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Strengthening the Foundations of Emotional Health in Early Childhood: A Handbook for Practitioners

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Strengthening the Foundations of Emotional Health in Early Childhood

A Handbook for Practitioners

SECOND EDITION

Edmund S. Muskie
School of Public Service

UNIVERSITY OF SOUTHERN MAINE
A Member of the University of Maine System
Strengthening the Foundations of Emotional Health in Early Childhood
A Handbook for Practitioners

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October, 2001
2nd Edition

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Strengthening the Foundations of Emotional Health in Early Childhood: A Handbook for Practitioners

Project AIMS and Associates

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The purpose of this handbook is to provide to practitioners who work with children key information about young-child and family emotional health, so that they can gain as much as possible from using the AIMS: Developmental Indicators of Emotional Health. AIMS is a professionally constructed system of psychosocial practices recommended for professional use with young children and their families. The system consists of: 1) intake forms, including family information and a family concerns indicator; 2) multiple, developmentally-specific measures of child-parent-family emotional health in the form of parent self-report questionnaires; 3) guidelines for professionals' observations of parent-child interactions, and for general interviews of parents and children; and 4) suggestions for focused interviews and brief psychosocial interventions. The system is appropriate for use by a broad spectrum of professional providers, such as nurses, physicians, social workers, child care providers, and early intervention professionals. The AIMS system is designed to facilitate family-oriented, wellness and strength-focused assessment and intervention practices, which are considered likely to promote positive emotional functioning in young children and their families.

Chapter I of this handbook addresses the socio-cultural backdrop of health care practices as they relate to the emotional health, or psychosocial needs and problems of young children in the context of their families. The section briefly reviews the history and current state of health care for young children, including early intervention services of all kinds. It also discusses the emergent fields of infant mental health and social science research in infancy, and how these two fields have informed clinical practice with young children and their families.

Chapter II looks at what professionals need to know about early childhood emotional development and the psychology of parenthood and parent-child relationships in order to make the best use of the AIMS System of Practice. Key concepts, assumptions, theory, and research findings pertinent to attachment, interaction, emotional mastery and support are presented, explained, and applied to the professional's task of assessing young children and families with empathy and insight.

Chapter III takes a close look at some basic professional skills needed to make use of the AIMS guidelines for professional observations, focused interviews and brief interventions. Skills needed for psychosocial assessments, relationship-building, and parent-professional collaboration are also discussed. (Another AIMS publication, a Training Manual for Health Professionals in Well-Child Care Settings, covers the additional topical areas of: Emotional Development of Children 0-5, Clinical Assessment of Children 0-5, Observation Skills, Interview Skills, Therapeutic Communication Skills, Attachment Problems/Failure to Thrive, Attention Deficit Disorder, Teen
Chapter IV returns the professional to issues of social change and policy, which are so frequently encountered by people working to incorporate the AIMS methodology into their practices. Since early childhood services are constantly changing and rapidly developing, it is imperative to consider the sociopolitical environment in which any system of practice operates. This section discusses obstacles to use of the AIMS System of Practice and challenges to enhanced psychosocial practices with young children and their families. Positive and informative examples are offered, such as illustrations of how Maine communities, agencies and professionals have responded to emotional health needs and problems. Recommendations for system-wide improvements are also presented.

We also offer a Word of Encouragement to users who may begin to experience what many of our former trainees have encountered: pressures due to lack of time, training, and/or confidence. We share our perspectives on the challenges and rewards of enhanced psychosocial practices on behalf of our very youngest clients and their families.

The Appendices include feedback on the AIMS: Developmental Indicators of Emotional Health, a description of AIMS: System of Practice with samples of the AIMS forms and guidelines. A list of Screening and Assessment Instruments which were reviewed by Project AIMS prior to the development of the AIMS System, as well as a listing of selected instruments addressing Early Social and Emotional Development including the AIMS System of Practice.

We hope this handbook will provide a rich backdrop that prepares professional providers to use the AIMS System and maximizes their effectiveness and positive impact on young children and their families. We additionally suspect that some readers may wish to know about the history of Project AIMS and the context in which the AIMS: Developmental Indicators of Emotional Health was developed. We therefore include the following brief discussion about the history of AIMS and its purpose.

**Project AIMS’ History and Purpose**

The 1st edition of this handbook was the result of five years of experience with Project AIMS. This 2nd edition includes an additional six years of experience fine tuning, editing and revising the AIMS System of Practice based on feedback from professionals trained in the use of this methodology. What originally led to the idea for this handbook was a series of discussions by the Project’s Instrumentation Team, who constructed the AIMS: Developmental Indicators of Emotional Health. These discussions led to the need for further explanation of such a system of practice and the importance of including emotional health assessment in the care of young children.

AIMS is a methodology or "System of Practice" which focuses on the emotional health of young children from birth through five years of age and their families. There are three parts to this system: two intake forms Family Information and Family Concerns Indicator, Parent Questionnaires (12 developmentally specific, self-report indicators of child-parent-family emotional health and well-being), and guidelines for psychosocial practices (interviews, observations, in-depth discussions of emotional health, and brief interventions). The Instrumentation Team, after developing the AIMS materials over a five-year period, determined that a practitioner-oriented handbook would help prepare professionals to make optimal use of the AIMS System of Practice.

Project AIMS began in 1986 as a Collaborative Agreement with the federal Maternal and Child Health Bureau of the Department of Health and Human Services, Public Health Service (MCU-233926-05). Its overall goal was to strengthen Maine’s service systems’ abilities to identify and treat emotional health problems in very young children and their families. From the beginning, our approach was multi-level. At the state level, we collaborated with early intervention administrators and policymakers. At the community level, we selected four Maine communities (Rockland, Norway, Lewiston, and Ellsworth) to participate as demonstration sites and with these, we conducted needs assessments, provided numerous workshops and presentations, and collaborated on the development of new services and resources for families with young children. At the group and individual levels, we conducted numerous trainings, research which suggested improved techniques for educating professionals, and group supervision and consultation. Always, the goal was to introduce infant mental health to professionals and systems, and to work together to increase professionals’ abilities to provide psychosocial supports to families.

While the community and state collaborations were underway, and training provided across the state, the Instrumentation Team worked to develop the AIMS: Developmental Indicators of Emotional Health methodology. The AIMS System of Practice is this interdisciplinary group’s attempts to capture the essentials of infant/early childhood emotional health and to categorize and present this information in such a way as to be readily accessible to practitioners. The system was designed with some basic “principles” in mind: a wellness orientation (as opposed to a pathology orientation); a developmental focus (measures geared to specific ages of children rather than a broad range of ages); a family orientation (as opposed to solely child-focused); and, availability to a multidisciplinary group of professionals. While primarily designed with well-child health care settings in mind, the materials are also intended for early intervention workers, mental health professionals, educators and a wide range of additional users who work with young children and their families.
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The infant mental health field has grown tremendously since its beginning in the early 1970's. Much more remains to be done to help all professionals and service systems become attuned to the emotional health needs of young children and their families. The work of Project AIMS, through the methodology of the AIMS System of Practice, and through its many years of collaboration within and outside of Maine, has, we hope, helped to move the infant mental health field forward.

Susan E. Partridge
Deborah Devine
John Hornstein
Jayne D.B. Marsh
Instrumentation Team Members

Acknowledgments

This was not an easy book to write. How does one truly capture the art and practice of providing family-oriented, supportive services to families with young children? To do so simply and straightforwardly seems almost to diminish the amount and complexity of knowledge, sensitivity and skills a practitioner actually uses when working effectively with families; these are not simple matters. Yet, to elucidate the complexities — the social and historical contexts of this work, the institutional resources and barriers, and the knowledge base and skills needed by a professional practitioner — is a massive challenge, indeed!

But, try we must, to distill our years of experience as staff members of Project AIMS. Our goal was to strengthen the services available to families with infants, toddlers, and young children, with particular regard to their emotional health needs. As such, we geared our work towards multiple levels of effort: planning and collaboration with community leaders; training; curriculum and materials development; construction of an emotional health brief assessment system (The AIMS: Developmental Indicators of Emotional Health); writing and publishing; presenting at conferences and workshops. This book represents our attempt to document what we have learned — certainly from books and articles, but mostly from people, those with whom we collaborated, those whom we trained, those who taught us, and parents and their young children to whom we intently listened.

There are many people to thank. First of all, the chapters' authors. Jayne Marsh, the most recent Project Director of Project AIMS and a Research Associate, surveyed and assimilated the literature for the social and historical context of "psychosocial practices in the health care field." We have learned that people can better grasp where the AIMS System of Practice is heading, to the extent that they understand the dilemmas and barriers present in current health care services. Jayne also managed to edit this 2nd Edition, supplementing the first with the Project's additional years of knowledge gained through its work and ongoing review of the literature. Each chapter was enriched with new content as well as format changes to enhance presentation of the material. An additional chapter on the study of AIMS was also added to this second edition, filling out the multiple years of experience and discovery in the work of Project AIMS.

Debi Devine, Research Associate with Project AIMS, pulled together our literature on the concepts of attachment, interaction, mastery and social support. Making these concepts available and accessible to professionals has been one of the major lessons we have learned from training. Debi's insights have continuously improved and enlightened all of the training we have accomplished.
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Jean Pinkham, Evelyn St. Pierre, and Terry Lapointe, each successive Administrative Assistant, did a tremendous job with typing, organization, and sundry details of making a book happen. Anne Bernard designed the cover and produced the book with her characteristic flair. Carol Boggs edited the manuscript for the 1st Edition; her skills are highly valued, as are her ideas for presentation and clarity. Sally Brown also helped with editing of the 1st Edition and made many helpful suggestions; Sally, a former Research Associate with the Project was the backbone of our detail work when it came to constructing the assessment system.

Finally, there was a tremendous amount of input from a variety of people who have contributed their talent and knowledge to Project AIMS over its history. First, the members of the Instrumentation Team: Anne Chaisson, Mike Cohen, Palmer Curtis, Gladys Richardson, Stephanie Walstedt, and Ron Taglienti all took part in “work teams” that helped review the literature, and established goals and major points for each of the handbook’s chapters. Their individual knowledge of Maine’s services to families with young children, their commitment to Project AIMS and the cause and practice of infant mental health, and their skills are unsurpassed. One couldn’t wish for a better team.

Other team members on the original work group to construct the AIMS System of Practice include Jean Judge, Betsy Squibb, Cathy Ayoub, Jane Weil, who also was a Research Associate with the Project and a key thinker, and Steve Bauer. Each of these individuals shared their extensive knowledge, their wisdom generated from years of work with young children and their families, and their personal philosophies. With the Project AIMS staff, they all helped to create a workable assessment and intervention system, which we hope will generate better services to families with young children.

Finally, I would like to thank the many — perhaps more than a 1,000 — parents, early intervention workers, and professionals from all disciplines who in one way or another contributed. Special thanks are extended to professionals from Lewiston (Eileen Fair and Laurie Bertulli), Norway (Sue Ellen Myers and Dolly Wetter), Rockland (Alan Letourneau and Davene Fahy), and Ellsworth (Cynthia Donaldson, Pearl Barto and Mary Veit), and all of whom represented our four community site participants. All of these associates gave feedback on our training, responded to articles or drafts of materials, asked questions, completed forms for pilot or field testing and the like. Many remain nameless, but we are convinced that we learned a great deal from them.

I couldn’t feel comfortable with this Acknowledgment without also thanking some special people in my life. I received my early training with a remarkable group of people who worked for the Child Development Project in Ann Arbor, Michigan, in the early 1970’s: the late Selma Fraiberg and Vivian Shapiro, and Edna Adelson. From them and from Linda Turner, a supervisor who followed them, I learned what it means to commit one’s self to clinical work on behalf of infants and young children. I learned a kind of attitude that is indelible, and I am truly grateful.

And I thank my husband, Roy, and children, Mara and Juliana, for bringing to my life, in a most passionate and personal way, what it really feels like to be a mother of a very young child in a family context. Without these joys and realities, how could one ever merge head with heart, a process so essential to infant mental health work? Our learning continues on and on.

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Susan E. Partridge, L.C.S.W, Ph.D.
The purpose of completing a second edition of the AIMS publication: *Strengthening the Foundations of Emotional Health in Early Childhood: A Handbook for Practitioners*, was to fill-out and supplement the content with additional literature review and experience in training and use in the field of the AIMS System of Practice. We have learned that the AIMS tool continues serving to guide and support professionals who work with young children and their families toward strengthening emotional development in early childhood.

Chapters 1 – 4 of the Handbook have been added to greatly through current literature review and additional experience gained in the field. Chapter 5 was added as a new chapter to help clarify the validity and reliability of the AIMS tool through summarizing and reporting the further study done subsequent to the first Edition of the Handbook. This chapter helps provide answers to questions surrounding the tool's validity, reliability and usability. This information had frequently been requested by professionals in the field and was a needed addition to the Handbook.

The AIMS System of Practice continues to be used across the country in practice and teaching settings where work is done to benefit young children and their families. The purpose of it's use remains: to better understand the child in the context of the family; to identify strengths as well as risks and concerns; to establish a relationship/partnership with families; and to enhance dialogue toward strengthening and supporting emotional development in early childhood through timely assessment and appropriate interventions.

The AIMS System of Practice continues to be available through the National Child Welfare Resource Center (1-800-HELP KID) at the Edmund S. Muskie School, Child and Family Institute, University of Southern Maine, in Portland, Maine. The staff of AIMS continue to provide training, workshops and conference presentations on AIMS as well as on other areas related to strengthening the foundations emotional health in early childhood.

AIMS has been included in a book published by Brookes titled: *Failure to Thrive and Pediatric Undernutrition: A Transdisciplinary Approach* (Kessler & Dawson, 1999), as Appendix E. AIMS is additionally included in a resource publication by the US Dept of Health Systems Research; Proceedings at the New England Grantees conference, Healthy Child Care New England (2000).

AIMS continues to play an integral part in moving the field of Infant Mental Health practice to the forefront for providers who engage with young children and their families across the country. As goes the children, so goes the nation. Where are we headed? We may learn from the Masai Tribes in Africa who place a high priority on the well being of children, evident in their customary greeting, *How are the children?* The traditional answer to this question is; *The children are well,* meaning
that life is good, that through the daily struggles of existence, even among a poor people, care of the young is the reason for being, it is the highest priority. *

To this end, in the future we may ask, in our own country, and in the larger world, as in the Masai Tribes of Africa, How Are the Children? And answer, The Children are Well.

Jayne Marsh, MSN, MPA

*excerpted/adapted from; Child Care Connections, Autumn 1995, Newsletter article; How Are The Children?

Chapter 1

Psychosocial Concerns of Health and Mental Health Providers

Jayne D.B. Marsh, MSN, MPA

The AIMS System of Practice was developed to enhance service delivery to families with infants, toddlers and young children. Why was there a need for such a system? This chapter presents the context in which The AIMS: Developmental Indicators of Emotional Health was constructed.

The notion of emotional health during infancy and early childhood has gained much momentum in the last decade. Fields of practice within and outside of mental health, specifically infant mental health, have recognized the need for their provision of services to attend to the psychosocial aspects of care (Davidson, 1988; Green, 1986, 1985; Granger, 1985; Albino, 1983; Cowen, 1983). Inclusion of psychosocial aspects serves to enhance the overall well being and health of young children and their families.

It has become much clearer that the early years of a child's life are a critical time for development. D.W. Winnicott (1969) made the basic observation that very young children need continuous and reliable care or they do not develop properly. More recently, Call (1987) suggests that the period from birth to age three probably includes more major shifts in development than take place in the remaining 65 or so years of life, during an average life-span. These developmental shifts include all aspects of human growth and development, not simply physical growth and development. Psychosocial or, emotional and behavioral development, is also a major aspect of this developmental process.

Dr. Bruce Perry (1995) identifies that the early experiences of childhood act as "primary architects" of the young brain's capabilities, which will have impact throughout the rest of life. Consistent, nurturing, predictable, structured and enriching experiences in a safe environment during early childhood have a positive impact on brain organization and function, leading toward more empathetic, responsible, and fully functioning adults. Parents have the most influence during this crucial time of development. They need to be supported and strengthened in their ability to positively support and strengthen the development of their children. "In the ways we care for our children, we create our society. We create the healers and the destroyers. Our children are reflections of the world in which we raise them. We reap what we sow" (CIVITAS INITIATIVE, 1997).
that life is good, that through the daily struggles of existence, even among a poor
people, care of the young is the reason for being, it is the highest priority.*

To this end, in the future we may ask, in our own country, and in the larger
world, as in the Masai Tribes of Africa, How Are the Children? And answer, The
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*excerpted/adapted from; Child Care Connections, Autumn 1995, Newsletter article; How Are The Children?

Chapter 1
Psychosocial Concerns of Health and
Mental Health Providers
Jayne D.B. Marsh, MSN, MPA

The AIMS System of Practice was developed to enhance service
delivery to families with infants, toddlers and young children.

Why was there a need for such a system? This chapter presents
the context in which The AIMS: Developmental Indicators of
Emotional Health was constructed.

The notion of emotional health during infancy and early childhood has gained
much momentum in the last decade. Fields of practice within and outside of mental
health, specifically infant mental health, have recognized the need for their provision
of services to attend to the psychosocial aspects of care (Davidson, 1988; Green,
1986, 1985; Granger, 1985; Albino, 1983; Cowen, 1983). Inclusion of psychosocial as-
pects serves to enhance the overall well being and health of young children and
their families.

It has become much clearer that the early years of a child's life are a critical time
for development. D.W. Winnicott (1969) made the basic observation that very young
children need continuous and reliable care or they do not develop properly. More
recently, Call (1987) suggests that the period from birth to age three probably in-
cludes more major shifts in development than take place in the remaining 65 or so
years of life, during an average life-span. These developmental shifts include all as-
pects of human growth and development, not simply physical growth and develop-
ment. Psychosocial or, emotional and behavioral development, is also a major aspect
of this developmental process.

Dr. Bruce Perry (1995) identifies that the early experiences of childhood act as
"primary architects" of the young brain's capabilities, which will have impact
throughout the rest of life. Consistent, nurturing, predictable, structured and enrich-
ing experiences in a safe environment during early childhood have a positive impact
on brain organization and function, leading toward more empathetic, responsible,
and fully functioning adults. Parents have the most influence during this crucial time
of development. They need to be supported and strengthened in their ability to posi-
tively support and strengthen the development of their children. "In the ways we
care for our children, we create our society. We create the healers and the destroy-
ers. Our children are reflections of the world in which we raise them. We reap what
we sow" (CIVITAS INITIATIVE, 1997).
The period of early childhood is a time of unparalleled growth and development from birth, when an infant is completely dependent on caretakers, to a preschool child who strives for his/her independence. Have Early Childhood practitioners and providers kept pace with the ever-changing needs of the young child in the context of his/her family during these important years of life? It is stated that in the United States, despite two centuries of extraordinary human achievements, our policies and practices do not reflect an understanding of the critical role that child well being and child rearing plays in the health and welfare of our society at large, and the world. The United States has been referred to as a third world country in the way we care for and nurture our children (Magid, 1990). This is an urgent issue facing all of us.

Fundamentals of Emotional Health

The constructs of attachment, interaction, mastery (for the child and the parent) and social support provide a common language or framework to understand emotional and psychosocial issues as important factors in child health and development. This framework can help organize and identify information about young children and their families toward gaining insight into how the child is developing and how the parent-child-family is functioning.

Emotional health develops in a nurturing, safe environment where there is trust, caring, consistency, structure and predictability, and builds on a foundation of secure attachment, positive interactions, mastery of abilities and developmental achievements, and the creation and use of social supports. Optimal emotional health development of the child is most likely to occur when the family is able, or assisted to provide this context. Early childhood emotional health is seen as critical, not only to later emotional development and well-being but also to academic competence and moral development. (Greenspan, 1997). Early childhood emotional health is looking at the child in the context of the family, connecting with the parent and understanding the parent and family role or impact on the young child. Working with the whole family becomes the preferred means of achieving positive results toward supporting and strengthening the emotional development of the child.

Emotional health is thus defined as an individual's ability to grow and develop, to work, play, and love, within the context of opportunities for attachment, interaction, mastery, and social support. These terms generate the A·I·M·S acronym of The AIMS: Developmental Indicators of Emotional Health or System of Practice, constructed to facilitate professional inclusion on emotional health assessment and early intervention in their provision of care to young children and their families.

The domains of AIMS (Attachment, Interaction, Mastery, Support) can be simplified as outlined in Table 1.1, where attachment reflects feelings; interaction relates to behavior; mastery illustrates capabilities; and support identifies resources:

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The concepts of attachment, interaction, mastery and support are further defined as follows:

- Attachment reflects the special and unique ties among parents and children where children learn to express trust and feel secure. Both parent and child become emotionally "tuned in" or attuned to each other. Attachment is considered the root of all emotional health and is therefore essential to overall emotional well being. Leach (1994) identifies attachment as the most critical accomplishment of a human infant's first year of life.

- Interaction relates to parent-child-family patterns of behavior and communication, with parents teaching and guiding children. This includes establishing routines and rituals, meeting survival needs and basic care giving, appropriate limit setting and discipline. Interaction focuses on behaviors, consistencies, and expectations turned into behaviors and the give and take between parent, child and family.

