low self-esteem
- Poor self-confidence
- Reduced enthusiasm, lack of exuberance of childhood
- Depression
- Anxiety
- Can extend into adolescence, adulthood

Prevention of Maltreatment

Two strategies to help prevent maltreatment

- Minimizing stress that often precedes maltreatment
    - Includes helping at-risk families meet daily needs and manage their daily lives and childcare
- Improving parent–child attachment relationships

Parenting is a Relationship not a Skill

Judith Musick:

"Parenting is not a job; nor is it a skill that can be learned in much the same way one learns to cook, or use a computer, or drive a car. It is a relationship, one that cannot simply be taught or retaught if it has not been 'learned' well initially"

Source: Shahmoon-Shanok (1990)

Relational Interventions For Families with Young Children

Given the impact of child maltreatment on the attachment relationship, and the importance of the caregiving adult in mitigating the impact of trauma, relational interventions are needed to effectively thwart negative developmental cascades that are often observed in such cases.

Evidence-Based Relational Interventions for very young children and their caregivers:

- Child Parent Psychotherapy
- Attachment and Bio-Behavioral Catch-up
- Circle of Security

Child Parent Psychotherapy (CPP)

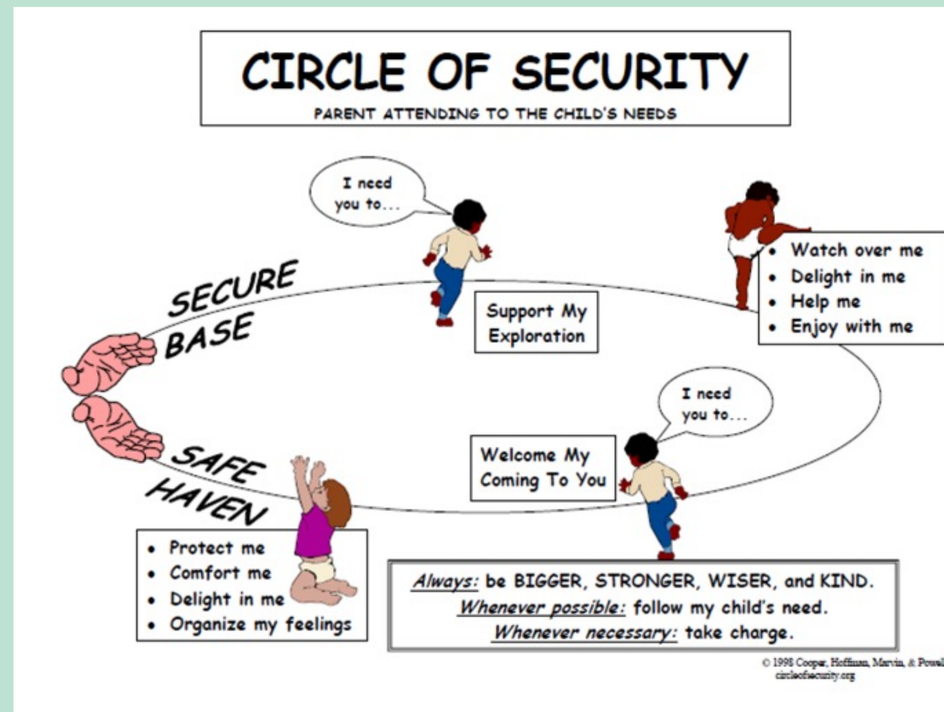
- Developed by Alicia Lieberman and Patricia Van Horn at the University of California San Francisco (UCFS) Child Trauma Research Program and designed to improve social-emotional, behavioral and cognitive functioning in children exposed to interpersonal violence and other traumatic events
- Target population: children 0-5 who experience mental health, attachment, and/or behavioral problems as a result of traumatic events
- Goals/strategies: Repair trust in the parent-child relationship following trauma by enhancing the parent's capacity to protect the child and helping the child regain a sense of safety in the relationship with the parent.
- Play-based dyadic therapy sessions often of a years duration
- Treatment responds to cultural, socioeconomic and immigration issues

Attachment and Biobehavioral Catch up Intervention (Dozier, Lindheim, & Ackerman, 2005)

- Short-term intervention, (10 dyadic sessions) developed by Mary Dozier at the Infant Caregiver Lab at the University of Delaware
- Designed to improve parental sensitivity, and attachment quality and biobehavioral regulation in children who have experienced abuse or neglect
- Target population: infants and toddlers in foster care or living with their parents
- Session goals:
    - Strengthen caregiver's sensitivity and responsivity to child cues
    - Provide nurturance even when it is not elicited. Use of video that displays babies directly eliciting care and babies that fail to do so.
    - Help foster parents to reinterpret their foster baby's signals, help them to be more in touch with their own reactions to their foster baby's signals

Circle of Security

- Based on attachment theory (but not a dyadic intervention)
- Parents of children between 1 and 5 years meet in small groups for 20 sessions where they watch and discuss video-recorded interactions between each parent and their young child.
- Parents are also provided with psychoeducation about attachment theory as they meet to discuss each parent's attachment relationship with their child, and areas for growth and change in order to promote the child's secure attachment.



Foster Care as an Intervention

- Until very recently, children's placement in foster care has been the most commonly used intervention when child abuse or neglect is substantiated
- This large-scale intervention focuses on the child's physical safety but sometimes neglects the child's emotional safety
- Though essential in some cases, there is only recent attention to the psychological costs to the child and to the family of child separation from parents and family

Principle to Consider

- We must consider all interventions through the "eyes of the child" and recognize that change in placement means change in relationships.
- We must preserve the child's relationships and recognize that infants and children must not bear the burden of inconvenience and redress when making plans and decisions about their lives.

Principle to Consider

- We must attend to the needs of all those who care for the child (birth and resource-Foster families).
- We must attend to the needs of the helpers, including the child protective staff and the judicial team members.

Reminders from Webinar 1.3 and 3.1: Brain Development and Effects of Stress

- Early experiences matter. Brain development in the first moments and throughout are experience and relationship dependent, and early brain circuits form foundations for higher level circuits.
- Brains are "co-constructed" and "sculpted" by what happens.
- Infant brains are more likely to form connections than "lose" them – for good or for bad.
- Consistent, predictable, regular, attuned loving care is necessary for development. Taking care of baby's physical needs is not enough.

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The Physiology of Bad Stress

- The allostatic system (controls hormones that mediate the effects of stress –especially on the cardiovascular system) becomes too charged with no chance to vent the buildup of energy
- Increases in cortisol, endorphins, adrenaline, and other hormones can become harmful
- The overload can damage memory, hurt your immune system, and enlarge your stomach

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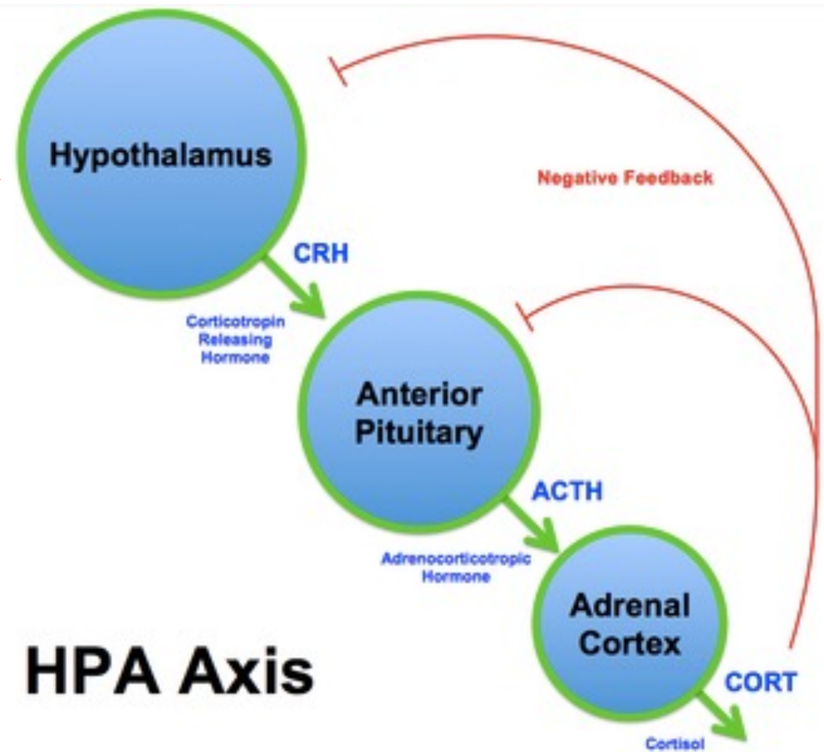
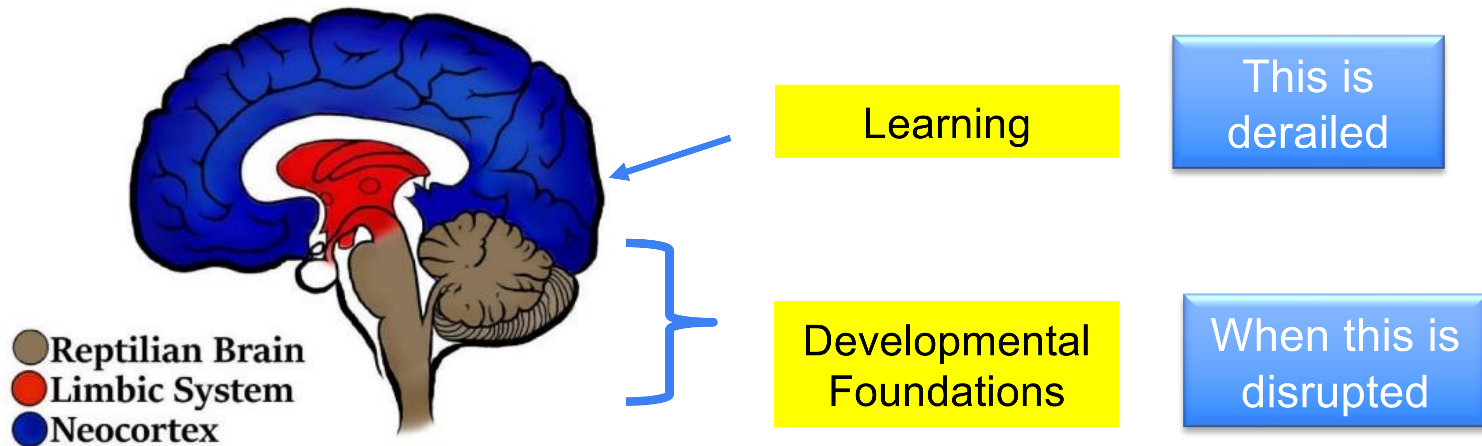
Hypothalamic-Pituitary Adrenal (HPA) Axis

Fear
Trauma
Danger

ABUSE
NEGLECT



An Artificial but Helpful Distinction



The Trauma of Investigation and Removal

- "Considering that children who enter the child welfare system may have already experienced trauma, ***it is especially important that they not be further traumatized by the system that seeks to help them and that they receive services as soon as possible to facilitate their recovery from the trauma they have experienced."***

Source:
Reducing the Trauma of Investigation, Removal & Initial Out of Home Placement in Child Abuse Cases (2009), p. 10

The Impact of What We Do NOW?

"While there is a wealth of literature pertaining to trauma in general and the trauma that children in child welfare may have experienced before entry into the system, ***there is little in the literature that speaks to the potential trauma during investigation and removal***.....(There is) the possibility that ***entry into the child welfare system is a trauma in itself***."

Source: Reducing the Trauma of Investigation, Removal & Initial Out of Home Placement in Child Abuse Cases (2009), p. 10,11

IMAGINE

- Imagine that one day, I came to your home and told you that you were moving to a new location. Imagine you were not permitted to take any food you had prepared, none of your clothing, you could not take any photographs of people you knew and loved, no "things" with you - not even your pillow. Then suppose, I moved you to a new place where your bed felt differently, the sun came into your room differently, the smell of the home was unfamiliar, the kinds of clothes, language and facial expressions that people had were strange to you. Then suppose I moved you like that 5 times in one year. Then suppose I did this all during the first year of life when you had no way to understand these changes nor language to express your confusion.