- Mastery illustrates the accomplishment of basic skills by the parent, and by the child, with a sense of competence and confidence. Mastery is twofold in regard to the parent's ability and skill at successfully performing basic child care, and the child's ability to successfully develop at increasingly complex levels. Both exhibiting ability to learn, adapt and problem solve along developmental lines.

- Support identifies the existence and use of social resources, such as seeking out, asking for, and/or accepting help when needed, and having regular contact with a social network of family, friends, and the community. Social Support can serve to decrease stress and illness, as well as facilitate parental competence and confidence.

The domains of Attachment, Interaction, Mastery, and Social Support are considered the building blocks of emotional health. These domains or concepts are not mutually exclusive. They are individually and collectively important in looking at emotional health. They are interconnected, interrelated and interdependent. They help define ways to observe for and ask questions around the emotional life of young children in the context of their families. Making observations and asking questions around these concepts provides clues or moments of opportunity towards understanding emotional development in assessment and early intervention situations. Each of these concepts are evidenced by a range of specific behaviors, attitudes, and/or qualities, some of which are represented in Table 1.2.
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Table 1.2
A-I-M-S Behaviors, Attitudes and Qualities

Attachment
- parent investment of emotional energy in the child
- parent adapting family life to include the child
- parent securing a protective environment for the child
- the child's preference for and seeking out of primary caregiver
- a mutuality or goodness of fit between parent-child-family
- the child's proximity-seeking behavior to the primary caregiver
- mutual pleasure upon reunion after a separation
- positive feelings, attitude of trust
- sense of security within the immediate family

Interaction
- parent provision of basic care-giving, survival needs
- parent establishing daily routines; feeding/eating, sleeping, etc.
- playing, having fun
- sharing companionship
- teaching and learning
- limit-setting, discipline
- exchanging information
- problem-solving and decision-making
- communicating feelings and thoughts, wants and needs
- negotiating conflict, utilizing coping skills

Mastery
- parental self-esteem
- parental competence and confidence
- child's development of basic competencies; cognition, language and communication, social and motor skills
- child's sense of confidence in own abilities
- parents' and child's reciprocal adaptation and coping
- mastery of stress and ability to resolve difficulties

Social Support
- parent asking for and/or seeking help
- parent access to resources within and outside of the family
- parent ability to accept resources
- parent maintaining contact with a social network
- parent-child-family sense of belonging within the extended family and the larger community

These four identified constructs or domains of emotional health; Attachment, Interaction, Mastery and Support provide a framework for emotional health assessment and early intervention of the young child in the context of their family. By understanding and applying these concepts, we can support and assist young children and families to grow and develop in healthy and happy ways.

Changing Perspectives on Health

There was a time when psychosocial or emotional health was not considered a very important aspect of overall health and well being. The "new" perspective, which regards psychosocial/emotional aspects of care as important, officially became evident through the World Health Organization's redefinition of health in 1946. This new definition of health; a state of complete physical, mental, and social well being, not merely the absence of disease or infirmity (Albino, 1983), marked the beginning of an attitudinal shift in the existing paradigm for the provision of overall health care in the general population.

Even earlier than this, specifically relating to children, President Herbert Hoover had established the White House Conference on Child Health and Protection in 1930. This Conference put forth 19 "aims" for the Children of America in the form of a Children's Charter. These aims reflected the emotional, psychosocial needs of children, along with the physical and environmental needs as evidenced in the following sampling of the Charter, Table 1.3. Evident in this Charter is a focus on each child as an individual with both physical and emotional needs. The importance of a safe and loving home with knowledgeable support from the community, and the importance of preparing for parenthood.

However, changing existing practices to include psychosocial care in various service delivery systems has remained problematic. Green (1985) notes that there has been a considerable lag between what is known and what has been applied in the developmental and psychosocial domains of well child care practice. While the potential value of including psychosocial aspects of child development was evidenced in the literature as early as 1930 (Anderson), this type of care was not clearly included in pediatric training until around the 1960s. Areas of concern in provision of care have generally dealt with physical health and illness. Even in the field of social sciences and psychology, a noted text (Kessler, 1966) identified only two areas of concern in the first three years of life: that of feeding and toilet training. Inclusion of psychosocial aspects of care did not become significant until the 1970's, when curricula in behavioral, biosocial and bio-psychosocial pediatrics were developed (Davidson, 1988). By the eighties, concerns in the psychosocial arena of care included 25 areas for potential diagnosis and treatment of children under three years old (Call, 1987).
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• a mutuality or goodness of fit between parent-child-family
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Table 1.3

Sampling of the 1930 Children's Charter

1. For every child spiritual and moral training to help him stand firm under the pressure of life.
2. For every child understanding and the guarding of his personality as his most precious right.
3. For every child a home and that love and security which a home provides; and for that child who must receive foster care, the nearest substitute for his own home.
4. For every child health protection from birth through adolescence, promotion of health, including health instruction and a health program, wholesome physical and mental recreation, with teachers and leaders adequately trained.
5. For every child a dwelling place safe, sanitary, and wholesome, with reasonable provisions for privacy, free from conditions which tend to thwart his development; and a home environment harmonious and enriching.
6. For every child a school which is safe from hazards, sanitary, properly equipped, lighted and ventilated. For younger children, nursery schools and kindergartens to supplement home care.
7. For every child a community which recognizes and plans for his needs, protects him against physical dangers, moral hazards, and disease; provides him with safe and wholesome places for play and recreation; and makes provision for his cultural and social needs.
8. For every child such teaching and training as will prepare him for successful parenthood, homemaking and the rights of citizenship; and, for parents, supplementary training to fit them to deal wisely with the problems of parenthood.
9. For every child the right to grow up in a family with a standard of living and the security of a stable income as the surest safeguard against social handicaps.
10. For every child a protection against labor that stunts growth, either physical or mental, that limits education, that deprives children of the right of comradeship, of play, and of joy.
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A study conducted during the 1980's, however, still concluded that there is little focus on actual interventions with parents and young children during the well child visit with regard to the professional provider's role in encouraging discussion of psychosocial concerns, the parents response to such encouragement, or how the provider responds to parents' expression of psychosocial issues (Sharp et al, 1992). Thus the lag reported by Green (1985) still exists between what is known and what is practiced.

Several leaders in child health care fields perceive a need to restructure care to recognize and respond to psychosocial needs, moving beyond the traditional practice that focuses on a child's physical being and illness, and only on the individual child, not the child in the context of the family. Morris Green (1985) specifically states that the challenge is to develop and implement new models of care that include a focus on the emotional, psychosocial aspects of child health. He additionally states that, "...physical well being and emotional health care are indivisible..." (Green, 1985). This is confirmed more and more through research efforts on the connections between physical illness and emotional, psychosocial factors, such as poverty, abuse and neglect. Perry (Not Yet in Print) adds that programs which support and strengthen families will serve to increase the likelihood of optimal childhood experiences and resultant positive psychosocial outcomes.

This recognized need to restructure well child care, stems from an awareness of what the literature has termed the "new morbidity" —the increased reporting of psychosocial problems that appear to not only interfere with healthy development of the child, but additionally can cause illness in the child and family (Davidson, 1988; Costello and Panino, 1987). More specifically, it refers to the most prevalent conditions of childhood being reported as developmental, learning and/or behavioral, social concerns or disorders (Zilland and Schoenborn, 1990; Haggerty et al, 1975).

These new morbidity issues require professionals in well child care to develop and integrate skills in psychosocial and developmental aspects of well child care, particularly pediatric well child care. These important areas of concern are not as likely to emerge in the traditional, medical model of care. Many professionals lack the training, time or resources to consistently and systematically address the new morbidity issues in their routine practice (Sharp, et al, 1992; Partridge, 1990; Bauer, 1987; Costello, 1986). This creates a real difficulty for professional in addressing these new concerns. There are few protocols or guidelines to help professionals deal with behavioral and developmental concerns presented by the new morbidity (Sia and Peters, 1989; Bauer, 1987). Professionals need knowledge around psychosocial issues and a methodology to effectively make assessments and provide supportive interventions to families with young children. "The ability to address psychosocial problems satisfactorily is critical to successful child health supervision" (Sharp et al, 1992, p. 622). Are professionals responding to these concerns? A 1998 article (Young et al) entitled, Listening to Parents... confirms that parents want this care from their well child provider, but the majority feels that they do not get it. Parents indicate that the physical needs of their young children are being meet, however, they need more information and support related to psychosocial concerns.
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Pediatric Well Child Care: Supply and Demand?

Pediatric care as a specialty area, is a relatively contemporary phenomenon. The emergence of pediatrics as distinct from other medical disciplines occurred early in the twentieth century (Hoekelman, 1983). Prior to this point, medical care for children consisted primarily of episodic care related to clear definition of symptoms and prescribed treatments to reduce or resolve those symptoms. This means of intervention has its roots in a medical model of practice that is heavily biopsychiologic, disease-oriented, episodic, prescriptive, and unbalanced in meeting total health care needs, particularly psychosocial needs and child development issues (Green, 1985).

Advancements in medical science prior to the twentieth century led to a reduction in morbidity from life-threatening infections and nutritional disorders, which had preoccupied much of the medical care provided to children at that time (Hoekelman, 1983). As Maslow's hierarchy of needs (1954) would suggest, the focus shifted; with survival needs fairly well addressed, primary preventative care emerged as a concern. This "new" agenda for pediatric practice translated to pediatricians spending the majority of their time (up to 65 percent, according to Davidson, 1981) providing well child care. A continued focus on the medical model of care, however, meant the pediatrician still devoted most of the care during health care supervision, to physical care through conducting routine physical exams (Casey, 1984). Additional pediatric care focused on chronic, episodic or acute illness intervention (Green, 1985).

The medical profession's new interest in children through the field of pediatrics was not initially due to an appreciation of the early years of life. Jones (1983) reported that the emergence of the pediatrician and specific pediatric care was in large part the result of relationship building between mothers and doctors. Medical doctors responded to an expressed need of mothers to develop strategies for mothering, and criteria for maternal competence related to childhood illnesses and feeding. The more organized motherhood groups sought out "scientific" medical information for defining the qualities of a conscientious mother, to ensure the health of their children (Jones, 1983). Pediatrics then, was a parent driven professional specialty.

Contemporary parents seek professional advice from pediatricians for far more than physical or illness care. A majority feel the need for guidance about behavioral and developmental aspects of parenting (Young et al, 1998; Sharp et al, 1992; Young, 1990; Granger, 1985; Casey, 1984; McCune et al, 1984; Hickson et al, 1985). Many express a need to learn about social, psychological, and behavioral issues — the ABC's of emotional health. Reports show that in the mid 1960s, 45 percent of mothers had more developmental and behavioral concerns than other concerns (Young et al, 1998). In the late 70s, studies report that 70 percent of mothers had concerns related to areas of parenting, child behavior, and development (Hickson et al, 1983). Multiple studies reported by Granger (1985) indicate that parents' primary concerns centered on developmental and/or psychosocial issues. Parents clearly need and want this kind of care from their early childhood service providers. Pediatricians and Family Practice physicians are two of the primary and most consistent sources of information in early childhood. They need to be prepared to respond to the psychosocial concerns/questions brought to them by parents. Parents see these professionals as the experts in physical and psychosocial health issues (Sharp et al, 1992).

It is found however, that while parents need and want assistance in developmental and psychosocial areas from their early childhood care provider, they frequently do not get it. Reported studies (McCune et al, 1984) showed that 81 percent of parents would discuss concerns about psychosocial issues if given the opportunity. However, a focus on parent-child relationships and children's emotional health has not become routine in well-child care practice. It is reported that during routine-care visits, the pediatrician spends the majority of the time in closed-ended interviewing, giving rather than gathering information, and still focusing on physical and illness-related aspects of care (Granger, 1985; Casey, 1984). In the 1970's, research indicated that physicians were actually giving cues to parents that discouraged or inhibited the parents' discussion of "non-medical" issues or concerns, as reported by Sharp et al (1992). In the same report, research during the 1980's showed some improvement in pediatricians and/or family practice providers, giving cues which "allow" parents to discuss "non-medical" concerns.

A current national survey of over 2000 parents (Young et al, 1998) continues to provide evidence that parents are not getting the information and support they need in the areas of behavioral and emotional development, and parenting of their young children. Most parents viewed the pediatric health care system as meeting the physical needs of their young children (66%), however many parents (53-79%) were less satisfied with the extent to which they received help/support in understanding their child's growth and development and child rearing concerns (Young et al, 1998). The issue seems to be how the care provider responds to and meets these parental concerns.

While research consistently demonstrates the relationship between the professional provision of emotional support and overall health in families (Young et al, 1998; Jones, 1995; O'Connell, 1992; Wieder et al, 1992; Cowen and Work, 1988; Shonkoff, 1984); it also indicates that the average time spent providing psychosocial guidance and support, is less than one minute per visit (Reisinger and Bires, 1980). Early childhood care providers need to be aware of their impact on parents, and be intentional in their influence. The authority and voice of health care providers in early childhood still have clout with parents and impacts parent behavior and response to their young children; so too, silence or avoidance of parents concern/questions constitutes a missed opportunity to support and strengthen families with young children (Young et al, 1998). In order to support and strengthen the overall health and development of young children and their families, these opportunities must not be missed, but utilized positively.
Pediatric Well Child Care: Supply and Demand?

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The Influence of the Infant Mental Health Field

In addition to pediatrics, other fields of practice and research have developed specialized services to young children and their families and conducted studies on the best methods of early intervention. Social work, psychology, nursing, and psychiatry have all contributed to the study of emotional health and development in early childhood termed, "Infant Mental Health." This interdisciplinary alliance has concerned itself with the care of children from infancy through the preschool years, with particular regard for the young child's emotional development. The work is based upon the belief that the early years of a child's life are critical, in terms of psychosocial development, and will have profound impact on a child's overall growth, development and well being (Greenspan, 1997; Bretherton, 1985; Main et al, 1985; Stern, 1985; Waters, 1978; Matas et al, 1978; Stern, 1977; Winnicott, 1969).

As early as 1914, a movement began to address parents need to have knowledge of infant care beyond physical care. This was evidenced by the Children's Bureau publishing a pamphlet entitled, "Infant Care" (Young, 1990), and followed by the emergence of Parents magazine in the 1920's, amidst the Parent education movement. The goal of these publications was to provide information to parents about infant development from experts in the field, pediatricians and, in particular, psychologists and child development specialists. These efforts were in response to parent's expressed need for information on parenting and infant development.

Infant Mental Health became a focus of concern as a result of research on the abilities of infants during the sixties (Smith, 1988). This research highlighted the infant's capacity for cognition, recall, social relatedness, and adaptability. Clinical studies also clarified the importance of early experiences, pointing out the negative impact of adverse experiences such as abandonment, neglect and abuse. Early intervention specialists working with young children and their families began to carefully address the early parenting environment and ways to enhance healthy infant-parent relationships. Psychosocial research and theory reflecting four ideologies of current culture (Kagan et al, 1978) heavily influenced this early intervention work. These four ideologies or concepts were as follows:

1. The influence of the child's early experience on later development.
2. The continuity of early childhood growth and development.
3. The centrality of the mother-infant relationship
4. The primacy of the family as the structural unit within a nurturing society.

These four ideologies or concepts further grounded the notion of Infant Mental Health and early intervention service to promote and support emotional well being in young children and their families. Home visiting, new infant assessment measures, such as the Bayley Scales of Infant Development (1969), infant-parent psychotherapy and multidisciplinary services were also created to prevent and/or attempt to reverse early psychopathology (Fraiberg, 1980).
are skilled in this area of early childhood care (Sharp et al, 1992).

In a study of the communication patterns in the patient-physician relationship, the average length of a routine visit, including a physical examination was 21 minutes. This time frame did not significantly change when psychosocial issues were addressed. One of the concerns of providers is the potential increase in length of visits when psychosocial issues are included. "Many physicians think that patient-centered visits, particularly visits in which psychosocial issues are addressed, are more time consuming than biomedical exchanges and more likely to overwhelm a tight schedule. This is clearly not the case here. Even the pattern of communication in which dialogue was predominately psychosocial did not result in significantly longer visits than the others (which predominantly were biomedical)" (Roter et al, 1997, p. 355).

However, the inclusion of psychosocial communication was associated with the highest level of satisfaction among the patients in the study, particularly in relation to a sense of partnership and support. The frequency of these types of visits continues to be low, less than 10 percent, and reflects a small proportion of overall routine care. The data also suggested that when time in routine care is shortened, psychosocial issues are the first to go (Roter, 1997).

The evidence is clear of the need for primary care professionals to routinely address emotional health in their delivery of care. Pediatricians and Family Practice Physicians specifically, as well as other early childhood providers, need to be better prepared to assist families toward overall child and family well being. "The ability to address psychosocial problems satisfactorily is critical to successful child health supervision... Addressing such concerns can often relieve anxiety, improve interaction skills of parents with their children, and potentially avoid parents returning again for the same concerns", (Sharp et al, 1992, p. 622). Pediatricians in particular, are the most consistent health-care provider throughout early childhood. The importance of their influence and effect on the well being of children and their families cannot be underestimated. Pediatricians are said to be the Gatekeepers to identification of the need for specialty care in children and families (Costello and Pantino, 1987). It is paramount that they understand and implement psychosocial aspects of care in their provision of care. Parents need and expect this aspect of care. The expectation that physicians are capable of responding to and caring for psychosocial concerns, places responsibility on the Health Care system to produce physicians who understand and are skilled in this area of early childhood care (Sharp et al, 1992).
Infant Mental Health work now consists of all types of professional activity engaged in for the purposes of enhancing human services and life conditions surrounding infants, young children, and their families, including promoting public policy that impacts their overall well being. Infant Mental Health work is relational and reflective. It responds to the centrality of parent-child-family relationships and the level of need and readiness of the parent-child-family; it requires self-awareness of skills, strengths and feelings and an awareness of the provider impact on the parent-child-family; it utilizes empathy, support and understanding; and it is flexible, non-judgmental, non-blaming and non-biased (Weider et al, 1992). Infant Mental Health practice is a combination of parental support, guidance, and education; provision of corrective emotional experiences for parents that promote and support their continued development; and facilitation of a growth promoting interpersonal environment for the young child in the context of a family through a variety of activities. These professional activities can include:

- Public Education about Infant Development and Needs
- Parent Education about Parenting Skills, and Infant Development
- Legislation/Advocacy about Early Intervention and Prevention
- Administration by Federal and State Early Intervention Agencies
- Training and Supervision for Infant Mental Health Work
- Evaluation, Assessment and Planning
- Case Management, Consultation and Collaboration
- Multiple Treatment Modalities

Much can be accomplished in Infant Mental Health practice. The knowledge and tools are available. Multiple professionals who are experts in the field, have shown through research and practice the positive effect of early identification and intervention around psychosocial concerns (Bronfenbrenner, 1986; Crnic et al, 1983). Conversely, the negative outcomes of unidentified psychosocial issues is also clear (Wolfe, 1991; Schorr, 1989; Cohn and Tronick, 1983; Belsky, 1980; Garbarino, 1977). These can include maternal depression, child maltreatment, failure to thrive, developmental delays, high level stress and physical illness. Infant Mental Health Prevention, Early Identification and Intervention are keys to improving social outcomes.

Approaches In Mental Health/Primary Prevention

Infancy research and the Infant Mental Health field hold great promise for advocacy of children's health services. However, there continues to be a large gap between the Infant Mental Health field and traditional Pediatrics, as well as between traditional mental health fields and early intervention services (Partridge, 1990). Physicians, therapists, nurses, early childhood educators and other professionals not specifically trained in mental health, still have little to no knowledge in psychosocial assessment and intervention. As these professionals become more aware of infancy and early childhood issues in the context of their work, they are struggling to incorporate psychosocial practice into their routine delivery of service without becoming a "mental health clinician". They need support from their own field of practice, as well as from the mental health care field.

As with pediatric practice, mental health care emerged from the larger field of medical health care. Medical health care focused on physical, physiologic wellness, and more specifically, diagnosis and treatment of physical illness related to survival. When medical care services were able to meet physical survival needs more consistently, consideration of psychosocial issues emerged and strengthened. However, the early approach to mental health care was a "spiritualistic, theological" one, still focusing on an individual's deviations from established norms (Cowen, 1983), and diagnostic and treatment issues. Contemporary mental health practitioners, including early-intervention specialists, have moved beyond this moralistic and narrow viewpoint, to a larger perspective, which has included the individual's living context. Environmental factors are now seen as significant contributors, positive and negative, to mental health and well being.

Thus, society's redefinition of psychosocial issues or concerns, reflects the resolution of basic issues of human survival, improved living conditions, advancements in science and technology, and the emergence of a social philosophy that places greater emphasis on total well being (Cowen, 1983). This expanded perspective of mental health is consistent with, and stems from, the World Health Organization's redefinition of health in 1946 given previously in this chapter, (page 5) as a state of complete physical, mental, and social well being, not merely the absence of disease or infirmity (Albino, 1983).

Since its inception, however, mental health care has traditionally followed a medical model of practice stressing diagnosis and treatment of disease states, with the goal of management or resolution (Scott, 1978). This viewpoint has limited mental health practitioners' ability to address conditions that cannot be specifically described or associated with disease processes or organic syndromes. Many concerns identified during psychosocial practice with families are not problems as defined in the Diagnostic and Statistical Manual of Mental Disorders, but are issues which are disruptive, with a potential to interfere with optimal functioning and well being (Sharp et al, 1992). Traditional medical and mental health delivery systems seem to offer "...too little too late" (Cowen and Works, 1988), with regard to helping people achieve and maintain an overall state of well being, or wellness. It tends toward reactive prescription and treatment rather than proactive prevention and early intervention.

Contemporary mental health practice emphasizes the importance of recognizing and understanding etiologic or causative factors (Albino, 1983). This concept of iden-
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Contemporary mental health practice emphasizes the importance of recognizing and understanding etiologic or causative factors (Albino, 1983). This concept of iden-
tifying potential underlying factors makes a connection between physical illness and
difficulties in living, regardless of symptoms. It also moves away from a sole focus
on diagnosis and treatment, to one that strives to identify the sources of difficulties in
living and serves to support and enhance coping abilities (Albino, 1983). It achieves
a more ecological or transactional perspective. This transactional approach recog-
nizes the influence of the social/environmental context of human development and
thus includes a focus on family dynamics and community living. It is less bound to
single diagnostic categories and resultant treatments, but is more focused on preven-
tion, support and maintenance. This model of practice falls into the realm of what is
discussed in the literature as ability-enrichment and assessment-intervention models
of practice (Scott, 1978).

Incorporation of this model of practice in the medical health care field was first
evidenced by changes in hospital birthing practices such as "rooming in", and eventu-
ally birthing rooms and birthing centers, which create or simulate more homelike,
wellness oriented environments. These models include a developmental focus and
place emphasis on early detection and intervention, or a "psychology of wellness"
(Cowen and Work, 1988). It is more proactive and prevention oriented. This serves
to support young children in the context of their families.

The behavioral, emotional and environmental aspects of child health and well be-
ing in the context of their family provide opportunities for supporting and promoting
growth, development and adaptation that could have significant, positive, long-term
outcomes (Bauer, 1987). The goals of assessment intervention models of practice
from this perspective are to enhance coping strategies, facilitate problem solving, de-
velop more positive conditions, provide education and support, and encourage a
sense of mastery or self-control for the parent, child and family. These goals are
within the scope of any professional provider working with young children and their
families. Effectively overcoming barriers toward reaching these goals of psychosocial
practice will serve to promote healthy early childhood development and family func-
tioning.

Early relationships are clearly important in preventing difficulties or dysfunction
in later life (Leach, 1994; Perry, Not Yet in Print; Werner and Smith, 1989; Zeitlin and
Williamson, 1986; Cohen and Syme, 1985). It is particularly critical to understand
parent-child relationships within the context of the family when establishing thera-
peutic relationships with young children, parents, and families. "...it is the quality of
the relationship between the parent and the professional that determines the likeli-
hood of parental changes in behavior to benefit the care and development of the in-
fant" (Weider et al, 1992, P. 101). Behavioral and developmental psychology have
recognized this important concept, and their practice models incorporate a family ap-
proach.

Traditional models of care, which focus on the individual and their physical be-
ing, could realize great potential benefit in supporting and strengthening overall
health and wellness, by adopting a family focus and inclusion of psychosocial as-
pacts of living. A connection with developmental, behavioral psychology could es-
establish this new level of care. The traditional one-to-one focus on the individual or
groups of individuals, without consideration of their social/environmental context,
along with a preoccupation with dysfunction, have limited the reach of mental health
and health care to intervention at secondary and tertiary levels (Jason and Bogart,
1983). This consistent focus on dysfunction or disorder after the fact, precludes the
possibility of prevention or anticipatory guidance. Kagan (1965) emphasized that be-
havioral and developmental psychology have an important role in early detection
and intervention. More recently it has been restated that, "...beliefs and practices
about infants and their upbringing have been influenced by developments in psy-
chological research and theory" (Young, 1990, p.18).

Effective anticipatory guidance and early detection include early identification of
strengths and delays in normal development, as well as placement of children at
their proper developmental stage (Scott, 1978). Anticipatory guidance, early detection
and identification of strengths and weaknesses, or delays in growth and develop-
ment, fall into the arena of assessment. Working with the whole family in its social/
environmental context becomes the preferred means of achieving the richest assess-
ment data toward more positive outcomes. Optimal development of the child is most
likely to occur when the family is able, or assisted to provide a supportive, nurturing
environment. Thus, preventive and early intervention care needs to assess family
functioning, as well as the child's function in context with the parents (Zeitlin and
Williamson, 1986). This will provide a more complete picture of the physical and
emotional life of the child, as we now clearly know that an environment which is
consistent, safe, nurturing, structured and enriching in the early years can result in
positive development and social outcomes, whereas neglect, chaos or violence can
lead to lost potential and negative social outcomes (Perry, 1995).

The traditional medical care model, which views the parent and child as second-
ary to the provider (Thomas, 1988), has served to hinder total care, specifically pre-
ventative care and early intervention. This is further exacerbated for the parents and
families of special needs or chronically ill children (Shelton et al, 1987). Multiple ap-
proaches are needed to support and address the emotional health needs of young
children and their families in all situations. Biophysical and psychosocial philoso-
phies must converge to improve service delivery to these families, many of whom
are not effectively reached by existing service systems, particularly children and fami-
lies whose needs are diverse and complex.

The Infant Mental Health field has established itself as a beacon to assist children
and families in meeting their psychosocial or emotional health care needs. This field
has put into practice research results regarding infancy and early parent-child rela-
tionships (Minde and Minde, 1986). The importance of the effect of this research on
practice is the actualization of early identification and intervention services with a fo-
cus on family relationships and total family function in the context of their specific
environments. In addition to helping all young families, research has identified three
fying potential underlying factors makes a connection between physical illness and difficulties in living, regardless of symptoms. It also moves away from a sole focus on diagnosis and treatment, to one that strives to identify the sources of difficulties in living and serves to support and enhance coping abilities (Albino, 1983). It achieves a more ecological or transactional perspective. This transactional approach recognizes the influence of the social/environmental context of human development and thus includes a focus on family dynamics and community living. It is less bound to single diagnostic categories and resultant treatments, but is more focused on prevention, support and maintenance. This model of practice falls into the realm of what is discussed in the literature as ability-enrichment and assessment-intervention models of practice (Scott, 1978).

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The behavioral, emotional and environmental aspects of child health and well being in the context of their family provide opportunities for supporting and promoting growth, development and adaptation that could have significant, positive, long-term outcomes (Bauer, 1987). The goals of assessment intervention models of practice from this perspective are to enhance coping strategies, facilitate problem solving, develop more positive conditions, provide education and support, and encourage a sense of mastery or self-control for the parent, child and family. These goals are within the scope of any professional provider working with young children and their families. Effectively overcoming barriers toward reaching these goals of psychosocial practice will serve to promote healthy early childhood development and family functioning.

Early relationships are clearly important in preventing difficulties or dysfunction in later life (Leach, 1994; Perry, Not Yet in Print; Werner and Smith, 1989; Zeithlin and Williamson, 1986; Cohen and Syme, 1985). It is particularly critical to understand parent-child relationships within the context of the family when establishing therapeutic relationships with young children, parents, and families. "...It is the quality of the relationship between the parent and the professional that determines the likelihood of parental changes in behavior to benefit the care and development of the infant" (Weider et al, 1992, P. 101). Behavioral and developmental psychology have recognized this important concept, and their practice models incorporate a family approach.

Traditional models of care, which focus on the individual and their physical being, could realize great potential benefit in supporting and strengthening overall health and wellness, by adopting a family focus and inclusion of psychosocial aspects of living. A connection with developmental, behavioral psychology could establish this new level of care. The traditional one-to-one focus on the individual or groups of individuals, without consideration of their social/environmental context, along with a preoccupation with dysfunction, have limited the reach of mental health and health care to intervention at secondary and tertiary levels (Jason and Bogart, 1983). This consistent focus on dysfunction or disorder after the fact, precludes the possibility of prevention or anticipatory guidance. Kagan (1965) emphasized that behavioral and developmental psychology have an important role in early detection and intervention. More recently it has been restated that, "...beliefs and practices about infants and their upbringing have been influenced by developments in psychological research and theory" (Young, 1990, p.18).

Effective anticipatory guidance and early detection include early identification of strengths and delays in normal development, as well as placement of children at their proper developmental stage (Scott, 1978). Anticipatory guidance, early detection and identification of strengths and weaknesses, or delays in growth and development, fall into the arena of assessment. Working with the whole family in its social/environmental context becomes the preferred means of achieving the richest assessment data toward more positive outcomes. Optimal development of the child is most likely to occur when the family is able, or assisted to provide a supportive, nurturing environment. Thus, preventive and early intervention care needs to assess family functioning, as well as the child's function in context with the parents (Zeithlin and Williamson, 1986). This will provide a more complete picture of the physical and emotional life of the child, as we now clearly know that an environment which is consistent, safe, nurturing, structured and enriching in the early years can result in positive development and social outcomes, whereas neglect, chaos or violence can lead to lost potential and negative social outcomes (Perry, 1995).

The traditional medical care model, which views the parent and child as secondary to the provider (Thomas, 1988), has served to hinder total care, specifically preventive care and early intervention. This is further exacerbated for the parents and families of special needs or chronically ill children (Shelton et al, 1987). Multiple approaches are needed to support and address the emotional health needs of young children and their families in all situations. Biophysical and psychosocial philosophies must converge to improve service delivery to these families, many of whom are not effectively reached by existing service systems, particularly children and families whose needs are diverse and complex.

The Infant Mental Health field has established itself as a beacon to assist children and families in meeting their psychosocial or emotional health care needs. This field has put into practice research results regarding infancy and early parent-child relationships (Minde and Minde, 1986). The importance of the effect of this research on practice is the actualization of early identification and intervention services with a focus on family relationships and total family function in the context of their specific environments. In addition to helping all young families, research has identified three
specific groups who can most benefit from early identification and intervention: 1) developmentally delayed or special needs children; 2) medically or biologically at-risk children; and 3) environmentally at-risk children (Zeitlin and Williamson, 1986). Knowledge of and skill in early identification and intervention practice with young children and their families is paramount. The earlier families in need are identified, the sooner supportive intervention services can be implemented toward strengthening the young child in the context of his/her family. Green (1985) identifies the well child visit as having the most opportunities for prevention, early identification and intervention, with potential for impact on the greatest number of young children and their families.

Where We Are Today

There seems to be little question about where opportunities exist for effective parent/family guidance, for the sake of preventing emotional health problems in young children. Clearly, health care supervision represents a tremendous opportunity for health promotion, education, and family support. Families with infants, toddlers, and preschoolers meet with physicians or nurse practitioners at least 12 times for well child care in the first 5 years of life. Providing education, guidance and support to parents is an expected part of this care. Are care professionals taking full advantage of these opportunities to cover more than the basics of height, weight, feeding, sleeping, elimination, language skills, and physical milestones? To what extent is the context of the family and family functioning a focus, and is the child's psychosocial/emotional health on the well child care agenda? Morris Green (1994) very specifically outlines that "...all our nation's children deserve the attention, the encouragement and the intervention of care providers from many disciplines to ensure that they develop the healthy bodies, minds, emotions and attitudes to prepare them to be competent and contributing adults".

There is far too little research which informs us about the strengths of health supervision, the best methods of educating parents about emotional health, the most relevant topics of concern, and the impact of a variety of supportive methods on parental and family functioning. "Longitudinal studies are still needed to document the efficiency of addressing behavioral concerns in improving child and family functioning and preventing problems in later childhood, adolescence and adulthood " (Sharp et al, 1992, p. 622). What we do know is that; very little time is spent on actual guidance, parents have many questions about emotional or psychological issues but frequently fail to bring them up on their own, and little time is structured into traditional health care to assist families with relationships, social behavioral issues or social support issues.

Physicians and nurses in health supervision settings are not the only professionals with prime opportunities to promote emotional health in early childhood. A growing number of early intervention services also provide care to families with young children. Their focus may be speech, occupational or physical therapy, nutrition and management of health concerns in a home setting, or early education/enrichment services. The knowledge and skills of these existing early intervention providers need to be more effectively utilized to better serve and assist young children and their families with emotional health issues. The barriers to promoting emotional health that these early intervention professionals face are often similar to those faced in traditional health care: lack of time in currently structured schedules; lack of money/reimbursement to pay for time spent in providing guidance or family support; and/or lack of knowledge/training/confidence and/or methodologies to assess and intervene around emotional health, emotional development and/or infant mental health issues.

Table 1.4 reviews barriers to Infant Mental Health or emotional health work as discovered by the AIMS staff through work with multidisciplinary professionals who serve young children and their families. Barriers as identified are experienced at three levels: the Personal or Individual Level; the Practice or System Level; and the Family or Client Level. Some strategies toward resolving barriers at these three levels are also provided.

These shortcomings and missed opportunities of the health care delivery system and their effect on the emotional development and well being of young children become more clearly evident as children enter school. School readiness is strongly associated with physical, emotional and social competence (Lewitt and Baker, 1995).

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Strategies toward Resolution of Barriers

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</tr>
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There is considerable evidence that many children are entering school without having established secure emotional ties to a primary caregiver, adequate ability to engage in appropriate interaction with others, a positive self esteem or sense of self as socially competent, or a consistently reliable system of support. Inadequate development and lack of capacity in these areas leads to behavior problems evidenced in school, and ultimately to larger social issues or problems. Among the worst of these issues are teen pregnancies, substance abuse, violent teen deaths and juvenile custody (Center for the Study of Social Policy, 1992). These are negative social outcomes, or what Lisbeth Schorr (1988) calls, “rotten social outcomes”. Contrasted with this is our society’s investment or lack thereof, in families and children. “During the eighties the United States spent less then 5 percent of the federal budget on programs supporting families with children...” (Leach, 1994, p. 6). We need to re-focus on families and young children today to improve social outcomes for the future.

What We Need to Know

Clearly, professionals in all disciplines need to know how emotional health develops, how to assess emotional health in young children and their families, what the basic symptoms of emotional dysfunction look like, and how to intervene to promote positive emotional health development. Basic professional skills in assessment and data collection (through observation, establishing a partnership, interviewing, self-report questionnaires, etc.) data analysis (toward profile development) and brief intervention (listening, reflecting back, communicating, relationship building, problem solving and the like) are also required in order for professionals to address concerns related to emotional health. Professionals need to be competent, confident and comfortable in these skills, and consciously, intentionally incorporate them into their practice. Professionals impact families continuously, making that impact conscious and intentional will better serve, support and strengthen young children and their families.

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The Healthy Start program, originally demonstrated from 1985-1988 in Hawaii, is an example of a current early intervention effort based on providing support, education and direct service in the home. The goals of Healthy Start as given in Table 1.5, are basic to the emotional health and well being of the young children and his/her family.

Table 1.5

<table>
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<th>Healthy Start Goals</th>
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<td>• Advance optimal child development</td>
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<td>• Provide positive parenting</td>
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<tr>
<td>• Enhance parent-child interaction</td>
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<tr>
<td>• Assure proper medical care</td>
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<td>• Prevent child abuse and neglect</td>
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The goals of healthy start reflect a similar philosophy as the AIMS System of Practice. Both serve to support young children in the context of their families and both focus on enhancing positive outcomes related to growth and development of the child, and overall family functioning and wellness.

The mission of Bright Futures is to promote and improve the health, education, and well being of children, adolescents and communities. Morris Green very specifically outlines in Bright Futures, “…all our nation’s children deserve the attention, the encouragement and the intervention of care providers from many disciplines to ensure that they develop the healthy bodies, minds, emotions and attitudes to prepare them to be competent and contributing adults.” He further states that health care practices have not kept up with these needs and that a “new health care supervision” is required to effectively respond to the new morbidity that impacts providers and the families they work with.

The mission of AIMS is to strengthen the foundations of emotional health in early childhood through normalizing and supporting psychosocial assessment and early intervention. AIMS provides a conceptual framework and a preventive intervention assessment tool, or System of Practice to achieve its mission. AIMS focuses on the period of 0 – 5 as having the most impact for supporting and strengthening emotional/psychosocial development toward positive social outcomes.

One of the major challenges for early intervention professionals, in all disciplines, is how to assess and evaluate emotional health; making appropriate interventions within the contexts of their ongoing, discipline-driven, task oriented activities. Professionals need to learn to accomplish these challenges without taking on the role of a mental health clinician. “The time is right to begin reconceptualizing how the needs of young children and their families may be met” (Young et al, 1998, p. 262). Delivery of care must be reflective of what parents say they need and want. Early childhood professionals need tools that facilitate these efforts, tools that are efficient and effective to use, and that provide guidance for supporting emotional health and recognizing emotional problems early on within their disciplinary settings. The AIMS System of Practice is such a tool.

Professionals need training and support in early assessment and intervention skills. They need to be knowledgeable in multiple sources of data collection for early assessment and intervention purposes. Training programs need to explicate a philosophical foundation that can guide assessment and intervention (Brown and Thorp, 1992). The AIMS (Attachment-Interaction-Mastery-Support) framework provides this base from which to build. The AIMS conceptual framework addresses the need for knowledge and skill development by providing an increased awareness and understanding of the Attachment process and potential barriers to attachment, Interaction
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Health supervision consists of those measures that help promote health, prevent mortality and morbidity, and enhance subsequent development and maturation.

Health supervision goals include enhancing families’ strengths, addressing families’ problems, promoting resiliency, building parental competence, and helping families share in the responsibility for preventing illness or disability and promoting health.

Health supervision requires a partnership between health professionals and families.

Health supervision is shaped primarily by issues raised by the parent and child, with their expectations, questions, and concerns addressed.

Health supervision involves assessing the strengths and issues for a specific child, family and community.

Health supervision includes the interview, the physical examination, observation of the child and family, and psychosocial, educational, and developmental surveillance. Additional screening procedures – including vision, hearing, and metabolic screening – are also included to identify areas that may warrant further assessment and intervention.

Health supervision that employs specific preventive and health-promoting interventions leads to improved outcomes.

These social, developmental and health outcomes occur along a continuum, varying in their timing from child to child and family to family.

Since health risks and needs can change over a period of weeks or months, they need to be reassessed periodically.

The benefits of continuing health supervision are best ensured by a medical home offering health services that are accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and integrated into a system of care.

Health supervision can be provided in many settings, often with collaboration between a variety of organizations and disciplines.

Health supervision helps educate children and families about the efficient use of health care and other community services.

Child development serves as the basic science for much of health supervision, especially health promotion.

Special populations such as those with chronic illness or disability will require more health supervision.

Supplemental health supervision may also be needed during periods of family transition or stress.

Table 1.6
Bright Futures Highlights

- Health supervision consists of those measures that help promote health, prevent mortality and morbidity, and enhance subsequent development and maturation.
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The AIMS: System of Practice

The AIMS: Developmental Indicators of Emotional Health, or System of Practice, was developed to help meet the need for methods of assessing emotional health and intervening in early childhood. The AIMS System is designed to enhance dialogue, build relationships, identify strengths, and provide information about the nature of relationships within a family, the child’s emotional well-being from the constructs of Attachment, Interaction, Mastery and Support, as well as the families’ network of social support. It provides a way for health care professionals and early interventionists to identify strengths and concerns of the family and child, to have a dialogue around these issues, and to provide supportive interventions. The AIMS System is not intended to be used as a tool to determine a child’s behavioral or emotional dysfunction. It does not provide a means for diagnosing or labeling young children and their families. It is not scored. It is intended to facilitate a dialogue with families, to enhance relationship building and provide multiple points of entry for dialogue.

The AIMS: Developmental Indicators of Emotional Health seek to reaffirm the declaration of responsibility for young children, created in 1991 by the Joint Ad Hoc Children’s Advisory Committee, given as Table 1.7, through its mission of strengthening the foundations of emotional development in early childhood. There seems to be a growing awareness of the rights of children as well as the responsibilities to children, who eventually grow up to “play” a larger role in society. The AIMS System of Practice can assist in accomplishing these responsibilities to children by increasing knowledge and skills of professionals in their delivery of care to young children and their families, in addition to providing a tool with which to enhance parent-professional communication and dialogue with families. It assists in establishing a partnership with parents and their young children and values what parents know about their child and the home environment.
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The AIMS: System of Practice

The AIMS: Developmental Indicators of Emotional Health, or System of Practice, was developed to help meet the need for methods of assessing emotional health and intervening in early childhood. The AIMS System is designed to enhance dialogue, build relationships, identify strengths, and provide information about the nature of relationships within a family, the child’s emotional well-being from the constructs of Attachment, Interaction, Mastery and Support, as well as the families’ network of social support. It provides a way for health care professionals and early interventionists to identify strengths and concerns of the family and child, to have a dialogue around these issues, and to provide supportive interventions. The AIMS System is not intended to be used as a tool to determine a child’s behavioral or emotional dysfunction. It does not provide a means for diagnosing or labeling young children and their families. It is not scored. It is intended to facilitate a dialogue with families, to enhance relationship building and provide multiple points of entry for dialogue.