IMAGINE

This is what happens to many young infants, when for their safety and protection, they are removed from families who gave birth to them or cared for them. Yet we now know that infants from the first moments of life recognize familiar smells, voices, can see and distinguish people, can show us through expressions and movements how they are doing and how ***we*** are doing with them. Such changes, even when they occur to protect the child from neglect, maltreatment and danger, have adverse effects on a child. Infants are not "too young" to suffer, be changed and be formed by these experiences. Even when parents and caregivers fail in their love and treatment, children form relationships with them.

Potential Trauma to Children During Investigation and Removal

- Surprise, fear, shock, chaos – parents in distress, "violence" of restraint; confusion, uncertainty as to "why"
- Abrupt and overwhelming change, loss of all things familiar
    - Places, pets, friends, routines
    - Extended families, siblings, medical providers
    - Changing or missing school, Church/Faith comm.
    - Loss of culture, different language, clothes, diet

Potential Trauma to Children During Investigation and Removal

- Loss of control, powerless and helplessness; sudden separation/loss from attachment/loved figures
- Betrayal, loss of trust, sense of world as unsafe
- Grief and bereavement
- Negative view of police and DCPP
- Fear of unknown and inability to seek support and answers from trusted others

Potential Trauma to Children During Investigation and Removal

- Sense of guilt or failure, sense of responsibility for “telling” or “showing”; self-blame
- Repeated interviews about traumatic events and negative self-traits.
- Older children: worry about parents and sibs
- “Loyalty” bind (“attachment reconciliation”)

Consider……..

- One way we can help children who undergo such changes in their relationships is to try our best to link those who cared for the child before the move, and those who are now caring for the child.
- These connections help the child and all caregivers with the extreme pain and worry that can accompany such disruptions in attachments. Of course, when the child has been removed from the birth mother, the pain to both is intensified.
- Both birth parent and foster parent need support to talk with each other, and to arrange thoughtful plans for ways to help the child learn that the ***adults in the child's life will bend over backwards to help promote security and love in the child.***

Redefine

Visitation as

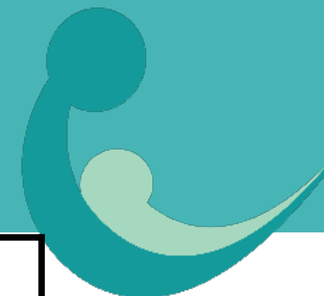
PARENTING TIME!

The goal is not simply to visit with their child but to BE A PARENT to the child in ways that reflect the centrality of this relationship!

REMEMBER

- Through the “eyes of the infant/child”
- Redefining the role of “resource family” and recruiting, re-tooling and supporting them accordingly.
- Developing judicial and protective service models less rooted in litigious process (e.g. prosecution, defense, etc.)
- Birth Family-Resource (Foster) Family Relationships and Work Redesigning an intervention protocol
- Creating “life narratives” and other representations that address not just the present, but anticipate the future developmental needs and strivings of children and their families

Recommended Contacts for Effective Visitation
(Michigan Ass. For Infant Mental Health)



Child's Age	Parent/Child	Contacts
0-6 months	Protection, comfort, interest/ Feels regulated, falls in love with caregiver	1 – 3 contacts of 1 – 4 hours per week
7 – 18 months	Sensitive, empathic reading of cues, loving/falls in love with caregiver, develops purposeful communication, intentionality	1 – 3 contacts of 1 – 4 hours per week
19 – 36 months	Pretend play, use of language, limits, logic/emotional ideas, foundation of a theory of mind	1 to 3 contacts of 1 – 8 hours per week

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What are some of the ways this can happen? Here are some ideas

- Be sure that all families, birth and foster, call the child by the same name, follow the same care practices (like eating and toilet learning), and talk without judgment or criticism about each other.
- Allow photographs of the birth and foster families to in each home. This can be quite difficult and may require some discussion and reassurances for both families.

What are some of the ways this can happen? Here are some ideas

- Transportation for visits with the birth family must be done by the same transportation staff in the same vehicle as much as possible. Ideally, it is better for the child to be brought to, and picked up, for a visit by his foster family. It is so helpful for a child to see that both mother and foster mother, for example, can see each, talk with each other and even share information about the child (e.g. how he slept last night, what he ate today, or that she had a tummy-ache last night).
- Visits should occur regularly, at least three times a week for an infant under 18 months, twice weekly up to age 3, and once weekly thereafter.

What are some of the ways this can happen? Here are some ideas

- These practices require much planning and support, and birth and foster parents should talk with their child's caseworkers and helpers to determine whether this can happen.

- It is not easy being a foster parent, to recognize that in cases where the placement is temporary, you must form a loving attachment with the knowledge that you may have to later say good-bye to the child you are caring for. Foster parents may also feel anger and resentment at a parent who has been neglectful or hurtful to their child. These feelings and beliefs need to be talked about with the persons who are helping you and the child. When they can be addressed, and we can help the child feel less "divided" between relationships, we really can help all involved.

The Importance of the Birth-Parent, Foster-Parent Relationship

One way we can help children who undergo such changes in their relationships is to try our best to link those who cared for the child before the move, and those who are now caring for the child. These connections help the child and all caregivers with the extreme pain and worry that can accompany such disruptions in attachments. Of course, when the child has been removed from the birth mother, the pain to both is intensified. Both birth parent and foster parent need support to talk with each other, and to arrange thoughtful plans for ways to help the child learn that the adults in the child's life will *bend over backwards* to help promote security and love in the child.

Components of Effective Visiting

(Burke & Pine, as cited in Dougherty, 2004)

- Structuring visits to enhance opportunities for parents to practice and enhance their caregiving skills. (i.e Allow a parent to cook/care not just snack time)
- Schedule visits at the homes of foster families, at times that include increasingly challenging situations, such as meal times and bedtimes.
- Include parents in activities that allow them to be part of their children's lives: school activities, doctor appointments, recreational activities
- Encourage birth parent-foster parent interaction

Intervention with Biological Parents: Promote Secure Attachment with Visit Coaching (Beyer, 2003)

- Principles:
    - Empowerment – build on family strengths.
    - Empathy-support families to meet the unique needs of their child.
    - Responsiveness-help families manage the conflict between adult and child needs.
    - Active parenting-help the family understand how the child's behaviors are shaped by their words, actions, and intentions.