The AIMS: Developmental Indicators of Emotional Health seek to reaffirm the declaration of responsibility for young children, created in 1991 by the Joint Ad Hoc Children’s Advisory Committee, given as Table 1.7, through its mission of strengthening the foundations of emotional development in early childhood. There seems to be a growing awareness of the rights of children as well as the responsibilities to children, who eventually grow up to “play” a larger role in society. The AIMS System of Practice can assist in accomplishing these responsibilities to children by increasing knowledge and skills of professionals in their delivery of care to young children and their families, in addition to providing a tool with which to enhance parent-professional communication and dialogue with families. It assists in establishing a partnership with parents and their young children and values what parents know about their child and the home environment.
Table 1.7

Declaration of Responsibility for Maine’s Children

- To be cherished and accepted in their own or extended families.
- To be nurtured by their families in a way that meets their individual needs, so that they can grow in ability to reach their fullest potential.
- To receive sensitive, continuing help in understanding, accepting and developing pride and confidence in their ethnic and religious heritage.
- To receive continuing, loving care and respect as unique human beings; children growing in trust in themselves and others.
- To grow up in freedom and dignity in a neighborhood of people who accept them with understanding, respect, and friendship.
- To receive help in overcoming any deprivation in their physical, emotional, intellectual, social or spiritual growth.
- To be given education, training, and career guidance to prepare them for a useful and satisfying life.
- To receive preparation for citizenship and parenthood.
- To be raised in an atmosphere free from the suffering of physical and emotional abuse.
- To be loved

The AIMS System specifically assists professionals in assessment and identification of emotional health strengths and concerns, in and through supportive interventions focusing on the identified strengths and concerns. This preventive intervention assessment methodology provides multiple sources of data collection as well as multiple points of entry for dialogue with the parent-child-family. The AIMS System serves to enhance relationship building and facilitates communication toward a partnership with parents.

The AIMS System of Practice specifically serves to enhance the following professional skills:
1. parent-child observation
2. parent-child-family interviewing
3. identification of psychosocial strengths in addition to concerns/problems/dysfunction
4. development of a clinical profile, and
5. brief psychosocial interventions to support positive emotional health

The goal of AIMS is to assist professional providers to gain a deeper understanding of the emotional health and development of young children, as well as a need for and the long-term benefits of normalizing psychosocial care in well child care service. The domains of AIMS (Attachment-Interaction-Mastery-Support) are considered the building blocks of emotional health in early childhood and essential to overall health and well being. The keys to helping young children develop lie in our ability as professionals to understand and apply the concepts of attachment, interaction, mastery and support. Use of the AIMS concepts and methodology of preventive intervention assessment can assist in supporting positive emotional development. Early and supportive identification and intervention in emotional development will have the most potential impact, particularly with identified problems in early childhood, which may prove to be more intractable in later life. The earlier the supportive intervention is provided/offered, the greater the chance of success and more positive outcomes for the child, the parent, the family, the community and society at large. The challenge belongs to all of us.
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Chapter 2

Understanding Emotional Health
Deborah Devine, Psy.D.

The AIMS: Developmental Indicators of Emotional Health center on four domains that define emotional health: Attachment, Interaction, Mastery and Social Support. What is the meaning of these domains and how do they serve to define emotional health in young children? A professional user of the AIMS System of Practice will benefit from knowing more about these domains. This chapter describes these domains as the AIMS conceptual framework.

This chapter addresses the theoretical foundation upon which the AIMS System of Practice is based and describes the conceptual framework for defining the major issues of emotional health in young children from a family perspective. It additionally discusses how the conceptual framework pertains to the design and content of the AIMS materials, as well as to optimal practice or clinical use of the AIMS System of Practice as an assessment, early intervention methodology.

Any assessment system first evolves from a theoretical base, from which specific points of focus are defined and made operational. In the assessment of psychosocial or emotional health, choosing and putting into operation basic concepts can be an overwhelming task. Therefore, from an analysis of the literature on child development and family functioning, four concepts evolved to illuminate and help define the domains of emotional health. These four constructs: Attachment, Interaction, Mastery and Social Support serve to provide what the literature identifies as a common language or framework from which to understand emotional or psychosocial issues as important factors in child health and development (Call et al., 1987). These concepts are believed to capture the major issues of emotional growth and development in that emotional health thrives on a foundation of positive attachments, healthy interactions, recognition of, and mastery of skills, and an active network of social supports.

While the four AIMS concepts are believed to represent major issues in the area of emotional health, it is clear that there is a high degree of overlap among the four domains. It is also clear from research on emotional development that other issues are also very influential. For example, an important concept relative to emotional health is temperament (Chess and Thomas, 1986). Temperament referring to the be-
havioral style, or way in which an individual does things. It is the how of behavior, the characteristics or qualities of a person, not their learned behavior or personality, which is more the what of behavior. Temperament is important because it helps us to understand behavior. Understanding temperament as part of the emotional development and life of a young child can help promote acceptance and support of that child, even in the case of a mismatch in the temperament of parent and child. Understanding temperament of both the child and the parent is an important factor in forming attachments and in parent-child interactions, however temperament is not specifically delineated as a "domain" in the AIMS system. The concept of temperament is subsumed in the domain of attachment, as well as included in several sections of the AIMS materials; for example, in the discussions of family interactions, in the focussed interview questions, and in the guidelines for psychosocial interventions. Other concepts such as "autonomy" are subsumed under the concept of "mastery." Thus, the AIMS materials offer a coherent way to organize information, but does not presume to be the only way to conceptualize mental or emotional health.

The four domains represented by the AIMS acronym provide a rich source of information about parent-child-family functioning. The following sections present how the attachment process, dyadic and familial interaction patterns, a child's and parent's sense of efficacy or mastery and the family's network of support are defined and made operational within the context of the AIMS System of Practice.

The Domain of Attachment

Attachment is considered the root of all emotional health and is essential to overall emotional well-being. Attachment is defined as an enduring, emotional tie between a primary caregiver and an infant or child. Attachment begins during pregnancy and heightens during the child's first year. This special relationship develops out of a two-way, give-and-take sharing of feelings, interests, and communication. Parental attachment involves a blending of the parent's past experiences, knowledge, and expectations with the child's temperament and developmental age. A child's attachment is manifested by his or her strong preference for and seeking of contact with the parent. Family attachment is manifested by the acceptance of new relationships between family members and a continued sense of stability and loyalty to the growing family. It is through these multiple attachment relationships that the child and family find a sense of security that enables growth, development, and exploration of the world (Project AIMS, 1987).

One need only to watch the smiles exchanged between a four-month-old and his/her parent, or the anxiety in a nine-month-old's face when his/her mother leaves the room, to understand the critical emotional importance of the attachment relationship. Out of the bonds of healthy attachments develop the basic trust that underlie all future relationships. When attachments are insecure, disordered relationship styles and patterns can develop.

What We Know About Attachment

The 1960s brought a burgeoning interest within the psychiatric and psychological communities with regard to early parent-child dyadic relationships. It was Freud who promulgated the notion (Lamb et al., 1984) that the infant-mother dyad was unique, without parallel, established unalterably for a whole lifetime as the first and the strongest love object and as a prototype of all later love relations for both sexes. While many may challenge Freud's seemingly immutable view of the effects of the parent-child relationship, few would question the importance of this dyadic experience with regard to subsequent emotional development for young children.

John Bowlby's work with mothers and babies led him to describe attachment as an innate, biologically based "need" for social interaction by human infants that eventually becomes focused on a specific figure (Lamb et al., 1984). Bowlby proposed (1982) the notion that attachment behaviors are equivalent to mating and feeding behavior in biological importance; moreover, attachment behavior has its own unique motivational system. To survive, helpless infants would have to possess an innate tendency to seek proximity to protective caregivers. Bowlby believed that infants form an emotional tie to adults who consistently respond to the infant's proximity-seeking signals: the infant gives the message, "Come here, I need you," and the adult readily complies. Mothers, within Bowlby's formulation, also are equipped with complementary caregiving behaviors that assure reciprocal evolution of the attachment process; they have a built-in need to protect and remain close to their infants.

Mary Ainsworth (1979) expanded Bowlby's theory of attachment by gathering empirical data that highlighted those behavioral components that affect and reflect the quality of the attachment relationship. She found, for example, that a mother's degree of sensitivity to her infant's signals is related to the infant's behavior. Conversely, a child's ability to signal his or her needs and respond to a parent's comfort was seen to be an integral part of the attachment process. Penelope Leach (1994) identifies attachment as the most critical accomplishment in the first year of life.

Ainsworth additionally developed an attachment classification system, identifying secure, avoidant and anxious attachments. Later research suggests a fourth group, disorganized attachments (Main et al., 1985). Numerous studies have documented the relationship between secure infant-parent attachments, measured early in life, and later healthy psychosocial functioning measured six months to five years later (Main et al., 1985; Bretherton, 1985; Waters, 1978; Matas et al., 1978). Insecure attachment at one year of age has been related to dependency and disruptiveness in the preschool years (Stroufe and Fleeson, 1986); and for toddlers with a lesser capacity to modulate impulses and emotions in kindergarten (Easterbrooks and Goldberg, 1990). The relationship between family stress and insecure attachment has also been documented (Egeland et al., 1980), showing the impact of certain environmental conditions on the attachment system. Ainsworth states that regular and prompt responses to infants help establish and promote secure attachment. Research on resiliency iden-
havioral style, or way in which an individual does things. It is the how of behavior, the characteristics or qualities of a person, not their learned behavior or personality, which is more the what of behavior. Temperament is important because it helps us to understand behavior. Understanding temperament as part of the emotional development and life of a young child can help promote acceptance and support of that child, even in the case of a mismatch in the temperament of parent and child. Understanding temperament of both the child and the parent is an important factor in forming attachments and in parent-child interactions, however temperament is not specifically delineated as a "domain" in the AIMS system. The concept of temperament is subsumed in the domain of attachment, as well as included in several sections of the AIMS materials; for example, in the discussions of family interactions, in the focussed interview questions, and in the guidelines for psychosocial interventions. Other concepts such as "autonomy" are subsumed under the concept of "mastery." Thus, the AIMS materials offer a coherent way to organize information, but does not presume to be the only way to conceptualize mental or emotional health.

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tifies that children who do well, despite severe stress, had established a strong relationship with at least one primary caregiver in early childhood (Werner and Smith, 1982). Additionally, cross-cultural studies indicate that children benefit most from multiple secure attachments (Van Ijzendoorn, Sagi and Lambermon, 1992).

Infants need to be understood within the context of these attachment relationships. Infants have a nine-month gestational period in the womb before becoming physically separate upon birth. The infant additionally requires a "gestational" period in the "womb" of a primary care-taking relationship before becoming psychologically separate, which occurs during the third year of life (Kaplan, 1978; Mahler, 1975). This psychological development of the self within a secure attachment is essential to achieve healthy individuation and separateness.

Research has also documented that the attachment relationship or system is affected by the quality of mothers' and fathers' childhood attachments to their own parents. Children who have mothers and fathers who describe insecure models of attachment in their own personalities are also more likely to be as insecurely attached themselves (Main et al., 1985).

The notion of "internal working models," the subjective experience by which a person establishes reality or an inner, working view of one's self and other people, has been explored within the framework of the attachment relationship. In other words, as a young child learns what life and love are like through repeated interactions and exchanges with the attachment figure, he/she constructs a model or theory that guides future behavior in relationships (Mahoney, 1991). Thus, attachment theory has done much to help us understand the process by which parents and infants come to find emotional security, or lack thereof.

In the last two decades, a theoretical basis has been developed regarding attachment processes, their roots in early family relations, their continuity and change over time, and their influence on later development. We have learned that while most children are highly adaptive and some are very resilient, humans need human attachments in order to grow, learn, and develop optimally.

Daniel Stern (1985, 1977) discusses the need for primary caregivers to, "...play back a child's inner feelings," using the term attunement to identify this response. He describes a parent responding to a child's squeals of delight with hugs and smiles, or offering a protective arm in the event of loud noises as a matched or reciprocal response to the child's. If this matched response does not happen consistently over time, the child can become confused and insecure in the developing relationship. In one study, Stern describes a mother who did not consistently match her baby's level of excitement, subsequently the baby became extremely passive and unresponsive.

A positive attachment may be manifested by a child seeking a parent's comfort when distressed, giving toys to the parent to share, making frequent physical and eye contact, and communicating easily. Contrarily, the child who cannot be comforted by a parent or rejects a parent following a reunion demonstrates an insecure attachment. When the attachment process goes well, children develop a model of themselves as competent and lovable. A secure attachment is also crucial to the development of trust, empathy, compassion and conscience. Data has shown that securely attached children go on to develop good social as well as cognitive skills.

Unfortunately, the attachment relationship does not always develop in secure, reciprocal ways for children, and the negative, maladaptive outcomes of such an unhealthy attachment often come to professional attention. This may be in the form of impulsive aggression, remorselessness and/or intellectually and socially impoverished individuals presenting at different ages and stages.

Clinicians know that the attachment process is a highly complex process that is organized by elements that are objective (behavioral) and subjective (related to beliefs, thoughts, or models). On the subjective side, those parents who experienced trauma, abuse, or neglect develop models of themselves as unlovable and not valued. These parents often carry such feelings into the parental role, negatively impacting the attachment process and resulting in the childhood family dysfunction being reenacted (Fraiberg, 1980). Attachment disorders stemming from the parent history can be evident in parental gaze or touch aversion, social distancing, inability to describe child with much detail or inability to discuss likes and dislikes of child. As a result the child may exhibit negative self-stimulation and feeding/sleeping disorders.

Chess and Thomas (1986) identify nine temperament qualities that lead to various types of child (and adult) behavior. These qualities are outlined as follows:

1. Activity Level (degree of activity)
2. Rhythmicity (regularity and predictability)
3. Approach/Withdrawal (responsiveness to new situations, persons or stimuli)
4. Adaptability (ability to modify/adjust behavior in new or changed situations)
tifies that children who do well, despite severe stress, had established a strong relationship with at least one primary caregiver in early childhood (Werner and Smith, 1982). Additionally, cross-cultural studies indicate that children benefit most from multiple secure attachments (Van IJzendoorn, Sagi and Lambermon, 1992).

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5. Sensory Threshold (level of stimuli needed to evoke a response)
6. Quality of Mood (negative or positive outlook)
7. Intensity (reaction/response energy level)
8. Distractibility (level of stimuli needed to divert attention)
9. Persistence (level of attention span)

These multiple temperament qualities combine in various ways to create what Chess and Thomas (1986) identify as difficult children (10%), easy children (40%), slow to warm up children (15%) and mixed/variable children (35%). Jerome Kagan (1984) outlines these combinations of temperament qualities as the bold child (40%), the shy child (15%) and the average child (45%).

Temperament then, basically is a term, which acknowledges that beginning in infancy, actually upon birth, infants have inborn traits or characteristics that influence their responses to other people, situations and stimuli. It is a predisposition to particular behavior patterns. These can be intensified or minimized by the environment or context, particularly in the infancy period and throughout early childhood. Being aware of this helps to understand the child in the context of his/her family. It also helps to understand the match or mismatch between parent, infant and/or the environment created.

On a behavioral level, difficulty in the attachment process can occur when there is a mismatch or poor "fit" between child and parent's temperamental styles. For example, a parent who is endowed with high energy may be raising a child with shyness and inhibition. The "match" or "mismatch" creates some tension and calls for sensitivity on the parent's part to the child's needs and style, and to the differences between them. Being aware of the goodness of fit or mutuality in temperament between parent and child is an important aspect of understanding attachment and the attachment process.

With regard to the child's contribution to the attachment system — a complex interaction pattern that involves sending and receiving messages related to distress, need satisfaction, proximity seeking, and felt security (Bowlby, 1982) — some critical characteristics can stress the readiness and capacity of infant or parent to make secure attachments at birth and during the postpartum period. The birth of a severely premature child, or one who requires extensive medical procedures that often must physically separate infant from mother at birth, stresses the evolving infant-parent attachment system. The infant's needs for touch or termination of interaction, for stimulation or for quietude and withdrawal from stimulation, are not necessarily communicated clearly by sick, premature, or handicapped infants (Klaus and Kennell, 1982; Goldberg, 1977; and Stern, 1977).

Infants with especially difficult temperaments, who are not comfortable being held, who do not self-regulate efficiently or quickly when stressed, or whose signals of distress are not conveyed in easily readable manners, also present challenges to caretakers (Brazelton, 1973). Infants born with physical problems, those of another gender than that preferred by the parents, and those with temperament qualities that fail to match qualities of the primary caretaker, represent the remainder of the group of infants bringing potentially troubling caregiving experiences that must be overcome for secure infant-parent attachments to develop.

Difficulties in parenting due to child characteristics — prematurity, temperament difficulties, ill health, and handicapping conditions affecting communication abilities — all affect the early parent-infant attachment process. On the parent's side, characteristics of the mother, father, and family can negatively influence the development of infant-parent attachment. Maternal depression, difficult and unresolved conflicts over pregnancy, traumatic birth experiences, incomplete grieving over the birth of a sick or handicapped child or other major losses, major family stress, insufficient spousal support during pregnancy and the postpartum period, lack of adequate social supports, relationship conflicts, and inappropriate working models of relationships derived from childhood abuse are among the factors that inhibit parental capacity for secure attachments (Greenspan, 1985; Main et al., 1985; Shea and Trenick 1984; Belsky et al., 1984; Fraiberg, 1980; Goldberg, 1977; Rubin, 1977).

The biology of our species makes necessary a huge parental investment in order to achieve the fulfillment of each child's potential... It is a continuous, relentless, recurrent demand for investment of time, energy, thought, consideration, and sensitivity. It is an investment in patience, understanding, and coping. It requires persistence, determination, commitment, and resiliency (Hamburg, 1992).

Early identification and supportive intervention can serve to enhance the development of positive attachment and ameliorate the more negative attachments—avoidant, anxious and disorganized. Professionals involved with infants and their primary caretakers can facilitate the development of healthy attachments by identifying at-risk factors, providing education and information about the child's capacity under different conditions of health, supporting parental strengths, providing clinical guidance to work through psychological conflicts and restructure working models of attachment, and offering careful combinations of parent guidance, parent support, and parent-infant psychotherapy (Fraiberg, 1980).

While the negative outcomes of a poor attachment relationship are not as immovable as Freud once believed, the emotional ties between a child and his or her parents are primary contributors to the development of a healthy sense of self and other social relationships, and therefore cannot be minimized. D.W. Winnicott (1969) summarized this issue simply; some parents are so caught up managing their own lives and difficulties, past and present, that they "...cannot do for the children what the children need" (p.122).

Without this continuous, reliable care, there is a disruption or gap in the child's ability to trust or ability to predict. Too many of these disruptions can automatically break up the child's developmental process, causing the child's integrity to be distorted or fragmented. This is of particular importance in the very young child whose
5. Sensory Threshold (level of stimuli needed to evoke a response)
6. Quality of Mood (negative or positive outlook)
7. Intensity (reaction/response energy level)
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These multiple temperament qualities combine in various ways to create what Chess and Thomas (1986) identify as difficult children (10%), easy children (40%), slow to warm up children (15%) and mixed/variable children (35%). Jerome Kagan (1984) outlines these combinations of temperament qualities as the bold child (40%), the shy child (15%) and the average child (45%).

Temperament then, basically is a term, which acknowledges that beginning in infancy, actually upon birth, infants have inborn traits or characteristics that influence their responses to other people, situations and stimuli. It is a predisposition to particular behavior patterns. These can be intensified or minimized by the environment or context, particularly in the infancy period and throughout early childhood. Being aware of this helps to understand the child in the context of his/her family. It also helps to understand the match or mismatch between parent, infant and/or the environment created.

On a behavioral level, difficulty in the attachment process can occur when there is a mismatch or poor "fit" between child and parent's temperamental styles. For example, a parent who is endowed with high energy may be raising a child with shyness and inhibition. The "match" or "mismatch" creates some tension and calls for sensitivity on the parent's part to the child's needs and style, and to the differences between them. Being aware of the goodness of fit or mutuality in temperament between parent and child is an important aspect of understanding attachment and the attachment process.

With regard to the child's contribution to the attachment system — a complex interaction pattern that involves sending and receiving messages related to distress, need satisfaction, proximity seeking, and felt security (Bowlby, 1982) — some critical characteristics can stress the readiness and capacity of infant or parent to make secure attachments at birth and during the postpartum period. The birth of a severely premature child, or one who requires extensive medical procedures that often must physically separate infant from mother at birth, stresses the evolving infant-parent attachment system. The infant's needs for touch or termination of interaction, for stimulation or for quietude and withdrawal from stimulation, are not necessarily satisfied. This creates some tension and calls for sensitivity on the parent's part to the child's needs and style, and to the differences between them. Being aware of the goodness of fit or mutuality in temperament between parent and child is an important aspect of understanding attachment and the attachment process.

While the negative outcomes of a poor attachment relationship are not as immutable as Freud once believed, the emotional ties between a child and his or her parents are primary contributors to the development of a healthy sense of self and other social relationships, and therefore cannot be minimized. D.W. Winnicott (1969) summarized this issue simply; some parents are so caught up managing their own lives and difficulties, past and present, that they "... cannot do for the children what the children need." (p.122).

Without this continuous, reliable care, there is a disruption or gap in the child's ability to trust or ability to predict. Too many of these disruptions can automatically break up the child's developmental process, causing the child's integrity to be distorted or fragmented. This is of particular importance in the very young child whose gender than that preferred by the parents, and those with temperament qualities that fail to match qualities of the primary caretaker, represent the remainder of the group of infants bringing potentially troubling caregiving experiences that must be overcome for secure infant-parent attachments to develop.

Difficulties in parenting due to child characteristics — prematurity, temperament difficulties, ill health, and handicapping conditions affecting communication abilities — all affect the early parent-infant attachment process. On the parent's side, characteristics of the mother, father, and family can negatively influence the development of infant-parent attachment. Maternal depression, difficult and unresolved conflicts over pregnancy, traumatic birth experiences, incomplete grieving over the birth of a sick or handicapped child or other major losses, major family stress, insufficient spousal support during pregnancy and the postpartum period, lack of adequate social supports, relationship conflicts, and inappropriate working models of relationships derived from childhood abuse are among the factors that inhibit parental capacity for secure attachments (Greenspan, 1985; Main et al., 1985; Shea and Tronick 1984; Belsky et al., 1984; Fraiberg, 1980; Goldberg, 1977; Rubin, 1977).
developing trust can easily be shattered resulting in the child not achieving the feeling of, "I am, this is me, I exist, it is I who love and hate, it is me that people see and that I see in mother's face when she comes, or in the mirror" (Winnicott, 1969, p. 131).

Key Issues to observe/or ask about when assessing Attachment are:
1. Two-way communication in the parent-child dyadic relationship.
2. Proximity seeking behavior of the infant/child to the primary caregiver/parent.
3. Protective, nurturant behavior of the primary caregiver/parent.
4. Frequent physical and eye contact in the parent-child dyad.
5. Parental sensitivity to the infant/child's cues and signals.

The Domain of Interaction

Interaction is a critical concept to understanding overall emotional health and development of young children. Interaction is defined as a communicative exchange of information between people. Interactions are of two basic types: those that are primarily oriented to the completion of activities, and those which establish social roles, values, needs, and feelings. Within a family, multiple parent-child interactions take place across a variety of situations. These include family caregiving, recreation, teaching, socialization, problem-solving, and the management of day-to-day life. In these interactive settings, family members negotiate rules of power and control, warmth and intimacy. Healthy interactions leave each member feeling some sense of control and connectedness in an environment perceived as generally supportive.

Interaction focuses on behaviors, consistencies and expectations turned into behaviors as well as the give-and-take between parent and child. The quality of interactive behaviors of the parent-child relationship stems from, and overlaps with the quality of the attachment process.

What We Know About Interaction

Nearly every study of parent-child interactions has documented a relationship between parental behaviors and child behaviors. Intrusive, rejecting, punitive, non-accepting, authoritarian, or inflexible parental behaviors are associated with negative child behaviors, such as inappropriate aggressiveness or passivity, low self-esteem, poor problem-solving of specific tasks at specific developmental stages, and, in some instances, delayed cognitive development and dampened achievement. In contrast, acceptance, warmth, responsiveness and consistency to the child's needs, and flexibility are parental qualities found by numerous researchers to be associated with secure children. These children are better at problem-solving, more able to attend longer to tasks, more sociable with peers and adults, less aggressive, more creative in responding to frustration, and more often having other socially desirable characteristics (Maccoby, 1980).

Results of parent-infant interaction research on infants and their parents conducted over the past 20 to 50 years, particularly cite the critical function of parental responsiveness. A parent who is sensitive to the infant's cues of distress, signals of hunger and satiation, needs for stimulation and play as well as the cessation of play, requests for assistance in solving puzzles and tasks, and other messages, is more likely to raise a confident child. Warmth and acceptance of the infant, including his/her styles, temperament, and other characteristics of individuality, are also important in the interaction process. Mutually satisfying interaction provides the basis for emotional regulation and modulation (Brazelton, Koslowski and Main, 1974). Infant development is facilitated by this mutuality, which refers to a sensitivity toward timing of interactions, development of a synchronized style of interacting with an infant, and emotional availability to the infant, as opposed to a narcissistic, self-imposing, controlling style based on the parent's own needs (Stern, 1977), which can delay or derail healthy emotional development.

The young child has been described as a "virtuoso performer" in regard to her or his ability to regulate the amount and nature of stimulation from a parent, as well as internal self-regulation (Stern, 1985). Parents are equally adept at regulation at activity in the dyadic relationship. When this goes well, the interactive exchange is likened to a dance, which is executed in synchrony and with attention to both partners' movement.

Table 2.2

<table>
<thead>
<tr>
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| **Parent**              |
| • Basic Care-giving, Consistency |
| • Sensitivity In Timing       |
| • Comforting Response        |
| • Playing, Socialization     |
| • Warmth and Acceptance      |
| • Teaching, Guidance         |
| • Routines, Structure, Predictability |
| • Limit Setting              |

Theorists over the last few decades have made empirical and theoretical strides in observing and understanding the interactive patterns between young children and their parents. It is within this mutual exchange that individual coping styles develop, as well as the family's teaching, socialization, and caregiving practices. Concepts such as fit, synchrony, reciprocity, matching, and attunement, are used to describe the positive mutual interplay between dyadic members. These relationships are trans-
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actional or reflective, in that one individual's behavior or actions impact and influence another's behavior in the interaction, which leads to a repetitive cycle of action, influence and responsive action. It is believed that consistent synchronous behavioral interchanges lead to positive and secure attachments as well as healthy patterns of interpersonal engagement.

When there is a good match or fit between infant and parent, the developing relationship tends toward interaction at increasing competence and effectiveness (Harter, 1978). This in turn leads to increasing enjoyment and satisfaction in the relationship which also becomes a repetitive cycle of positive interaction. When there is not a good “fit” or a mismatch occurs, both child and parent experience some kind of disequilibrium or disharmony. Tronick (1984) and others believe that all relationships experience some degree of mismatch at some time and that it is the coping behavior used to repair the mismatch that is important in maintaining a sense of emotional well-being for children and parents. It has also been learned from research and clinical observations (Tronick, 1986) that chronic, unrepaired mismatch within the parent-child dyad can lead to disruption in healthy emotional development, such as depression. At issue for both the child and parent are difficulties in developing a sense of self. For the parent, frustration and disappointment over difficulty in fitting with or meeting the needs of a particular child become apparent. Questions about one's adequacy as a parent, anger toward the child, and disengagement, are outcomes of a chronically poor interactional pattern. Infants whose mothers are emotionally unavailable, have difficulty regulating their emotions (Cohn and Tronick, 1983). Additionally, the infant and older child learn coping styles and/or defensive strategies that may serve initially to insulate him or her from this dysfunctional interaction with the parent, but at an emotional cost for the child. Depression, aggression, or lethargy are possible outcomes for a child whose parent is not emotionally or physically available to him or her (Tronick, 1986).

Interaction is the way in which humans relate to each other. By observing the interactional patterns and exchanges within families, the professional has a brief glimpse into the way in which family members regulate and express needs, thoughts, affects, and behavior. At a more complex level, one can see how issues of power, control, socialization, discipline, tolerance of frustration, and regulation of impulses are handled. Parents who talk about feelings and conflicts have children who develop a better understanding of emotion (Bretherton et al., 1980) and those who encourage the expression of negative emotion, within the context of warmth and support, have children who develop more sympathetic, adaptive and competent social behavior (Eisenberg and Fabes, 1994).

Observing the dyad, one can also learn about behavioral manifestations of the attachment relationship, as well as how signals are given and received, and how needs are satisfied. For example, one may observe, as Tronick and his colleagues have, the response of an infant to the non-responsive (still face) expression from his/her mother. Most infants will first try valiantly to engage the parent by smiles, coos, and gestures. When these are not reciprocated, the child eventually stops trying and withdraws. While this interactive vignette demonstrates an obvious mismatch in communication, dysynchrony can be present in much subtler ways. A toddler playfully dancing around a smiling yet passive parent may experience an interactive mismatch.

In contrast, when a parent and child are able to communicate in reciprocal ways, it looks and feels very much like a smooth dance. Both partners of the dyad move with each other, and though there may be a misstep, the pattern is picked up and tried again. Within a secure, primary attachment relationship, infants are motivated to develop at increasingly complex levels of interaction, beginning with their internal biophysical rhythms, and progressing through social, sensori-motor, behavioral and symbolic/representational levels of interaction.

Patterns and styles of interaction are fundamental to all emotional growth and development. When there is a goodness of fit or an overlap in the parent-child relationship, interactions are more organized and progressive in predictable and patterned ways. The interactions are more mutually enjoyable and satisfying to both the parent and child, foster trust, and tend toward increasing levels of interaction and a more secure relationship. Relationships based on mutual trust, warmth and acceptance, open communication, clear expectations and consequences of misbehavior foster growth, not only of the child, but of the parent and family as well.

Key Issues to observe for or ask about when assessing Interaction are:
1. Parental responsibility to the infant/child’s cues and signals.
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3. Synchronized behavioral style in the parent-child dyad.
4. Mutuality in stimulation and play activities.
5. Emotional attentiveness and availability.

The Domain of Mastery

Mastery is another building block toward understanding the foundations of emotional health and development in early childhood. Mastery is two-fold: that of the child and that of the parent. Mastery is defined as a child’s development of increasingly complex physical, cognitive, linguistic, emotional, and social abilities. Through maturation and interaction with the world, this developing mastery allows the child to discover his or her own efficacy, which is the power to have an effect on people and/or things. This process enhances the child’s emerging self-esteem, identity, self-control, and motivation to explore and enjoy the world. Parental mastery both emerges from and facilitates adequate performance of the parental role, attainment of parental self-esteem, and promotion of the parent’s and child’s developing selfhood. Family mastery coalesces as family members successfully negotiate issues of intimacy, power, and the needs of self versus others, culminating in a growth-promoting group identity.
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Mastery is a critical concept in the ongoing development of a child's physical, cognitive, linguistic, emotional, and social skills. It is through adaptation and practice that a child finds solutions to challenges posed by the environment. These challenges can be either exchanges with the inanimate environment (e.g., negotiating stairs, riding without training wheels) or the animate environment (e.g., learning to talk with others and to ask for help).

What We Know About Mastery

The process of mastery is particularly important to a child's emotional well-being. Imagine the familiar scene of the toddler who stands up without holding on for the first time, the look of pure delight (and simultaneous terror) as the small child realizes his/her solitary position. Successful accomplishment of these developmental milestones or tasks, facilitates a feeling of efficacy and enables a child to move on to the next developmental task, or to explore the next challenge with new confidence and competence.

Likewise, for a parent, the role of raising a child brings an array of new challenges unlike any other interpersonal situation experienced. As Partridge (1988, p. 281) contends, "Somewhere among recognition of conception, delivery of an infant, and the early months of the child's life, a parent is born." Thus, successful negotiation or mastery of the emotions, skills, and parental role that are part of life with a child, leads to increased self-esteem, self-confidence and positive self-regard for the parent. This can be seen, for example, by the new mother who successfully identifies and quiets the distress of her week-old infant or the father who is highly adept and fully enjoys playing hide-and-seek with his child.

Parents navigate through three basic, overlapping and progressive stages of mastery as discussed in 1960 by D.W. Winnicott during three BBC broadcast talks (Winnicott, 1993). Initially, in the first stage, a parent takes full responsibility and control for the infant. This responsibility changes over time and diminishes slightly as the child progresses through developmental stages, becoming more self-aware and striving toward independence. This stage only very slowly, if ever, becomes obsolete as the child grows up and out of the need for parent/family control, as an independent member of society.

During the second stage, the parent imparts his/herself on the child, in terms of expectations and views of the world. The parent acknowledges the infant/child's increasing ability to understand things and thus begins to teach right from wrong, what is allowed and what is not. This is not about moral rights and wrongs in the second stage, but issues of safety and protecting the child from real danger. Parents begin to "say no" to their child without explanation.

The "saying no" stage transitions to the third stage, as the child is better able to attend and "hear" explanations of why something is "No". This is the stage of expla-
nation, as the parent engages the child's cooperation by providing an explanation of "No". The progression from stage 2 to stage 3 is very individual and highly dependent upon the development of the child and of the parent.

Table 2.3

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
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<tbody>
<tr>
<td>Full Responsibility</td>
<td>&quot;Saying No&quot;</td>
<td>Giving Explanations</td>
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</table>

The parents' sense of mastery is not only contingent on feelings of their own efficacy, but on the progress of their child. Parents feel competent as their children grow and develop in expected and valued ways. It is important for parents to have realistic expectations for the child's unique pattern of development and for their own capabilities. This is particularly salient for parents of children with special needs. These children often do not progress along expected developmental lines, and they and their parents may feel frustration and loss that will directly impact their sense of mastery and ultimately, in cases where there is constant failure, their emotional development. The families' sense of mastery is not only affected by the actual special need, but additionally by the multiple stressors involved in the adaptation to the special need. Everyday events/activities are escalated or exacerbated and minor crises can easily become major crisis for these families, which can have a negative effect on coping and their sense of efficacy and mastery.

The sense of efficacy is intrinsically tied to feelings of competence, confidence, and growing self-esteem. When a young child successfully negotiates developmental tasks, each accomplishment builds onto others, enabling the child to tackle the next developmental challenge. For many children this is a natural, satisfying process. This process does not always go as well, however, particularly for children whose development is delayed by a handicapping condition or past abuses. For example, sick or handicapped children sometimes have difficulty with mastery of their world (i.e., the child with spina bifida might not easily move around his/her house) as they struggle to achieve independence. Children who have been emotionally, physically or sexually abused often fail to see themselves as good, capable or as able to fully impact their world. Their emotional mastery is therefore blunted and they often lack the emotional resources to move on developmentally.

On the parental side, practitioners are frequently faced with parents who feel incompetent and unable to meet their child's needs. Often, the initial tasks for the clinician are assisting families to find their personal resources and breaking the psychological cycle of feelings of failure. This is complicated when the child has fewer personal resources, and when the parent has a history laden with dysfunction and feelings of powerlessness. The clinician will need to learn from the parent, what their specific needs are. "Some need a listener, an unburdener; ...some need a coun-
sor; others need an advisor, a person with medical knowledge off of whom they can bounce ideas about their child's well being... If you listen carefully enough almost every patient and family member will tell you right up front what it is he or she needs from you" (Marion, 1995).

Table 2.4
What Parents Want From Professionals

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<th>Parent</th>
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<tr>
<td>Understanding</td>
<td>Performance of Basic Caregiving</td>
</tr>
<tr>
<td>Acceptance</td>
<td>Provision of Safe Environment</td>
</tr>
<tr>
<td>Validation</td>
<td>Knowledge of Growth &amp; Development</td>
</tr>
<tr>
<td>Collaboration</td>
<td>Provision of Opportunities for Exploration/Maturation</td>
</tr>
<tr>
<td>Respect</td>
<td>Realistic Expectations of Child</td>
</tr>
<tr>
<td>A Family Focus</td>
<td>Confidence/Competence in the Parent Role</td>
</tr>
<tr>
<td>Clear Communication</td>
<td>Predictability</td>
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<tr>
<td>Honesty</td>
<td>Reliability</td>
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<td></td>
<td>Adaptation/Coping Skills</td>
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<td>Development of Self-esteem</td>
<td>Provision of Safe Environment</td>
</tr>
<tr>
<td>Development of Self-identity</td>
<td>Knowledge of Growth &amp; Development</td>
</tr>
<tr>
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<td>Provision of Opportunities for Exploration/Maturation</td>
</tr>
<tr>
<td>Development of Self-confidence</td>
<td>Realistic Expectations of Child</td>
</tr>
<tr>
<td>Progressive Developmental Pattern</td>
<td>Confidence/Competence in the Parent Role</td>
</tr>
<tr>
<td>Predictability</td>
<td>Predictability</td>
</tr>
<tr>
<td>Consistency</td>
<td>Reliability</td>
</tr>
<tr>
<td>Adaptation/Coping Skills</td>
<td>Adaptation/Coping Skills</td>
</tr>
</tbody>
</table>

In considering the infant's emotional development, basic capacities must be understood not only in terms of the infant's overall ability and developmental level per se, but also in terms of the parent's response to these capabilities. Are these accepted, supported, and facilitated, or hindered and denied by the parent? Does the infant experience limitation in skills as acceptable challenges, or as frustrating conflicts? Early emotional states can be deduced from observation and clearly related to emotional development, particularly as the infant becomes more socially aware, communicative, and cognitively able to classify experience.

Parental mastery is critical. Parents must master the experience of conception, pregnancy, and birth; certain factors, such as previous birth trauma, miscarriage, stillbirth, and family or personal stress or psychological problems create challenges in this area. Parents must also master the transition to parenthood, both from the perspective of social role and that of human growth and development (identity). Finally, parents must master unique skills, affects, experiences, and functions pertinent to the stages of the infant's development. A parent of a newborn must master a different set of experiences than a parent of a two-year-old, for example. Parenting is a dynamic process; mastery of the parenting role throughout the life cycle is one of life's major challenges.

Parents who have integrated the role of parent and its specific experiences with other aspects of their personality, overall identity and sense of self, are more likely to be adequate, secure parents. Research has documented that this personality integration, ego capacity, or insightfulness into the meaning of parenting is a quality that differentiates abusive parents from non-abusive parents (Brunquell et al., 1981).

This research highlights the importance of parental self-understanding, self-awareness (Newberger, 1980), and self-concept (Partridge, 1988). Parents must deal with their inner working models of parenting and qualities of attachment to master their current parenting role (Main et al., 1985).
selor; others need an advisor, a person with medical knowledge off of whom they can bounce ideas about their child’s well being... If you listen carefully enough almost every patient and family member will tell you right up front what it is he or she needs from you” (Marion, 1995).

Table 2.4

<table>
<thead>
<tr>
<th>What Parents Want From Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recognition/An Audience</td>
</tr>
<tr>
<td>• Understanding</td>
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<tr>
<td>• Acceptance</td>
</tr>
<tr>
<td>• Validation</td>
</tr>
<tr>
<td>• Collaboration</td>
</tr>
<tr>
<td>• Respect</td>
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<tr>
<td>• A Family Focus</td>
</tr>
<tr>
<td>• Clear Communication</td>
</tr>
<tr>
<td>• Honesty</td>
</tr>
<tr>
<td>• Positive Support</td>
</tr>
<tr>
<td>• Tolerance and Forgiveness</td>
</tr>
<tr>
<td>• Flexibility</td>
</tr>
<tr>
<td>• Information</td>
</tr>
<tr>
<td>• Resources/Referrals</td>
</tr>
<tr>
<td>• Solicitation of Their Perspective/Insights/Knowledge</td>
</tr>
<tr>
<td>• Good Questions</td>
</tr>
<tr>
<td>• Patience</td>
</tr>
</tbody>
</table>

Being aware of and responding to what parents want and need from professionals is paramount in providing optimal care toward the healthy overall development of young children. The infant's biology, constitution, temperament, health status, family context and history clearly affect his or her total capability for performance in any given area. Whatever the degree of performance demonstrated, infants develop mastery over certain skills; this mastery relates very directly to the child’s capability for engaging in interactions with others. It also affects the quality of the infant's subsequent experience of the world and of other people. Deaf children must learn to recognize their primary-attachment persons by means other than sound of footsteps or voice; blind children register maternal care by sensing the presence and quality of touch. Over time, the capabilities of infants to perform tasks, accept challenges, and master skills and behaviors feeds their sense of self, self-esteem, and control over their own bodies and their particular place in the world (Maccoby 1980).

Table 2.5

<table>
<thead>
<tr>
<th>Elements Of Mastery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child</strong></td>
</tr>
<tr>
<td>• Physical Cognitive, Linguistic, Emotional and Social Abilities</td>
</tr>
<tr>
<td>• Discovery of Self-efficacy</td>
</tr>
<tr>
<td>• Development of Self-esteem</td>
</tr>
<tr>
<td>• Development of Self-Identity</td>
</tr>
<tr>
<td>• Progressive Self-control</td>
</tr>
<tr>
<td>• Development of Self-confidence</td>
</tr>
<tr>
<td>• Progressive Developmental Pattern</td>
</tr>
<tr>
<td>• Predictability</td>
</tr>
<tr>
<td>• Consistency</td>
</tr>
<tr>
<td>• Adaptation/Coping Skills</td>
</tr>
<tr>
<td><strong>Parent</strong></td>
</tr>
<tr>
<td>• Meeting Survival Needs</td>
</tr>
<tr>
<td>• Performance of Basic Caregiving</td>
</tr>
<tr>
<td>• Provision of Safe Environment</td>
</tr>
<tr>
<td>• Knowledge of Growth &amp; Development</td>
</tr>
<tr>
<td>• Provision of Opportunities for Exploration/Maturation</td>
</tr>
<tr>
<td>• Realistic Expectations of Child</td>
</tr>
<tr>
<td>• Confidence/Competence in the</td>
</tr>
<tr>
<td>Parent Role</td>
</tr>
<tr>
<td>• Predictability</td>
</tr>
<tr>
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Key Issues to observe for/or ask about when assessing Mastery are:

1. The ability of the child to perform developmentally appropriate tasks.
2. The way a parent and child solve problems, and cope with difficult tasks.
3. Parental expectations of the child’s ability to perform developmental tasks.
4. Parental responsiveness to the child and quality of “mirroring.”
5. Parental and child self-esteem.

The Domain of Social Support

Social support is the last concept of the AIMS domains toward understanding the emotional health and development of the young child in the context of their family. Social support is defined as a network of people, resources, and influences available to families that enhances healthy attachment, interaction, and mastery of skills. These resources are both formal and informal, and may include extended family, neighbors, friends, co-workers, church groups, clubs, community organizations, governmental and non-governmental agencies, and helping professionals. By identifying and working with this network, family members develop an increasing sense of empowerment, competence, connectedness, and ability to cope with and adapt to life events.

In the last decade or so, it has become increasingly clear that social support decreases stress, facilitates coping, and increases emotional well-being and family functioning. The impact of social support on the developing dyad of parent and child is evident across the domains of attachment, interaction and mastery.