Visit Coaching (Beyer, 2003)
Key Points

- Pre & Post visit meetings
  - Prepare before; self assessment and prepare for next time after
- More visit time
  - Coached visits more than once per week may be needed to meet the needs of the child, parent, or family.
- Conducive environments
  - The visit does not have to be contained in an office.
- Make visits challenging relative to the reason for removal.

Potential Benefits of Visitation

- Best predictor of reunification
- Supports parent-child attachments
- Reduced sense of abandonment while in care
- Enhances the well being of children in care
- Frequency of visiting the child in placement is associated with change for the better in parental feelings toward the placement and also with less time in placement.
- Written visiting plans correlated with increased frequency of visits and reunification

Infant Toddler Courts

- Infant Toddler Courts bring expertise in infant mental health and early child development to Family and Dependency Courts
- Zero to Three provides a national model: Safe Babies
- Infant Toddler Courts work to promote community engagement in meeting the needs of court involved young children and their families by inviting cross-discipline and cross-systems collaborative efforts to wrap supports around these families, and address gaps in services
- They also provide an intensive case management, referral to targeted services and a modified court calendar for families with young children facing child protection cases
- Strong focus on strengthening, protecting and repairing children's important relationships and a strong reliance on Child Parent Psychotherapy and other relational interventions

Infant Toddler Courts impact

- Children and families receive the services they need and are connected to these services in a more timely way than usual
- Judges and attorneys learn more about effective interventions for young children and their caregivers
- Reunification was the most common permanency outcome for ITCT children and was significantly higher among ITCT children than children in a comparison group
- Less time in foster care than children in a comparison group
- Shorter mean time to permanency

NYS Modifications to Mandated Reporter Training

- Acknowledgment of the role of poverty in problems that look like neglect
- Appreciation of the very significant disproportionate minority representation and substantial over-representation of Black families in the child welfare system
- Appreciation of the trauma of child protection investigations and of child removals from their family
- Many problems families have are related to financial stressors that can, and should, be addressed through means other than the child welfare system
- Families may be better assisted through community-based services and supports that build protective factors
- Training provides many resources for connection to community-based services and supports

Revisions to Mandated Reporter Training in NYS

- New training aims to root out “implicit bias” in reports called into the SCR
- “Of the 100,000 calls made to the SCR in NYS in 2022, only 27% were actually “indicated” for maltreatment
- Focus on the Adverse Childhood Experiences (ACE) studies so practitioners understand the role of trauma in child and adult behaviors/conditions, and do not re-traumatize the child and family
- Replaces the professional guidance from, “When in doubt, call the SCR” to “You don’t have to report a family in order to support a family”
- HEARS family line – hotline that refers families to resources for food, clothing, housing, medical and behavioral health care, parenting education and child care

Goals of Revisions to Mandated Reporter Training in NYS

- Mandated reporters are required to call the SCR if they have **reasonable cause** to suspect that a child under 18 is being maltreated or abused by a parent or person over the age of 18 who is legally responsible for the care of the child
- Improved skills to recognize signs of abuse and maltreatment in virtual settings with the increase in telemedicine, remote psychotherapy and virtual schooling
- Families in crisis may not meet legal criteria required to call the SCR, and may be better served by being connected to community services and supports
- Reduce bias in decision making process
- Trauma-informed practice

The Need for Reflective Practices

We must attend to the needs of the helper.

The Need for Reflective Practices

Rice and Groves (2005) talk about what *can* be associated with caregivers "bearing witness" to child trauma, such as...

- Experiencing some of the same symptoms (as the child)
- Having one's internal view of the world shifted
- Possibly feeling helpless/hopeless

The Need for Reflective Practices

- Compassion Fatigue:
  - A state of tension and preoccupation with individual or cumulative trauma of clients (Figley, 2002, p.125).
- Vicarious Traumatization:
  - The transformation or change in a helper's inner experience as a result of responsibility for an empathic engagement with traumatized clients (Saakvitne, Gamble, Pearlman, and Lev, 2001).

Vicarious Trauma/Caregiver Fatigue

A physical, emotional and spiritual fatigue or exhaustion that takes over a person and causes a decline in their ability to experience joy or to feel and care for others.

Reflective Practice

Reflection:

Stepping back from immediate experience to sort through thoughts and feelings about what one is observing and doing with children and families.

(Rebecca Parlakian, 2001)

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Reflective Practices/Supervision

REACTIVITY

- Immediate
- No planning
- Putting out fires

REFLECTIVE RESPONSIVITY

- Slower paced
- Self and others aware
- Preventing fires

Reflective Practices
Three Essential Features:

- Reflection – stepping back, slowing down, wondering
- Collaboration – having a “partner” in the process of reflection
- Regularity – occurs consistently and is “protected” time

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How Else Can Early Childhood Professionals Help?

For all children:

- Support child's participation in high quality early care and education programs
- Home visiting programs (Healthy Families, Nurse Family Partnership, Child First)
- Developmental monitoring
- Trauma-informed strength-based approach to parents
- Importance of touch, and a language rich environment

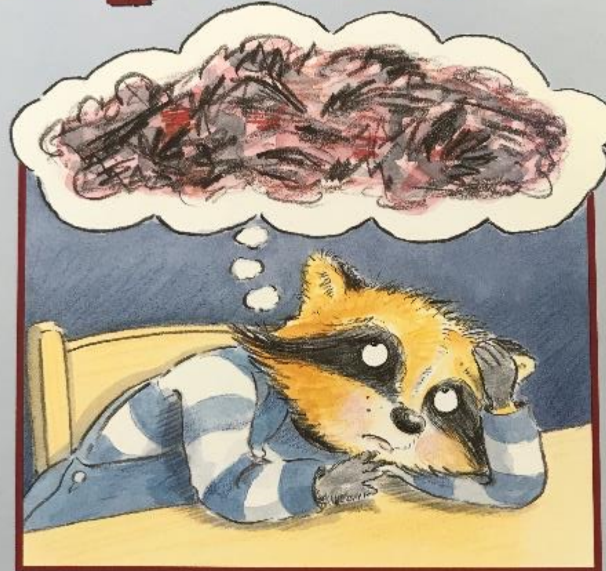
For Children in Foster Care and Out-of-Home Placement