What We Know About Support

The American Journal of Public Health has reported the importance of social support in the development of children (Shonkoff, 1984). Multiple research cited reflected the positive, health promoting aspects of social support. One study identified a “...clear and consistent...” association between maternal/social support and the security of the infant-mother attachment. In another study, mothers with greater supports were identified as being significantly more positive in their attitudes and interactive behavior with their infants. Thus, successful interventions on behalf of children must address the needs of the parent and family, as well as the child. Early intervention which serves to enhance support to parents and their children directly impacts parenting skills, a sense of parental competence and confidence and improved parent-child interaction (Jones, 1995) toward more positive child development.

The literature is replete with data regarding the damaging effects of stress on individuals and families. Stress is said to alter the susceptibility of individuals to disease (Haggerty, 1990). While it is not entirely clear how this works, there appears to be some mechanism by which stress affects resistance to disease. Those studying the incidence of medical illness report a clear connection for some families between a stressor, such as family crisis, loss of job, or social disorganization, with strep infection, increased use of medical services, pregnancy complications, myocardial infarction, and so on (Rohmann and Haggerty, 1972; Nuckolls et al., 1972; Rahe et al., 1967; Meyer and Haggerty, 1962). Investigators have also become interested in families or individuals who seem to have high levels of stress but do not respond with a medical illness. Researchers have been busy over the last decade attempting to identify factors that appear to buffer stress and prevent maladaptive results.

The concept of social support has gained attention as one such protective buffer against the consequences of stress (Shonkoff, 1984). Social supports have been defined elsewhere as people with whom one has attachments (Caplan, 1974), helpful information from others that allows one to feel cared for and loved, and a social network of mutual obligations (Cobb, 1976). The quality of the social supports available to a young child and their family can serve to support or compromise the overall well-being and development of that child. This can have lifelong effects for the child, especially in terms of their emotional well-being and ability to grow and learn.

Table 2.6

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>• Positive Attachment</td>
</tr>
<tr>
<td>• Healthy Interaction</td>
</tr>
<tr>
<td>• Developmental Mastery</td>
</tr>
<tr>
<td>• Pattern of Progressive Growth and Development</td>
</tr>
<tr>
<td>Parent</td>
</tr>
<tr>
<td>• Existing Support Network</td>
</tr>
<tr>
<td>• Access to/Use of Support Network</td>
</tr>
<tr>
<td>• Available Resources</td>
</tr>
<tr>
<td>• Coping Skills</td>
</tr>
</tbody>
</table>

The sense of social support is transmitted to individuals and families through a variety of means such as intimate relationships, friendships, and informal neighborhood contacts (Cric, 1983). Feelings of connectedness, decreased stress and decreased sense of isolation are some of the positive effects of social support. In addition to mediating stress, social support has been found to produce positive effects on attitudes and behavior, specifically concerning parent-child interaction and child development. Crochenberg (1981), for example, found a connection between a mother's social support and the security of attachment of the twelve-month-old child. His study showed that mothers with great stress and few supports showed less positive attitudes toward their child. Conversely, mothers with equal stress but more support showed significantly more positive attitudes and behavior toward their infants. For families who have children with special needs, the impact of social support (or lack thereof) is even greater. Hanson and Hanline (1990) report that stress in parents of children with special needs seems to be more strongly associated with perceptions of social support than to the child with special needs.
Key Issues to observe for/or ask about when assessing Mastery are:

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The more social support available to a mother, the more responsive and adequate a parent she is, according to Belsky (1984). Research has shown that mothers who receive support from the infant's father and maternal grandmother (Colletta, 1983, 1981) are less likely to be depressed. Parenting is a "buffered system"; in addition to the strengths of the parent and infant, strengths in the social network surrounding the family create a buffer for easing of particular difficulties inherent in these domains (Belsky, 1984). Support for primary caregivers is associated with greater mastery, and certainly aids the transition to parenthood for first-time parents (Cutrona, 1984; Kahn, 1980).

Social support is also of direct benefit to the infant. Infants in buffered systems, particularly in multi-risk families, are more likely to show developmental gains than infants in a non-buffered system with few supports. These positive effects are likely to be at least partially direct, and not just an indirect result of the parents' feeling better. Protective services have often recommended day care for infants in highly stressed environments; while involving separation, which can have its own repercussions, daycare does provide respite from the stressful environment while additionally introducing the infant to alternative models of relating and alternative social experiences.

It is largely through support to the infant and primary caretakers that professionals from any discipline are able to provide their earliest and perhaps most profound assistance to families. Professional provision of support and guidance to infants, young and their families has a positive impact on the overall health of the child and family. Healthy Start reports that the simple, most effective strategy for preventing child abuse is to provide parents with education and support (O'Connell, 1992).

Key Issues to observe for/or ask about when assessing Social Support

1. The availability of a social support network(s).
2. Access to/use of resources
3. Positive parental behaviors and attitudes.
4. Predictable and consistent parental development.
5. Predictable and patterned child development.

Summary and Case Illustration

In this chapter, we have presented information about the domains of attachment, interaction, mastery, and social support, as they pertain to the development and functioning of infants, young children, and their families. We have discussed the importance of parent-child-family attachments, effective parent-child-family interactions, mastery of basic skills appropriate to the developmental level of the child, and mastery with regard to parental competence, adaptation and self-esteem, and access to and use of social supports.

Without attachments to primary caregivers, young children do not develop the capacity to trust and to enter into healthy relationships. Without effective interactions with caregivers and parents, children fail to learn control of their aggressive or sexual impulses, and in some instances, might even fail to develop basic skills of communication, turn-taking, and play. Without mastery of particular abilities, feelings, or psychological challenges (e.g., learning to separate from parents) and its outgrowth—a sense of competence—children's development can be impeded or halted. Without social supports, individuals and families are isolated and left to cope on their own, with fewer sources of ideas/information, services, and/or practical assistance. In many instances, these resources and social supports can make the difference between family function or dysfunction, adequate or abusive parenting, and health or illness.

The broad goals of service providers wishing to strengthen a young child and family's emotional health can simply be to:

- Reinforce and Strengthen Attachments
- Encourage Positive Interactions
- Acknowledge and Facilitate Mastery (child and parent), and
- Promote Access To and Use Of Social Supports

How a professional accomplishes family supportive goals is an important topic of discussion. Intervention methods are many. Their effectiveness depends on the professional's basic skills in such areas as interviewing, listening, observing, and communicating. These skills, and their impact on work with young children and their families, are the subject of the next chapter of this handbook. What follows here is a case study illustrating how helpful it can be to evaluate a child and family in the areas or domains of Attachment, Interaction, Mastery and Social Support.

The AIMS: Developmental Indicators of Emotional Health was used to assist the provider in the following case study in accomplishing family and wellness-oriented, supportive goals. What is presented here is a fictional case, illustrating the use of the AIMS System of Practice.

Case Study/Sample Exercise

The following is a fictional, composite case study to illustrate use of the AIMS materials. The exercise includes a brief descriptive vignette, intake forms, an 18-month parent questionnaire that the parent completed before the visit, and points of observation noted during a general interview. As the service provider, how would you proceed with your interview and/or brief intervention, with this family in your setting?
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Case Vignette

You are seeing 18-month-old Bobby and his 26-year-old mother Ann. The information you have about this case is that Ann had gone through a painful divorce shortly after the birth of Bobby, and seemed to be alone and overwhelmed. Your impression of Ann is that she is a very caring mother. The first year went relatively well, with Bobby growing and developing at a normal rate.

As you enter the room Bobby is standing next to his mother. He becomes very shy with you, though you have been seeing him since he was small. Ann sits down and puts Bobby in her lap. He sits there passively for a while, then tries to get down. Ann wraps her arms around him and says, "Where are you going, you little imp?" He does not protest. You notice that Bobby has few words, and Ann is able to know what he wants without his cueing her. Bobby appears well cared for, but seems to be a shy, somewhat sad little boy. Ann reports that he is a "wonderful" child who never gives her any trouble. He continues to have trouble sleeping and she often feels that he is alone and overwhelmed. Your impression you have about this case is that Ann had gone through a painful divorce shortly after the birth of Bobby, and seemed to be alone and overwhelmed. Your impression of Ann is that she is a very caring mother. The first year went relatively well, with Bobby growing and developing at a normal rate.

The pages that follow are the "raw data" from which a clinical profile will be developed.
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**Case Vignette**

---

**Sample Exercise**

**FAMILY INFORMATION**

<table>
<thead>
<tr>
<th>Date:</th>
<th>__________/<strong><strong><strong><strong>/</strong></strong></strong></strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. IDENTIFICATION</td>
<td>Bobby</td>
</tr>
<tr>
<td>Name of Child</td>
<td>Home Telephone:</td>
</tr>
<tr>
<td>First name</td>
<td>middle name</td>
</tr>
<tr>
<td>Child's Current Age</td>
<td>18 months</td>
</tr>
<tr>
<td>Name of Mother</td>
<td>Ann</td>
</tr>
<tr>
<td>Mother's Address</td>
<td>Manchester, NH</td>
</tr>
<tr>
<td>With whom does child live? (Check all that apply)</td>
<td>Mother</td>
</tr>
<tr>
<td>Billing Address</td>
<td>Access</td>
</tr>
<tr>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Name of Responsible Party:</td>
<td></td>
</tr>
<tr>
<td>Medicaid #:</td>
<td>1-3456789</td>
</tr>
<tr>
<td>Insurance Co.:</td>
<td>Group No.</td>
</tr>
<tr>
<td>Zip</td>
<td>Cert. No.</td>
</tr>
<tr>
<td>Ethnicity of Child: (optional)</td>
<td></td>
</tr>
<tr>
<td>Current marital status of parents:</td>
<td>Married</td>
</tr>
<tr>
<td>Total number of people living in home:</td>
<td>Number of adults</td>
</tr>
<tr>
<td>Have there been any changes in the past year of people moving in and out of your home?</td>
<td>Yes</td>
</tr>
<tr>
<td>B. EMPLOYMENT</td>
<td></td>
</tr>
<tr>
<td>Mother:</td>
<td>Work:</td>
</tr>
<tr>
<td>Employment:</td>
<td>employee address</td>
</tr>
<tr>
<td>Father:</td>
<td>Work:</td>
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<tr>
<td>Employment:</td>
<td>employee address</td>
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<tr>
<td>C. EDUCATION</td>
<td></td>
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<tr>
<td>Highest grade completed — Mother:</td>
<td>(Check one):</td>
</tr>
<tr>
<td>Less than 12th</td>
<td>High school</td>
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<tr>
<td>Less than 12th</td>
<td>High school</td>
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<tr>
<td>Highest grade completed — Father:</td>
<td>(Check one):</td>
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<tr>
<td>Less than 12th</td>
<td>High school</td>
</tr>
<tr>
<td>Less than 12th</td>
<td>High school</td>
</tr>
<tr>
<td>D. TRNSPORTATION</td>
<td>Do you have reliable transportation?</td>
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<tr>
<td>E. SERVICES</td>
<td>Does anyone in your family currently receive services from any of the following? (Check all that apply.)</td>
</tr>
<tr>
<td>Child/Family Services</td>
<td>Economic Services</td>
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<tr>
<td>Adoption Services</td>
<td>AFDC</td>
</tr>
<tr>
<td>Child Day Care (foster care, preschool)</td>
<td>Food Stamps</td>
</tr>
<tr>
<td>Employment Services</td>
<td>SSI</td>
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<tr>
<td>Legal Services</td>
<td>Other:</td>
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<tr>
<td>Other:</td>
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<tr>
<td>Educational/Social Services</td>
<td>Health/Rehabilitation</td>
</tr>
<tr>
<td>Counseling</td>
<td>Drug/Alcohol Services</td>
</tr>
<tr>
<td>Housing Assistance</td>
<td>Family Planning</td>
</tr>
<tr>
<td>In-home Parent Aid Services</td>
<td>Psychotherapy/Family Counseling</td>
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<tr>
<td>Parenting Classes</td>
<td>Rehabilitation</td>
</tr>
<tr>
<td>Preschool Education Services</td>
<td>Therapy (e.g., speech, PT/OT)</td>
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<tr>
<td>Special Education Services</td>
<td>WIC</td>
</tr>
<tr>
<td>Transportation Assistance</td>
<td>Other:</td>
</tr>
<tr>
<td>Other:</td>
<td>Visiting Nurse</td>
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<td>(Over, please)</td>
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</tbody>
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**F. BIRTH HISTORY INFORMATION:**

1. PREGNANCY, LABOR AND DELIVERY

   **Pregnancy** (Provide as much information as you have available.)
   
   - Check if adopted: [ ]
   - Age at adoption: [ ]
   - [ ] No problems
   - [ ] Alcohol or Drug Use
   - [ ] Bleeding
   - [ ] Prematurity
   - [ ] How early?
   - [ ] Infection
   - [ ] Other

   Was the timing of this pregnancy good for you? [ ]
   - [ ] Yes
   - [ ] No
   - [ ] Premature
   - [ ] How early?
   - [ ] Infection
   - [ ] Other

   Did you receive regular medical care during this pregnancy? [ ]
   - [ ] Yes
   - [ ] No

   Where was the child born? [ ]
   - [ ] Eastern Me, Medical
   - [ ] Bangor

   Child's birthweight: [ ]
   - [ ] 7 lbs

   Circumstances at birth:
   - Labor and Delivery: [ ]
   - [ ] Vaginal delivery
   - [ ] Cesarean delivery
   - [ ] Premature
   - [ ] Breach
   - [ ] Twin (1st born, 2nd born)
   - [ ] Other

   Hospital Stay: Child: [ ] days
   - [ ] Mother: [ ] days

2. OTHER PREGNANCIES: How many? [ ]

   - Problems: [ ]
   - [ ] Yes
   - [ ] No
   - [ ] Before this child
   - [ ] After this child
   - [ ] Abortion
   - [ ] Miscarriage
   - [ ] Stillborn
   - [ ] Premature
   - [ ] Other

3. EARLY LIFE WITH CHILD (birth to six months):

   **Sleeping:**
   - [ ] No problems
   - [ ] Problems
   - [ ] Some difficulty going to sleep often had to, [ ]

   **Feeding:**
   - [ ] breastfed
   - [ ] Bottle fed
   - [ ] No problems
   - [ ] Problems
   - [ ] Nursing
   - [ ] Swallowing
   - [ ] Eating problems (fitty eater, excessive spitting of food, allergies)
   - [ ] Other

   How would you describe your baby during infancy?
   - [ ] Quiet
   - [ ] Irritable
   - [ ] Hard to deal with
   - [ ] Average
   - [ ] Overactive
   - [ ] Other

4. LATER LIFE WITH CHILD (six months to five years)

   **How Would You Describe Your Child Now?**
   - [ ] Quiet
   - [ ] Irritable
   - [ ] Hard to deal with
   - [ ] Average
   - [ ] Overactive
   - [ ] Aggressive
   - [ ] Other

This information will be kept private. Thank you.
F. BIRTH HISTORY INFORMATION:

1. PREGNANCY, LABOR AND DELIVERY

Pregnancy (Provide as much information as you have available.)

- [ ] Check if adopted

Age at adoption: No problems
- [ ] Alcohol or Drug Use
- [ ] Bleeding
- [ ] Prematurity
- [ ] Other

Was the timing of this pregnancy good for you? Yes

Did you receive regular medical care during this pregnancy? Yes

What month of the pregnancy did you start to see a medical provider? 3 months

Where was the child born? Eastern Md. Medical Bangor

Child's birthweight: 7.1 lbs

Circumstances at birth:

- Labor and Delivery: Normal
- Cesarean delivery: No
- Premature: No
- Breach: No
- twins: 1st born, 2nd born: No
- Other:

Hospital Stay: Child: 3 days Mother: 3 days

2. OTHER PREGNANCIES: How many? 1

Problems: [ ] Yes [ ] No

If yes: [ ] Before this child [ ] After this child

Type of experience: [ ] Abortion [ ] Miscarriage [ ] Stillborn [ ] Premature

Other:

3. EARLY LIFE WITH CHILD: (birth to six months)

Sleeping: [ ] No problems [ ] Problems

If problems, describe: difficulty going to sleep

Feeding: [ ] Bottle fed [ ] Breastfed

If problems, what kind: [ ] Lack of [ ] Swallowing

Other:

How would you describe your baby during infancy? Quiet

Other:

4. LATER LIFE WITH CHILD: (six months to five years)

How would you describe your child now? Quiet

Other:

This information will be kept private. Thank you.

---

Sample Exercise

FAMILY CONCERNS INDICATOR

<table>
<thead>
<tr>
<th>Occurred Within My Family</th>
<th>Concerns At This Time</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Problems/Disabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Disabilities including reading or school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech/Language Delaying Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with Social Services or Schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulties with Childcare, Help or Services</td>
<td></td>
<td></td>
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<tr>
<td>FAMILY LIFE</td>
<td></td>
<td></td>
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<tr>
<td>Marriage or Relationship Problems</td>
<td></td>
<td></td>
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<tr>
<td>Child Living Outside of Family Home</td>
<td></td>
<td></td>
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<tr>
<td>Few Friends or Close Family Members</td>
<td></td>
<td></td>
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<tr>
<td>Financial Problems or Difficulties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional/Mental Health Problems</td>
<td></td>
<td></td>
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<tr>
<td>Behavior Problems</td>
<td></td>
<td></td>
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<tr>
<td>Family Violence (physical/emotional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td></td>
<td></td>
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<tr>
<td>Problems with Alcohol or Drugs</td>
<td></td>
<td></td>
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<tr>
<td>Concerns About Safety</td>
<td></td>
<td></td>
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<tr>
<td>Housing Difficulties</td>
<td></td>
<td></td>
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<tr>
<td>Transportation Difficulties</td>
<td></td>
<td></td>
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<tr>
<td>Prescription or Long Separations</td>
<td></td>
<td></td>
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<tr>
<td>LIFE CHANGES</td>
<td></td>
<td></td>
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<tr>
<td>Divorce or Change of Marital Status</td>
<td></td>
<td></td>
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<tr>
<td>New Child in Family/Recent Pregnancy</td>
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<tr>
<td>Change of Residence</td>
<td></td>
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</tr>
<tr>
<td>Job/Work Difficulties/Change of Employment</td>
<td></td>
<td></td>
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<tr>
<td>Financial Difficulties</td>
<td></td>
<td></td>
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<tr>
<td>Unfortunate Life Events (fire, theft, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td></td>
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</tr>
</tbody>
</table>

OTHER CONCERNS

Specify: __________

This information will be kept private. Thank you.
A. Feelings of Attachment

This part covers ways that family members feel about one another.

1. I enjoy watching my child do things on his/her own.

Very Often Sometimes Rarely Never
1 2 3 4 5

B. Family Resources and Supports

This part covers the kind of help and supports you and your family have.

6. I do outside the home.

C. Family Abilities and Feelings of Mastery

This part covers the way you, your child, and your family play, work and talk together.

9. My child appears to enjoy child care.

Very Often Sometimes Rarely Never
1 2 3 4 5

10. My child and I laugh together.

D. Family Resources and Supports

This part covers the kind of help and supports you and your family have.

11. My child leaves his/her side to do things.

Very Often Sometimes Rarely Never
1 2 3 4 5

12. My family spends time together.

13. My child leaves his/her side to do things.

E. Family Behaviors and Interactions

This part covers the way you, your child, and your family play, work and talk together.

14. My child appears happy most of the time.

Very Often Sometimes Rarely Never
1 2 3 4 5

15. My child and I laugh together.

16. My child seems to enjoy child care.

17. My child appears happy most of the time.

F. Family Feelings of Attachment

This part covers ways that family members feel about one another.

18. I enjoy watching my child do things on his/her own.

Very Often Sometimes Rarely Never
1 2 3 4 5

19. My child appears happy most of the time.

20. My child and I laugh together.


22. My child appears happy most of the time.

G. Family Resources and Supports

This part covers the kind of help and supports you and your family have.

23. I do outside the home.

24. My family spends time together.

25. My child leaves his/her side to do things.

26. My family feels that his/her home is a good place to be.

H. Family Abilities and Feelings of Mastery

This part covers the way you, your child, and your family play, work and talk together.

27. My child appears happy most of the time.

Very Often Sometimes Rarely Never
1 2 3 4 5

28. My child and I laugh together.

29. My child seems to enjoy child care.

30. My child appears happy most of the time.

I. Family Behaviors and Interactions

This part covers the way you, your child, and your family play, work and talk together.

31. My child appears happy most of the time.

Very Often Sometimes Rarely Never
1 2 3 4 5

32. My child and I laugh together.

33. My child seems to enjoy child care.

34. My child appears happy most of the time.

J. Family Resources and Supports

This part covers the kind of help and supports you and your family have.

35. I do outside the home.

36. My family spends time together.

37. My child leaves his/her side to do things.

38. My family feels that his/her home is a good place to be.

39. My child appears happy most of the time.

Very Often Sometimes Rarely Never
1 2 3 4 5

40. My child and I laugh together.

41. My child seems to enjoy child care.

42. My child appears happy most of the time.
B. Family Behaviors and Interactions
This part covers the ways you, your child, and your family play, work and talk together.