- Support all of the child's important relationships
- Help coordinate information and care between parents and foster parents
- Advocate for developmentally appropriate transitions for children
- Suggest therapeutic support for visits / visit coaching
- Psychoeducation to foster parents about trauma, neglect, attachment disruptions to prevent placement breakdown
- Psychoeducation to parents (e.g., child calls foster parent, "mommy'; child distressed at separation from foster parent for visits with parents

Resources for Children and Families

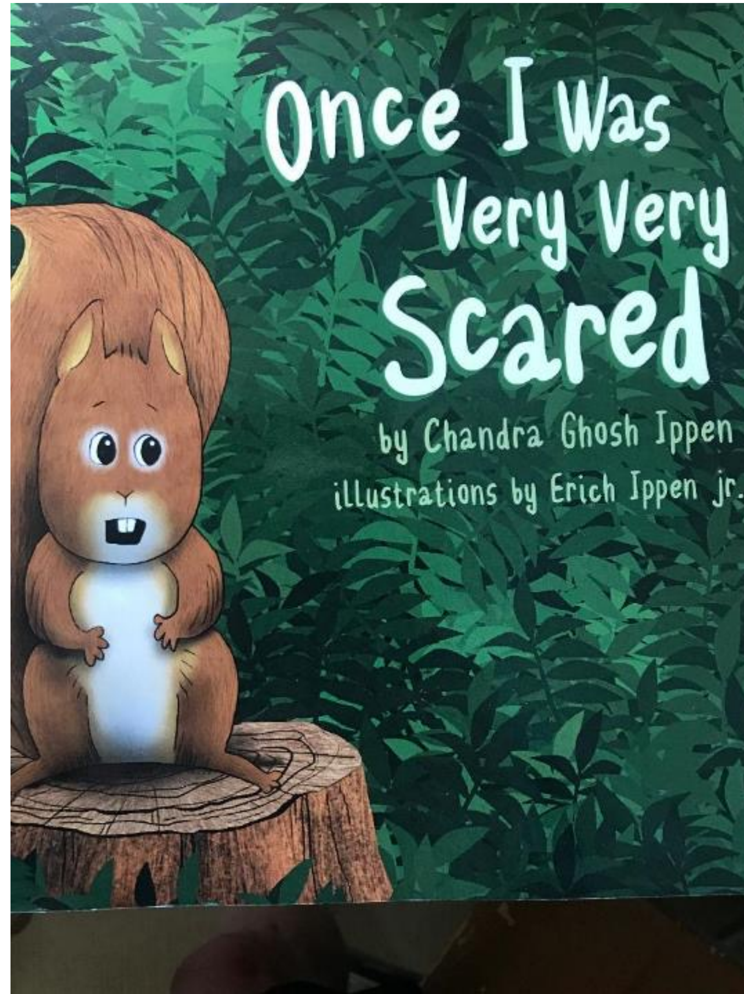
- Picture books that address issues of trauma, separation and loss
- Sesame Street in Communities (trauma, foster care, parental substance use disorder, autism)
- Resources for children with incarcerated parents
- Rise Tip Sheets for Parents
- Rise video on parent-child visits
- Picture albums for infants and toddlers
- ACS Visit Policy and Visit Coaching

A Terrible Thing Happened



By Margaret M. Holmes   Illustrated by Cary Pillo

Books by Chandra Ghosh Ippen



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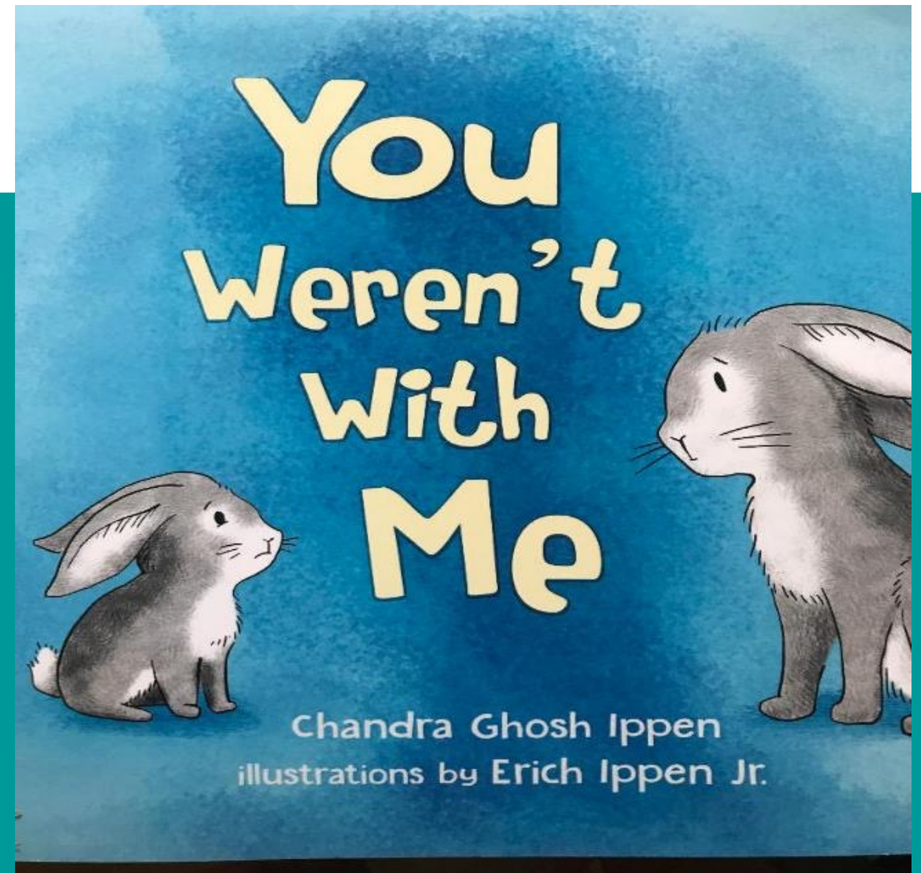
Separations



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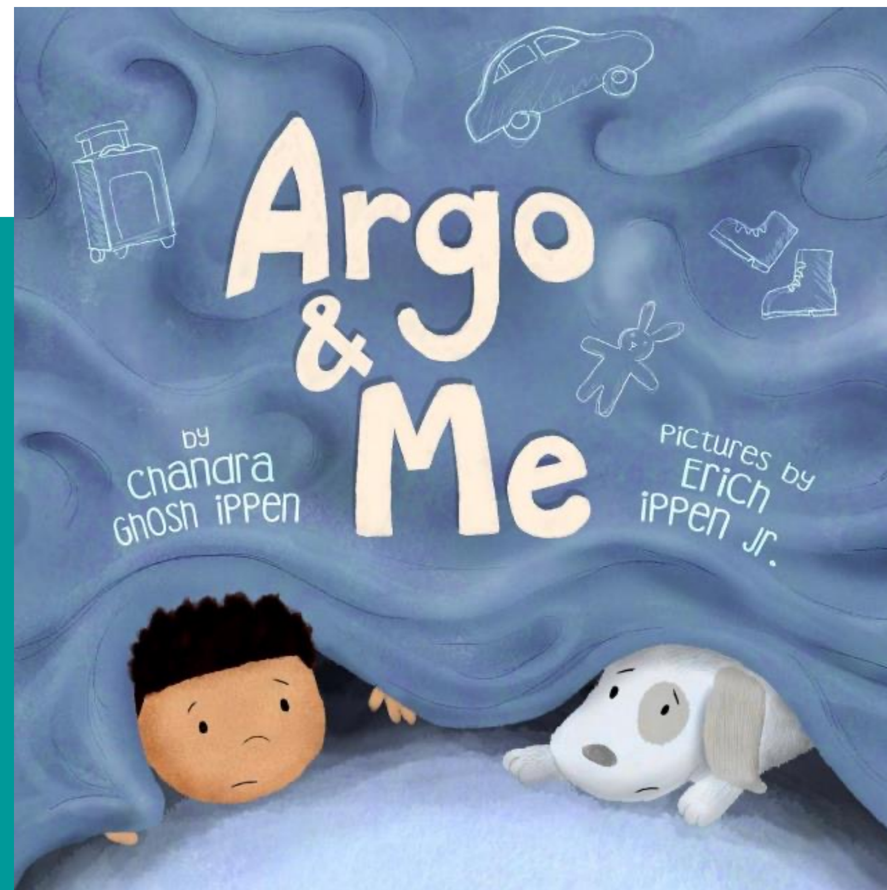
Multiple Homes



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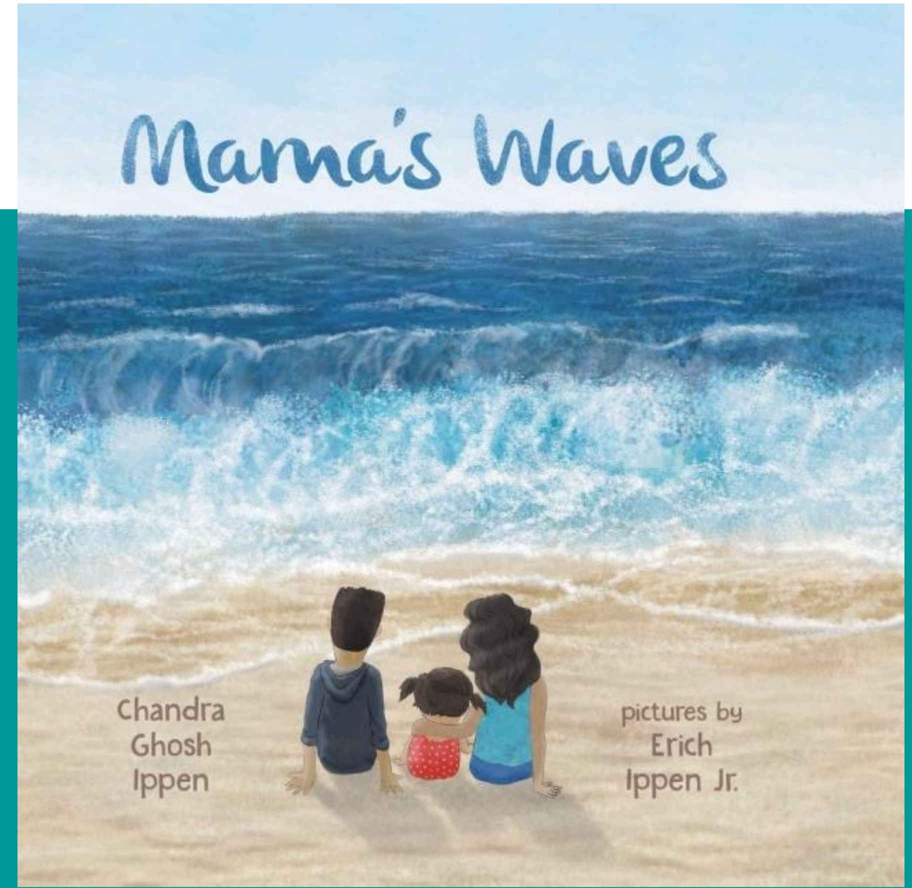
Fluctuations in Parental Functioning