1. Our family spends time together.
Yes
No

2. I say to my child when I have done something wrong.

3. My child likes to do what other people do.

4. My child tells me what was wrong with something.

5. My child likes to play with other children.

6. My child talks about things that happened.

7. I let my child feel safe.

8. I give my children personal space.

9. My child is enough to play outside.

10. I believe in what the other child does.

11. My child's other parent understands what our child is trying to say.

C. Family Abilities and Feelings of Mastery
This part covers the ways you, your child and your family develop, learn skills and solve family problems.

1. I accept my child telling me to "no" without getting upset.

2. I let my child have things he wants.

3. I am happy with how my child's other parent cares for our child.

4. My child is able to look after himself for a short time.

5. My child menu uses for long parts of the day or night.

6. I am able to keep my child safe.

7. My child's other parent and I agree about how to raise our child.

8. Children in our family can cope with the many constant stresses.

9. I get concerned about the way to parent my child.

10. My child is able to adapt.

11. My child does things to get what he wants.

12. My family members share feeling with each other.

D. Family Resources and Supports
This part covers the kind of help and supports you and your family have.

1. We don't get along outside the home.

2. We can count on others when I need them.

3. Relatives let me know they think I am a good parent.

4. I feel okay getting the services my child needs.

5. I worry that people outside our family will not care about my child.

6. Other parents give me good ideas about family and child care.

7. I take care of my child.

8. My child's behavior appears random or disorganized.

9. My child's behavior shows purpose; appears to know what he/she wants and how to get it.

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Case Study Worksheet

How does a provider make use of family information about attachments, interaction, mastery and support? The task is to develop a clinical profile. Some helpful questions are offered below.

I. Developing the Clinical Profile

Family, parent and child strengths
What are the strengths? How does this information emerge?
Possible concerns
What are the possible problems? How does this information emerge?

II. Initiating and Interview/Dialogue with the Parent, and Observing

Pursuing information
What general questions would be good to ask? Why?
Observing
What information is needed from observations of parent and/or child?

III. Giving Feedback: Choosing Appropriate Brief Psychosocial Interventions

Phrasing feedback about strengths
What specific information can be shared about strengths? How can this be done?
Phrasing feedback about concerns
What specific information can be shared? What needs to happen for the problem to be resolved? What interventions are appropriate? What is the goal of the interventions?

CASE STUDY INTERPRETATION: ONE CLINICIAN’S VIEWPOINT

Ann is a young single mother, working part-time, adjusting to a divorce, and raising a child who is in the middle of a developmental transition. Mom probably feels alone, as she does not like to ask for help, feels she cannot count on others to help, and does not keep up with old friends. She makes several statements indicating that there is a lot of tension with the child’s father.

Bobby is, according to his mom, sometimes unhappy for long periods at a time and he is rarely curious or investigative enough to climb on things to get what he wants. He is rarely able to look at picture stories for a short time, and only sometimes, wants to do this on his own. Mother very often wishes he needed her more, though he seems fairly close, maybe clingy, at the present time.

Despite these tensions, there appears to be a good attachment between mom and son, with mutual enjoyment. Bobby and she are affectionate; they laugh together, and seem to communicate, at least adequately, according to Ann.

Several impressions emerge. One is that Ann is feeling lonely and depleted, and perhaps still grieving the failed marriage. Her son may be her only source of gratification, and she might wish that he remain a baby, to stay close to her. If she could recognize the need for more support in her life, remove whatever obstacles lie in her way of connecting to her own family, and achieve better resolution of her divorce, she would have much more energy, and ability to support her son’s development. She may as well be so drained now, that it is too difficult to let him explore and become more assertive and independent.

I would try to help Ann realize how much stress she has experienced and would commend her on her ability to hold down a job, manage the logistics of child care, and raise a healthy boy. I’d ask her to tell me how she has coped so well. As soon as she told me about any current hardship, I would validate the level of stress she is experiencing and see if she could point out how that stress can have an impact on parenting. I would say something about how it’s often hard for parents to follow their child into a new stage when they are still trying to adjust to the old stage. Then I would talk about the challenges of toddlerhood and give some suggestions about helping a toddler explore, develop autonomy, and deal with inevitable frustrations. I would be sure to explain that she will continue to be vitally important to Bobby, even as Bobby seems to move away from her.

I would try to finish the appointment by reassuring her about Bobby’s overall health, their strong bond, and I would remind her that she is important too, and that all parents need help. I would give her some suggestions for getting support — groups, friends.

Finally, I would make a note to myself to check in with her again, if she’s due for another visit, or to ask her to call in 3-4 weeks to see if her stress has lessened. I would keep in mind that she might need a referral for more intensive help or consultation.
Case Study Worksheet

How does a provider make use of family information about attachments, interaction, mastery and support? The task is to develop a clinical profile. Some helpful questions are offered below.

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What information is needed from observations of parent and/or child?

III. Giving Feedback: Choosing Appropriate Brief Psychosocial Interventions

Phrasing feedback about strengths
What specific information can be shared about strengths? How can this be done?
Phrasing feedback about concerns
What specific information can be shared? What needs to happen for the problem to be resolved? What interventions are appropriate? What is the goal of the interventions?

CASE STUDY INTERPRETATION: ONE CLINICIAN’S VIEWPOINT

Ann is a young single mother, working part-time, adjusting to a divorce, and raising a child who is in the middle of a developmental transition. Mom probably feels alone, as she does not like to ask for help, feels she cannot count on others to help, and does not keep up with old friends. She makes several statements indicating that there is a lot of tension with the child’s father.

Bobby is, according to his mom, sometimes unhappy for long periods at a time and he is rarely curious or investigative enough to climb on things to get what he wants. He is rarely able to look at picture stories for a short time, and only sometimes, wants to do this on his own. Mother very often wishes he needed her more, though he seems fairly close, maybe clingy, at the present time.

Despite these tensions, there appears to be a good attachment between mom and son, with mutual enjoyment. Bobby and she are affectionate, they laugh together, and seem to communicate, at least adequately, according to Ann.

Several impressions emerge. One is that Ann is feeling lonely and depleted, and perhaps still grieving the failed marriage. Her son may be her only source of gratification, and she might wish that he remain a baby, to stay close to her. If she could recognize the need for more support in her life, remove whatever obstacles lie in her way of connecting to her own family, and achieve better resolution of her divorce, she would have much more energy, and ability to support her son’s development. She may as well be so drained now, that it is too difficult to let him explore and become more assertive and independent.

I would try to help Ann realize how much stress she has experienced and would commend her on her ability to hold down a job, manage the logistics of child care, and raise a healthy boy. I’d ask her to tell me how she has coped so well. As soon as she told me about any current hardship, I would validate the level of stress she is experiencing and see if could point out how that stress can have an impact on parenting. I would say something about how it’s often hard for parents to follow their child into a new stage when they are still trying to adjust to the old stage. Then I would talk about the challenges of toddlerhood and give some suggestions about helping a toddler explore, develop autonomy, and deal with inevitable frustrations. I would be sure to explain that she will continue to be vitally important to Bobby, even as Bobby seems to move away from her. I would try to finish the appointment by reassuring her about Bobby’s overall health, their strong bond, and I would remind her that she is important too, and that all parents need help. I would give her some suggestions for getting support — groups, friends.

Finally, I would make a note to myself to check in with her again, if she’s due for another visit, or to ask her to call in 3-4 weeks to see if her stress has lessened. I would keep in mind that she might need a referral for more intensive help or consultation.
A Final Word

The reader will notice that not all information was covered by the clinician attending to this family. The clinician did, however, work from a "clinical profile" and use the hypothesis within the profile to guide the choice of interventions. The interventions were supporting, affirming, informing, reassuring, teaching, giving positive feedback and making plans to follow-up.

Other approaches are valid. This is one of several appropriate responses. Another clinician may have pursued the divorce more, or focused more on the child's development. The goals should leave the parent with a stronger sense of self, more insight into the child, greater awareness of family strengths, and more understanding of areas of concern with ideas about how to deal with the concerns. There are many pathways towards achievement of these goals.

Basic Principles of Psychosocial Practices in Early Childhood

Susan E. Partridge, L.C.S.W., Ph.D.

How does a professional respond to information about Attachment, Interaction, Mastery and Social Support, shared by a family through the AIMS Parent Questionnaire? How can observations and interviews, and sensitive, clinical use of one's self, combine to create a multi-method assessment approach? How does a professional ready him/herself to intervene on behalf of the emotional health needs of a young child and their family? This chapter addresses these questions which lie at the heart of psychosocial practices for all early intervention providers.

Several dimensions of psychosocial practices with young children and their families will be explored in this chapter. Psychosocial practices are behaviors engaged in by professionals that have an impact on, relate to, or are designed to influence the psychosocial functioning of clients. In the case of early childhood work, psychosocial practices undergird the development of the working relationship with parents on behalf of their young children. There is always a purpose to this alliance: to help heal a child's illness, to promote a child's development, to remove obstacles to a child's self-esteem, to improve parental functioning in order to alleviate a child's stress, and the like. The professional seeks an alliance with parents, and with children directly, to achieve specific goals believed important to the child's well-being.

Psychosocial practices consist of all that a professional does, because everything that she/he does has some bearing on the nature and course of the human process of change. Many psychosocial practices can be grouped by types of professional endeavor, such as diagnosing, advising, educating, reassuring, supporting, guiding, confronting, reinforcing, and promoting. But these activities can be performed in an infinite number of ways. This means that how a professional behaves—the ways he/she asks questions, responds to concerns, and communicates with, guides, advises, or educates parents—are critical components of psychosocial interventions. It is how these tasks are conducted, including the expression of a professional's attitude, choice of timing, sensitivity, responsiveness, and the like, that often make the difference in effective versus ineffective family work. Because this is a very complex topic, the focus here selectively includes the following aspects:
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1. Setting the stage for parent-professional collaboration, building on a critical awareness of the special needs of infants, toddlers, preschoolers, and their families;

2. understanding some basic principles of infant mental health practices;

3. improving the building blocks of psychosocial practices—the working alliance, parent-child observations, and interviews;

4. synthesizing assessment data, using a conceptual framework that promotes emotional health—the AIMS model;

5. selecting interventions; and

6. creating opportunities for mastery, both for professionals and families.

Many specific psychosocial practices are covered in detail, with attention to the particular complexities of child and family work. However, it is impossible to cover every aspect of practice, since there is no way to enumerate all the possible situations a professional will encounter. These situations, to be sure, vary with the presenting problem or challenge, such as prematurity, developmental delays, child abuse, or neglect. Professional-client relationships also differ in terms of the personality and unique history of those involved, as well as the nature of the relationship they jointly create (Mahoney, 1991). A provider must be ready to adapt the principles discussed in this chapter to the unique challenges he/she faces.

A second caveat relates to the definition of "professional." This chapter refers to professionals as people knowledgeable in child/family development, who work in settings that serve children and families, for the purpose of promoting child development and well-being. By definition, parents are viewed as clientele in addition to their children, even if the work with parents is indirect. Thus, professionals by this definition include the following: child care providers, nurses, physicians, early-childhood educators, occupational, speech, and physical therapists, social workers, psychiatrists, psychologists, counselors, child advocates, and policymakers.

Setting the Stage for Infant Mental Health Work

Over the past fifteen years, an enormous amount of research, theory and writing has focussed on infants and their needs (Provence, 1990; Lieberman, 1988; Fraiberg, 1980). One of the major findings of this burgeoning knowledge is the important role played by social support to families with infants and young children. Professionals are a source of this support. Whether a preschool teacher, pediatrician, community health nurse, or a social worker, all professionals encounter numerous situations that present opportunities for infant mental health practices — to inform and educate parents, to reassure and support, to provide guidance, to prevent problems, and to promote infant well-being (Bonkowski and Yanos, 1992).

There are many contexts for infant mental health work. Some are "known," planned, and intended and others are "unknown," where the emotional support given is therapeutic but not a primary focus of concern. For example, when an infant is referred to a social worker for non-organic failure to thrive, the social worker "knows" that infant mental health work will be part of the intervention. On the other hand, when a young child with an ear infection is taken to the physician's office, and the doctor discovers a behavioral problem through interviewing the parent, the doctor does not necessarily "know" that infant mental health work is taking place. It is infant mental health work if the doctor takes advantage of the opportunity to promote emotional health in the child and his/her family.

Do all providers of service to young children view their work as infant mental health? Clearly, some professionals tend to say, "This isn't my work. I'm not a mental health clinician. I do something else here." Granted, helping services have boundaries that define the limits of the service or the primary focus of their work. But this focus does not prohibit professionals from recognizing valuable opportunities to support children's and family's emotional health. For instance, well-child health supervision consists of the physician monitoring and promoting the physical, cognitive, language, and social development of the young child. Early intervention services may target speech and language skills, early education, or occupational therapy. Visiting nurses may focus on infant nutrition and self-care of the mother. None of these three services would be likely to define family functioning or emotional health as their primary focus, yet attention to emotional health can be a catalyst for improved family functioning, as well as enhanced provider-parent relationships and dialogue. In fact, children's services are changing and more and more service providers are attending to emotional health issues. The trend in child health and allied services is to view children holistically and engage in multidisciplinary collaboration to assure complete treatment of the child (Bonkowski and Yanos, 1992; Szanton, 1991; Provence, 1990). Part of this trend consists of understanding the transactions among a child and his/her family and environment. In this framework, when a professional such as a physician asks, "Is the child doing well?", emotional health surfaces as a visible target of assessment and intervention. Therefore, psychosocial practices become more and more a basic aspect of routine child health and allied health care (Provence, 1990; Green, 1985). Good psychosocial practices enhance parent and child sharing and participation and, through parent-professional collaboration, family functioning often improves.

Two methods, of which all professionals can take advantage, have received increasing attention and study in recent years. They are developmental surveillance and parent-professional collaboration. Developmental surveillance is defined as:

...a flexible, continuous process whereby knowledgeable professionals perform skilled observations of children throughout all encounters during child health care...development is continually monitored within the context of the child's overall well-being. Such surveillance acknowledge...
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edges the importance of early intervention through attempts to promote infant development by sharing with parents information about children's developmental stages and helping them with suspected developmental abnormalities for diagnostic and therapeutic services. Surveillance demands of the involved professionals a thorough knowledge of child development such that skilled observations may accurately and promptly detect significant deviations from normal. The limitations of parents as partners in the monitoring process are addressed, because one important goal of surveillance is to assist parents to become better observers of their children's development and respond appropriately to their concerns (Dworkin, 1989, p. 1001).

Although addressing well-child health supervision, Dworkin's article applies to all child-oriented services, including public health nursing, interventions with families of young children, child care/day care, early childhood education programs, and collaborative intervention services for children at risk, and mental health services. In each instance, professionals have an opportunity to monitor a child's developmental progress and to incorporate into their usual routines some practices geared towards promoting psychosocial/emotional health in children and their families.

The second method, parent/professional collaboration is the spirit of family-centered care (Shelton et al, 1987, p. 7). Parent/professional collaboration hinges on egalitarian information sharing and joint determination of intervention plans for a child in need of service. All participants feel respect for their individual roles and responsibilities. Parents are expected to be equal partners in the care and treatment of their children's medical or other problems. Strengths, as well as limitations, are emphasized in assessment and intervention. Professionals are expected to work with parents, rather than apart from parents in monitoring and assuring children's optimal development. In this model, professionals bypass the often occurring and recurring struggle to maintain traditional balance of power between parents or clients (Thomas, 1988). As a result, this level of parent participation requires that professionals think carefully about their relationships with parents (Shelton et al, 1987).

To put this method into practice demands collaborative skills, including those of effective listening and communication, assertiveness, creativity, problem-solving and conflict resolution. Although at times harder to engage in, the collaborative model of service is more productive in the long run, improving not only the quality of services but also enhancing the functioning of children, families, and professionals (Shelton et al, 1987). A study on communication patterns of physicians found that collaborative models of practice also provide the highest level of satisfaction among patients (Roter et al, 1997). The collaborative model applies both to service delivery and to developmental surveillance.

To practice both a collaborative approach and developmental surveillance, what does the professional need to know about families, parents, and the emotional development of children? The next section takes a look.

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**Principles of Practice**

**The Family in Perspective: Vulnerability and Strength**

A family with a newborn or a family caring for a very young child, is not like any other family; each stage of the family life cycle has its unique needs, challenges, and rewards (Carter and McGoldrick, 1988). When thinking about how best to work with the young family, it is helpful to be aware of these special characteristics.

An infant, toddler or preschooler is in constant transition. Physical growth is rapid. No less amazing is the amount of learning that occurs in the first five years. Cognitive, social, motor, and language development all show vast change from neonatal through preschool years (Minde and Minde, 1980). In the midst of these transformations in the child, parents face numerous emotional challenges—helping the child to learn to control impulses, engage in socially accepted behaviors, express strong emotions, regulate his/her body functions, and achieve a viable personal identity and sense of reality. The parents are also going through transformations of parenting simultaneously—such as parental competence and confidence in the provision of basic care and safety, as well as meeting the developmental needs of the child. As these tasks for the parent, family and child are so complex and consuming, the family, to some degree, is in a relatively constant state of flux.

In contemporary society, many parents do not feel confident about their childrearing (Young, 1990). There are many reasons for this, such as individual or personality-based, familial and/or cultural. This lack of parental confidence can be traced in part to the rapid change in ideas about what is considered "good" parenting over the last three or four decades. Should a parent spank a child? Should a baby be allowed to "cry himself" through the night and not be attended to? Can you spoil a child by giving him/her too much attention in the early years? More recently, giving a child "time out" for misbehavior is also being questioned as an effective method (Parenting, 1994). These and numerous other issues continue to be controversial.

Parent's history and experience of being parented also greatly impacts their own skills, abilities and confidence in parenting. Timing of the pregnancy and other life stage issues can additionally impact a parent's sense of confidence in childrearing. Another issue that impinges on parents is their own temperament qualities as compared with their child's. Are they in sync with one another or are they at odds. Recognizing all of these possible influences to parenting is important in developing coping strategies and adapting to the role of parent, one of, if not the single greatest challenge in life.

Has research helped parents raise their children? Research on effective parenting tends to document some key factors associated with positive child development outcomes, such as creative problem-solving, good peer relations skills, positive self-esteem, and school readiness and success. Two key factors have been identified in a great deal of this social science research. These are parental warmth and firm-
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nless (Maccoby, 1980). Parents who can, in a warm and nurturing way, provide sufficient structure and stability, and consistent, meaningful limits on children's behavior, tend to have children who function well in later years. These research conclusions are important, but many questions remain. How does a parent whose style may begin as somewhat cold or harsh "become" warm? How do a father and mother meet limits consistently? The application of good parenting "principles" can be very complex and challenging.

Further complicating the task of parental learning is the fact that ideas about "good" parenting and childrearing change quickly. "Experts" filter social science research and theory, and communicate with parents through books, magazines, television talk shows, newspapers, and the like. As ideas and thoughts change, different "experts" advise different techniques. A plethora of parent-advice material is available, some of it contradictory or, idealistic and hard to put into practice. Some parents try to adhere to the newer prescriptions, while others do not have, or make use of, access to the most current educational materials. In many cases, despite "knowing what is best," parents often succumb to the heat of an emotional parent-child interaction, and revert to ineffective child-rearing methods they would not have used in a calmer moment. Then, having "studied" or learned about what "should" happen, parents compare their own actions to the ideals, and often end up feeling inadequate, frustrated, confused, and guilty. All of these factors contribute to parental vulnerability and increasing needs for social support.

That we may know how an effective parent behaves, does not make easy the job of counseling parents. Many parents do not know how to parent effectively, and they carry through successive generations the coercive, harsh, cold, or abusive methods their parents may have used on them as children. Few parents enter childrearing without some unresolved emotional issues related to anger, envy, childhood abuse or neglect, or ineffective coping skills. This, of course, does not mean that parents lack resourcefulness or inner strength. Indeed, there are countless examples of parental and family strength. The key for the helping professionals is to work with parents across multiple opportunities and to provide a sufficiently supportive structure in which parents can learn and grow. Parents of infants and very young children have unique needs. They are often more vulnerable than others simply because their children are so rapidly growing and changing, and there is so much to learn — about their young child and about themselves. This learning is ongoing throughout a parent and child's development.

What Young Families Need

How are families with young children unique? Young children and their families have needs that are special and necessary for optimal growth, development and wellness. These needs are summarized in Table 3.1.

<table>
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<th>What Young Families Need</th>
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<tr>
<td>An Audience (to be heard)</td>
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<tr>
<td>Understanding (to be listened to)</td>
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<tr>
<td>Good Questions</td>
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<td>Acceptance</td>
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<td>Recognition</td>
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<td>Clear Communication</td>
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| Young families first and foremost need an audience. They need to be heard. Often times young parents are eager to share their joys as well as the concerns they have for their family. A young family needs someone who will hear what they have to say, their perspective, their feelings, of what is going on in the life of their family. This is really the first step toward building a relationship and meaningful dialogue with a young family toward having the greatest positive impact. |

| Young families also need understanding. They need to be listened to. They need to know that what they say will be taken into account. We may not agree with the parent's perspective or their actions, but we need to listen to their point of view before we can fully understand the family situation. This is another important step in building a trusting relationship and dialogue with the family. |

| Young families need good questions. Finding out what parents think and why, what they want for their children and what they feel they need are important questions to ask. Listening to their answers promotes resourcefulness and encourages collaboration and problem-solving (Wender, 1983). Asking good questions and then really listening to the response are two of the most important aspects of establishing a partnership with parents. |

| Young families need acceptance. They need to be accepted wherever they are in their parenting role. They need to be validated that what they say and know about their child and family is important. They are the experts on their child and family. They need affirmation that what they say counts in the helping relationship. This may include tolerance and forgiveness for some parent behaviors or actions. No parent wants to be a bad parent, but many do not have the knowledge or experience of parenting young children in a positive, supportive way. Often they are doing the best that they can. An intense interest in learning opens many parents to discussion of ideas and a readiness to be influenced; it also leaves them vulnerable to criticism, especially from authority figures. "Am I doing it wrong?" is a major concern, as much as "Am I doing it right?" Many parents seek feedback that is both positive and constructive. The need for validation and affirmation is great, especially in the societal context of uncertainty and cultural change. |
ness (Maccoby, 1980). Parents who can, in a warm and nurturing way, provide sufficient structure and stability, and consistent, meaningful limits on children's behavior, tend to have children who function well in later years. These research conclusions are important, but many questions remain. How does a parent whose style may begin as somewhat cold or harsh "become" warm? How do a father and mother meet limits consistently? The application of good parenting "principles" can be very complex and challenging.