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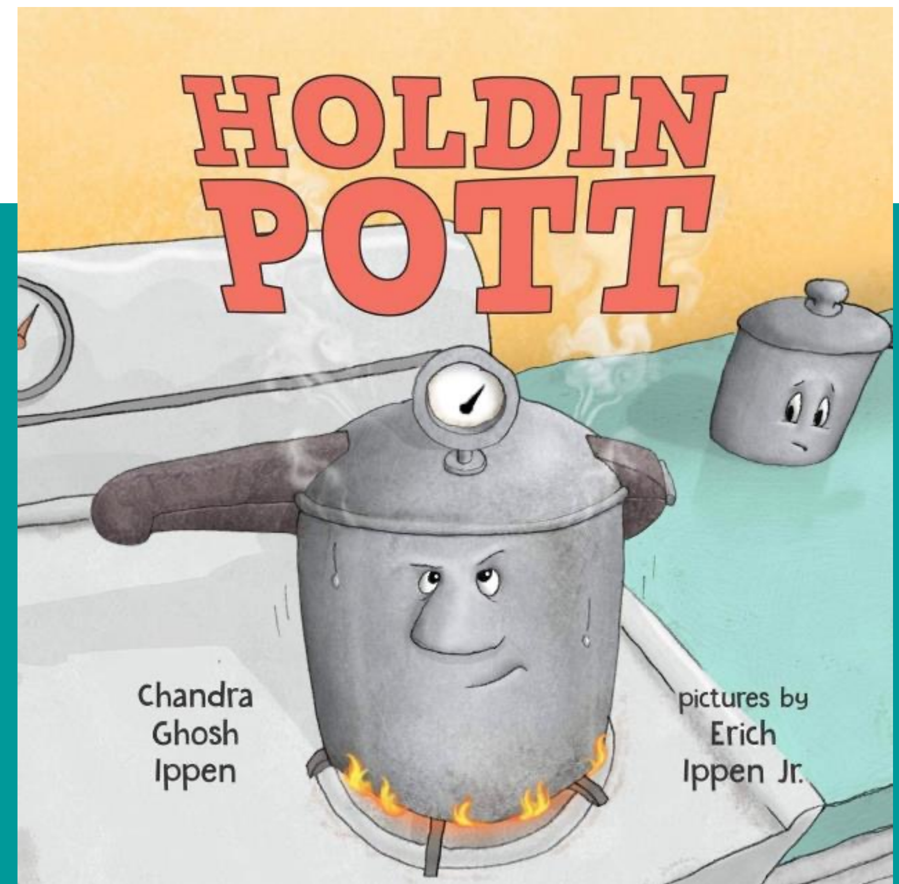
Coping with Stress



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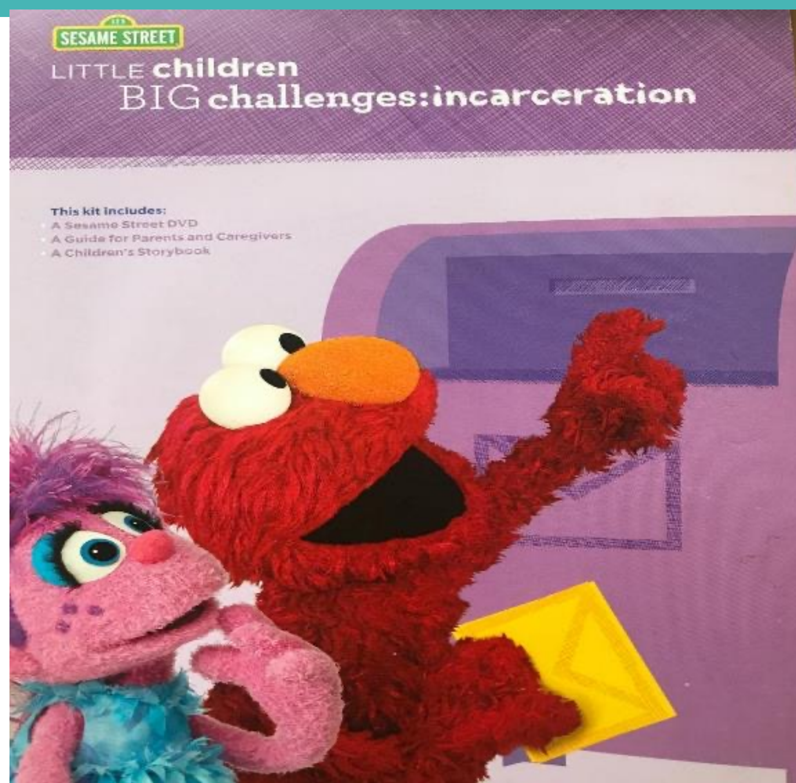
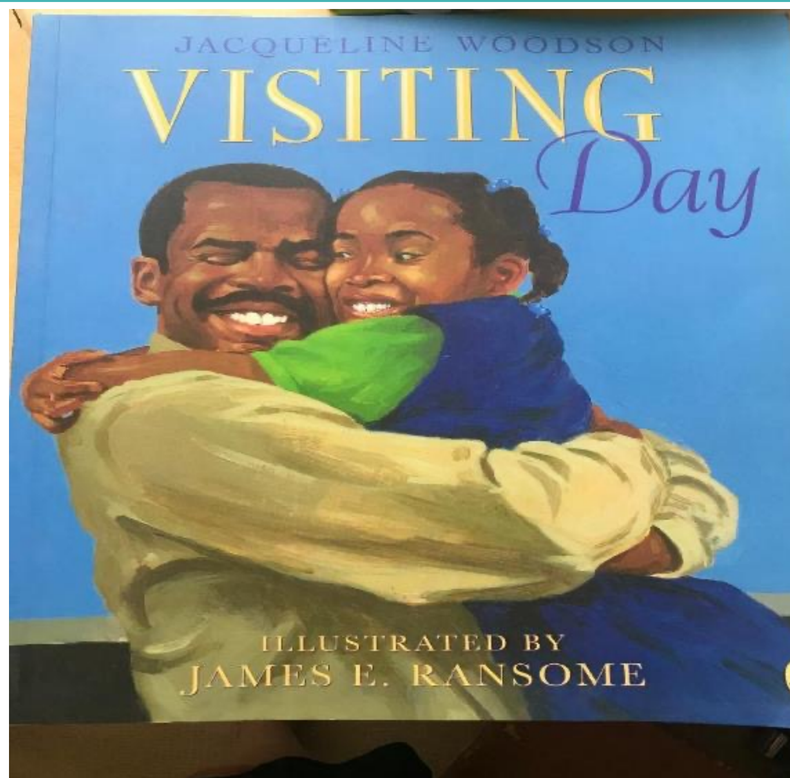
Sesame Street Tool Kit



Children with Incarcerated Parents



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I’m Here for You Now

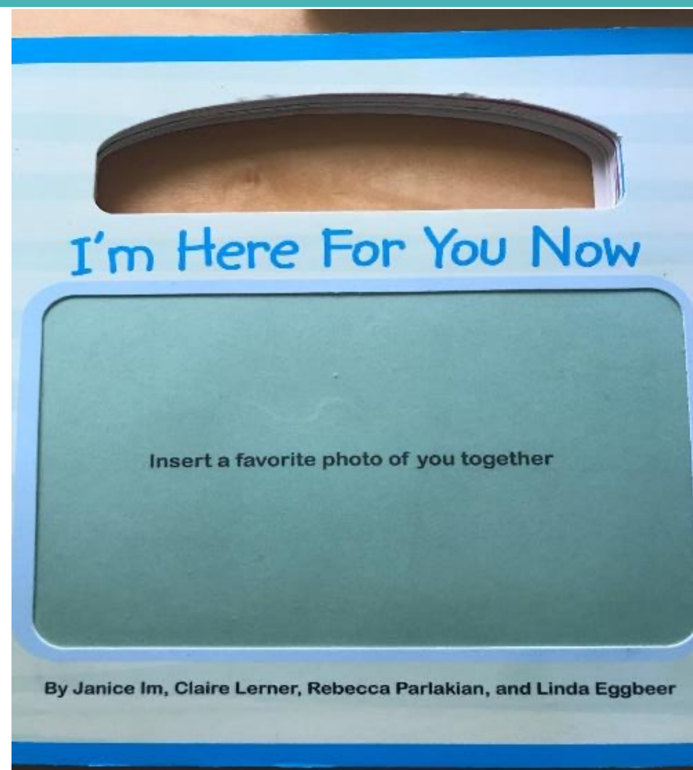


Photo book

Rise

Building a Bridge

Stories about connections between parents and foster parents.

Rise TIPS

BY AND FOR PARENTS IN THE CHILD WELFARE SYSTEM

Visiting Do's & Don'ts

Below are general guidelines about visits. However, every case is different. Ask your caseworker and your attorney about your case.

1. VISITS WITH YOUR CHILDREN SHOULD:

- Start within a week of your child entering foster care
- Take place for at least 2 hours each week and more often for infants and toddlers
- Be unsupervised as much as possible

2. BEYOND VISITS, YOU CAN:

- Ask for contact by phone or email (If you have a positive relationship with the foster parent)
- Exchange photos and letters
- Participate in children's medical visits, school conferences and activities

3. VISITING TIME SHOULD INCREASE IF YOU'RE:

- Attending consistently and on time
- Paying attention to your child for the whole visit
- Showing progress on the goals in your case — not just attending programs, but showing behavior changes related to the safety concerns in your case
- Being nurturing and loving

4. YOUR CASEWORKER REPORTS TO THE COURT WHETHER YOU:

- Attended your visit
- Came on time
- Called in advance if you were going to be late or had to reschedule
- Gave your attention to your child the whole time
- Disciplined your child appropriately
- Kept anger and frustration out of time with your child

5. YOUR VISITS MAY BE SUPERVISED, OR BE SET BACK TO SUPERVISED, IF:

- There's a concern that your child will be unsafe with you
- You are not showing a change in being able to keep yourself and your child safe
- You are not taking steps to address mental health problems or addiction
- There's a concern you will run off with your child
- There's a concern that you will influence your child's testimony in court

6. IT'S RARE BUT YOUR VISITS MAY BE CANCELLED ON THE SPOT IF YOU:

- Are drunk or high
- Act aggressively or make threats
- Hit your child – including "popping" your child – or threaten your child
- Blame, shame, or threaten your child in any way, especially saying that it's your child's fault that you have a case
- Can't calm down even after a warning
- Arrive very late without calling

How to Self-Advocate

1. Talk to your caseworker and lawyer about your visiting plan and ask for a copy of the court report.

2. Ask your caseworker to explain exactly what you need to do to make progress and ask for feedback after each visit.

3. Keep a "Visiting Notebook." Write down:

- Whether you attended and if you were on time;
- How the visit went;
- If your visit was cancelled and why, and whether it was made up.

4. If your visit is cancelled, speak to your caseworker to reschedule. If your visits are not made up, show your Visiting Notebook to your caseworker's supervisor, a parent advocate and to your lawyer.

Please note: These are general gu... that may not apply in eve...

New York City Early Childhood Mental Health Network

To refer a family or request information, contact your nearest clinic:

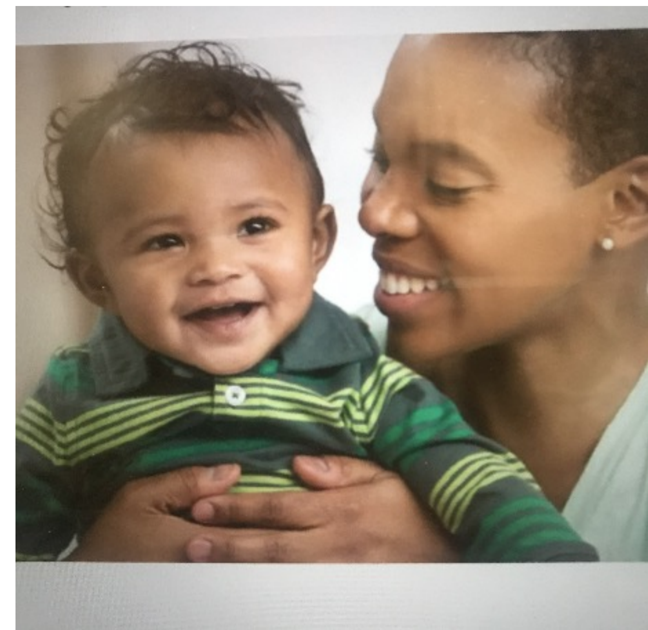
https://ttacny.org/clinical-services/

- Association to Benefit Children
  Phone: 929-288-4320
- Northside Center for Child Development
  Phone: 212-426-3400
- The Child Center of New York
  Phone: 718-530-6892
- OHEL Children's Home and Family Services
  Phone: 800-603-6435 (800-603-OHEL)
- Staten Island Mental Health Society, a division of Richmond University Medical Center
  Phone: 718-448-9775, ext. 551

The Early Childhood Mental Health Network is managed by the New York City Department of Health and Mental Hygiene

Reunification Supports

- Specialized Preventive Programs
- Home Visiting Programs (Healthy Families, Early Parent Child Home Program)
- Early Head Start
- High quality early childhood programs
- Power of Two



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