Further complicating the task of parental learning is the fact that ideas about "good" parenting and childrearing change quickly. "Experts" filter social science research and theory, and communicate with parents through books, magazines, television talk shows, newspapers, and the like. As ideas and thoughts change, different "experts" advise different techniques. A plethora of parent-advice material is available, some of it contradictory or, idealistic and hard to put into practice. Some parents try to adhere to the newer prescriptions, while others do not have, or make use of, access to the most current educational materials. In many cases, despite "knowing what is best," parents often succumb to the heat of an emotional parent-child interaction, and revert to ineffective child-rearing methods they would not have used in a calmer moment. Then, having "studied" or learned about what "should" happen, parents compare their own actions to the ideals, and often end up feeling inadequate, frustrated, confused, and guilty. All of these factors contribute to parental vulnerability and increasing needs for social support.

That we may know how an effective parent behaves, does not make easy the job of counseling parents. Many parents do not know how to parent effectively, and they carry through successive generations the coercive, harsh, cold, or abusive methods their parents may have used on them as children. Few parents enter childrearing without some unresolved emotional issues related to anger, envy, childhood abuse or neglect, or ineffective coping skills. This, of course, does not mean that parents lack resourcefulness or inner strength. Indeed, there are countless examples of parental and family strength. The key for the helping professionals is to work with parents across multiple opportunities and to provide a sufficiently supportive structure in which parents can learn and grow. Parents of infants and very young children have unique needs. They are often more vulnerable than others simply because their children are so rapidly growing and changing, and there is so much to learn — about their young child and about themselves. This learning is ongoing throughout a parent and child's development.

What Young Families Need
How are families with young children unique? Young children and their families have needs that are special and necessary for optimal growth, development and wellness. These needs are summarized in Table 3.1.

Young families first and foremost need an audience. They need to be heard. Often times young parents are eager to share their joys as well as the concerns they have for their family. A young family needs someone who will hear what they have to say, their perspective, their feelings, of what is going on in the life of their family. This is really the first step toward building a relationship and meaningful dialogue with a young family toward having the greatest positive impact.

Young families also need understanding. They need to be listened to. They need to know that what they say will be taken into account. We may not agree with the parent's perspective or their actions, but we need to listen to their point of view before we can fully understand the family situation. This is another important step in building a trusting relationship and dialogue with the family.

Young families need good questions. Finding out what parents think and why, what they want for their children and what they feel they need are important questions to ask. Listening to their answers promotes resourcefulness and encourages collaboration and problem-solving (Wender, 1983). Asking good questions and then really listening to the response are two of the most important aspects of establishing a partnership with parents.

Young families need acceptance. They need to be accepted wherever they are in their parenting role. They need to be validated that what they say and know about their child and family is important. They are the experts on their child and family. They need affirmation that what they say counts in the helping relationship. This may include tolerance and forgiveness for some parent behaviors or actions. No parent wants to be a bad parent, but many do not have the knowledge or experience of parenting young children in a positive, supportive way. Often they are doing the best that they can. An intense interest in learning opens many parents to discussion of ideas and a readiness to be influenced; it also leaves them vulnerable to criticism, especially from authority figures. "Am I doing it wrong?" is a major concern, as much as "Am I doing it right?" Many parents seek feedback that is both positive and constructive. The need for validation and affirmation is great, especially in the societal context of uncertainty and cultural change.

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<td>• Good Questions</td>
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Young families need clear communication. They need to be heard. Of course, we can talk about their needs, but they must know that what they say will be taken into account. We may not agree with the parent's perspective or their actions, but we need to listen to their point of view before we can fully understand the family situation. This is another important step in building a trusting relationship and dialogue with the family.

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Young families need recognition. They need respect for the challenging role of being a parent and that they have knowledge which is important in the parent-professional partnership. That they are part of the process of providing service to their child. That it is a collaborative effort and their participation is essential. Establishing the trusting relationship recognizes and respects this role of the parent as collaborator in the parent-professional partnership.

Young families need clear communication. They need open ended dialogue, two way, give-and-take communication and permission to share their experience and feelings about their child, family and parenting. They need dialogue and information shared on a level that they can comprehend. No professional jargon, or labeling. Professionals will also need to be careful about the pitfall of advice giving and lecturing.

Young families need knowledge and information. Parents generally want to know how to be good parents, especially for their particular child (Fraiberg, 1980). Most parents are truly motivated to do the best they can for their children though they often do not know what that might be. Research on parents in a large pediatric practice demonstrated that up to 70 percent of parents had developmental and/or psychosocial/behavioral questions about their young children and wanted to discuss their concerns (Hickson, et al, 1983). Parent magazines and self-help books have been popular for many years now. Numerous research studies have demonstrated parental interest in procedures, instruments, and activities that help them better understand their child's unique characteristics, whether temperament, talents, or achievements. This may be all the more applicable to parents of infants.

Young families need reassurance, support and resources. Psychologically speaking, parents are "born" when children are born or enter into a family's life through adoption or foster care (Partridge, 1988). The early months and years with a child lay a foundation for how parent and child will relate to one another over the course of the child's growth and development. Together, parents and children establish "rules of the relationship". These rules include ideas or expectations about how each expresses and handles conflict, how each negotiates and expresses intimacy, and how they perceive one another's roles in the family. These rules and "working models" develop and change over time within the family system. Parents learn, grow, and change, just as children do. Most parents need reassurance that their current experiences and feelings are normal and acceptable, and support that their situation is common to a given stage of family or child development. They need reassurance and support that it is okay to change, and encouragement to be flexible and accepting of the complexities of parenting. Linking parents to one another, through support groups or parent programs, helps parents tremendously as well (Worthington, 1991).

Parents also need much more than emotional support. They need concrete, structural supports and resources. Families clearly need the basic structure of their lives to be stable for them to fully function; this means that families function best with adequate housing, finances, clothing, health care, transportation, school, and social supports and resources. The importance of comprehensive supports to families cannot be overemphasized (Schorr and Schorr, 1989). Research has shown that the most powerful predictors of children's future success are the level of family poverty and parental education (Cohen and Ooms, 1994). However, as of 1974, children replaced the elderly as the predominant age group living in poverty (Smithsky et al, 1988). Yet Federal spending on young children in the eighties was less than 5% as compared to 24% spent on the elderly (Leach, 1994). This clearly needs to be addressed on the policy making level.

Young families need a non-judgmental/non-blaming approach. They need professionals to accept them where they are and as they are, without being biased and passing judgement. Professionals need to make assessments of young children in the context of their families, not judgements. Professionals need to be open minded about helping families in difficult situations, recognizing that all families have the potential for positive change. Our approach to families may be the key. Unwittingly, many professionals will convey messages to parents that "if only..." they had done something differently with their child, or "if only they could..." do things the way the professional suggests or suggested, that the child would be okay. These statements frequently are made with little regard to the details of why a parent acted the way he/she did, and often, without much questioning or discussion with the parent.

Whether the parent actually made mistakes or not, parent blaming tends to burden mothers and fathers with shame and guilt. For many, this shamed reaction makes it more difficult for them to learn from and trust professionals (Lavigne and Burns, 1981; LaGreca, 1983). This will interfere with a parent's ability to move on, adapt and develop skills needed. Professionals need to be aware of the power of their words with families. Their words can help heal, or cause further injury.

Young families need honesty with empathy. Parents do not need to hear that "everything will be okay," when this might not be so, or that their child "is too young to remember... or to feel bad" about a difficult process or event. Young children can experience powerful feelings. They may well remember painful procedures or acute crises. Parents also can feel intensely. Both children and adults often have a resiliency and adaptability to survive difficult news and traumatic events. Most parents do not want or need to be shielded from the truth. They want an accurate picture of the child's situation (Lavigne and Burns, 1981). This information, however needs to be shared in a supportive manner by the professional, with opportunities for questions and discussion. How information is shared is equally important as to what information is given. They need to know what the professional sees as the families' strengths as well as the concerns. What are the child's strengths? "Isn't he a real person?" one parent asked after an evaluation which focused only on her son's impairments. Appreciation of the whole child, information on skills and competencies and balanced feedback are key elements in parent and family support (Schantz, 1991). Providing parents a balance and pointing out the parent-child-family strengths can also serve to enhance family functioning and facilitate support. Professionals are obligated to report concerns related to abuse or neglect and the family needs to know if the professional has these concerns. Establishing a relationship that is collaborative with the parent will assist in sharing honestly, with empathy, the concerns.
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Young families need a family focus. That the child is seen in the context of a family, whatever that family make up is. It may include siblings, grandparents or others who are living in the home. All children are part of some kind of family configuration. They are affected by, and effect what goes on in the family. The whole family experiences an impact when the child undergoes a procedure or treatment, or has a setback or a success. Awareness of the familial context of a child’s life impels the service provider to consider the impact of a specific recommendation on day-to-day family life (Provence, 1990). This awareness can serve to enhance family functioning and facilitate support.

Young families need flexibility. Professionals’ approach to families needs to remain flexible to the multiple demands on families and the great diversity among families. Families do not need to be told to function like everyone else, whatever that might be. All persons are different in one way or another. Failure to respect the diversity, which is found among families, is damaging to working relationships between families and service providers. Whenever a professional operates from an inflexible, narrow definition of “normal,” and communicates this to parents through written, verbal or gestured messages, there can be some impairment to the parent-professional collaboration. Well-meant but inappropriate or narrow view comments can invalidate the uniqueness of each parent-child-family situation. Whether it be cultural, religious, or other, matters. What is unique to a given family is important (Szanton, 1991).

Remaining flexible in our approach to families will allow for diversity among families.

In the first years of a child’s life, everything is new. Parents and children often are most open and ready to learn during this time. It is a very important time for the entire family. It is a time ripe for positive influence, when helping professionals can make a real difference, setting the stage for lifelong learning and psychosocial well-being.

Building and Strengthening Alliances with Families

Understanding the uniqueness of families with young children and maintaining a professional, supportive stance are basic prerequisites for therapeutic service delivery. Beyond this helpful orientation, however, the professional can adopt many specific interventions that provide the foundation for therapeutic work with families and their young children.

Table 3.2
Developing Alliances with Families

- Provide information about the helping process.
- Start where the client is.
- Inform and educate in supportive ways.
- Work with the parent’s basic motivation.
- Stress the importance of the parent professional partnership.
- Encourage the partnership between parent and child.

Provide Information about the Helping Process

Many individuals do not know how to seek and/or use professional help for their emotional problems and concerns. After establishing rapport, the next step for the professional is to gauge the level of intervention that will be required to maximize parental participation. At a minimum level are:

1. an explanation of the process;
2. an invitation for the parent to ask questions; and
3. acknowledgement of the parents’ essential role in the child’s life.

At a very intensive level, the parent will need a great deal of encouragement to speak, raise concerns, offer input, and fully participate. Early on, parents need to be informed about the professional’s role, the expected outcome of the service, and any limitations on what can be accomplished.

Some of the more commonplace statements to make early in the helping encounter are the following: “It takes time to understand a child’s situation”; “One almost always needs to know the family and parent(s) to truly help a child”; “There is probably no such thing as ‘fixing’ a child’s problem, even though much can be done to help”; and, “A professional can be most helpful when there is a clear partnership with the child’s caregivers.” These and other such statements communicate a message to parents that their involvement is needed and valued, and their role in the child’s life is irreplaceable.

Start Where the Client Is

This old adage remains highly applicable to child work today. Start with the parent’s concerns and the child’s current, presenting issues or development. “What’s on your mind? Tell me what I can do for you” and other such statements demonstrate a genuine interest in the child and family. Introduction of one’s self by name, and addressing parents and children by name, help to welcome and relax clients (Wender, 1983). Establishing rapport is essential; good eye contact, personable exchanges, and the gathering of basic background information about who the parents
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and children are, build rapport (Wender, 1983). It is good practice to establish rapport with the child as well as with parents (Kanfer et al, 1983). Actively including parent and child in the process enhances the developing working relationships and acknowledges the child in the context of a family.

Inform and Educate in Supportive Ways

Blaming parents, whether done intentionally or not, blights professional-parent relationships. Parents are frequently blamed when they are perceived as "unable" to control their children, or when a treatment regime or suggestion has not been followed. Such blame can be imparted directly, or indirectly through nonverbal messages. In most instances, when professionals communicate blaming or shaming messages, the "working alliance" is thrown off balance. Parents are put on the defensive, rather than helped to present and optimize their strengths.

If a professional hears about or observes parental behaviors that can be harmful to a child, it is appropriate and necessary to point out the negative consequences to the child, to suggest alternative parenting techniques or to reach out and engage the parent in dialogue. Sometimes a referral to child protective services will be warranted. However, how the education is provided or referrals made, is crucial. Reacting with shame, blame, and harsh criticism is not educational. Educating parents with clear concern for the child and for the parent who is inflicting harm, is far more effective in setting the stage for positive change.

Building an alliance with parents on behalf of their children's well-being begins with respect for the parental role (Lavigne and Burns 1981). It is only in the minority of cases that parents are unable to care for their children and protective services must remove a child from the home or at least monitor the situation closely. In abusive or even in non-abusive families, there is usually opportunity for growth in the parent-child relationship. Growth-promoting interventions occur as professionals build alliances with parents establishing interactive communication and dialogue, through which they can serve to inform, educate and support parents. Interactive, two-way communication helps to create and support the partnership with parents. "One-down" talking inhibits the development of a partnership or alliance with parents and tends to place and keep the parents in a child-like role, which can exacerbate parental dysfunction. "One-to-one" communication is more effective at reaching and educating parents in a positive way.

Work with the Parents' Basic Motivation

Most parents want to be good parents. Those fortunate enough to have had healthy, effective role models in their own mothers and fathers can freely "repeat the past." However, many parents feel the need to do a better job with their own children than their parents did with them. It is important to affirm this positive, "core" motivation many times during the course of working together. It also helps to acknowledge how difficult or challenging it can be to break with one's own past and incorporate new childrearing ideas, while letting go of methods that are now considered to be coercive or destructive to healthy child development. The experience of being parented is a powerful predictor of future parent behavior. Recognizing its impact and being intentional about parenting choices is an important part of the parent self- hood.

Frequent reference to the parents' healthy core motivation—to do his/her best for the child helps further establish an alliance with parents. Returning frequently to verbal acknowledgements of this basic common goal by both professional and parent helps to "anchor" the work with parents. This is especially important to do when feelings are intense, such as in parent-child power struggles, chronic illness, parent-professional disagreements over a course of treatment, or other "heated" situations. Centering on the child's needs does not mean neglecting or avoiding parental needs. It means helping parents to remember their primary concern: the child's well-being, and the development of healthy relationships. It is important that the professional remain centered on this goal (Thomas, 1988). Reinforcing this goal with parents will assist them in being intentional about their parent behavior, maintaining a focus toward positive impact and outcomes.

Stress the Importance of the Parent Professional Partnership

The idea that an effective relationship between a professional and parent hinges on a partnership is gaining increasing recognition (Wieder et al, 1992; Shelton et al, 1987). First, this means that the professional seeks and gives value to information provided by parents; together, parents and the professional arrive at an understanding of the child's problems and/or needs. The parent usually has the most information about the child. At times, the professional may need to help bring this information to the surface by asking good questions and providing information on child development, or translating theoretical or diagnostic concepts into language the parent can understand and thereby respond to. This approach is especially challenging with parents who are shy, reticent, intimidated or threatened by professionals, unquestionably accepting of authority, or of very low education. Nonetheless, the professional who acts on the assumption that parents do have much information and seek to participate in interventions, more often than not will receive such information.

Second, maintaining a positive parent-professional alliance requires frequent verbal acknowledgement of the parent's importance to the process: "What you say is important to your child and to me as a professional"; "You play a major role in your child's life, regardless of how much outside intervention there needs to be"; or "You have a right to disagree with me or to challenge my viewpoints or treatment choices." Many parents need such messages frequently, especially in situations where...
and children are, build rapport (Wender, 1983). It is good practice to establish rapport with the child as well as with parents (Kanfer et al., 1983). Actively including parent and child in the process enhances the developing working relationships and acknowledges the child in the context of a family.

**Inform and Educate in Supportive Ways**

Blaming parents, whether done intentionally or not, blights professional-parent relationships. Parents are frequently blamed when they are perceived as "unable" to control their children, or when a treatment regime or suggestion has not been followed. Such blame can be imparted directly, or indirectly through nonverbal messages. In most instances, when professionals communicate blaming or shaming messages, the "working alliance" is thrown off balance. Parents are put on the defensive, rather than helped to present and optimize their strengths.

If a professional hears about or observes parental behaviors that can be harmful to a child, it is appropriate and necessary to point out the negative consequences to the child, to suggest alternative parenting techniques or to reach out and engage the parent in dialogue. Sometimes a referral to child protective services will be warranted. However, how the education is provided or referrals made, is crucial. Reacting with shame, blame, and harsh criticism is not educational. Educating parents with clear concern for the child and for the parent who is inflicting harm, is far more effective in setting the stage for positive change.

Building an alliance with parents on behalf of their children’s well-being begins with respect for the parental role (Lavigne and Burns 1981). It is only in the minority of cases that parents are unable to care for their children and protective services must remove a child from the home or at least monitor the situation closely. In abusive or even in non-abusive families, there is usually opportunity for growth in the parent-child relationship. Growth-promoting interventions occur as professionals build alliances with parents establishing interactive communication and dialogue, through which they can serve to inform, educate and support parents. Interactive, two-way communication helps to create and support the partnership with parents.

"One-down" talking inhibits the development of a partnership or alliance with parents and tends to place and keep the parents in a child-like role, which can exacerbate parental dysfunction. "One-to-one" communication is more effective at reaching and educating parents in a positive way.

**Work with the Parents’ Basic Motivation**

Most parents want to be good parents. Those fortunate enough to have had healthy, effective role models in their own mothers and fathers can freely "repeat the past." However, many parents feel the need to do a better job with their own children than their parents did with them. It is important to affirm this positive, "core" motivation many times during the course of working together. It also helps to acknowledge how difficult or challenging it can be to break with one’s own past and incorporate new childrearing ideas, while letting go of methods that are now considered to be coercive or destructive to healthy child development. The experience of being parented is a powerful predictor of future parent behavior. Recognizing its impact and being intentional about parenting choices is an important part of the parent self- hood.

Frequent reference to the parents’ healthy core motivation—to do his/her best for the child helps further establish an alliance with parents. Returning frequently to verbal acknowledgments of this basic common goal by both professional and parent helps to "anchor" the work with parents. This is especially important to do when feelings are intense, such as in parent-child power struggles, chronic illness, parent-professional disagreements over a course of treatment, or other "heated" situations. Centering on the child’s needs does not mean neglecting or avoiding parental needs. It means helping parents to remember their primary concern: the child’s well-being, and the development of healthy relationships. It is important that the professional remain centered on this goal (Thomas, 1988). Reinforcing this goal with parents will assist them in being intentional about their parent behavior, maintaining a focus toward positive impact and outcomes.

**Stress the Importance of the Parent Professional Partnership**

The idea that an effective relationship between a professional and parent hinges on a partnership is gaining increasing recognition (Wieder et al., 1992; Shelton et al., 1987). First, this means that the professional seeks and gives value to information provided by parents; together, parents and the professional arrive at an understanding of the child’s problems and/or needs. The parent usually has the most information about the child. At times, the professional may need to help bring this information to the surface by asking good questions and providing information on child development, or translating theoretical or diagnostic concepts into language the parent can understand and thereby respond to. This approach is especially challenging with parents who are shy, reticent, intimidated or threatened by professionals, unquestionably accepting of authority, or of very low education. Nonetheless, the professional who acts on the assumption that parents do have much information and seek to participate in interventions, more often than not will receive such information.

Second, maintaining a positive parent-professional alliance requires frequent verbal acknowledgement of the parent’s importance to the process: "What you say is important to your child and to me as a professional"; "You play a major role in your child’s life, regardless of how much outside intervention there needs to be"; or "You have a right to disagree with me or to challenge my viewpoints or treatment choices." Many parents need such messages frequently, especially in situations where
their authority may be challenged, such as in acute crises, hospitals, and protective service settings. Such validation provides a kind of "antidote" to the powerful and still widespread model of professionalism, which emphasizes authority and authoritarian interactions: "We will tell you what is best for your child;" (Thomas, 1988). The newer service delivery model, that of parent-professional collaboration, stresses partnership over authority. "...It is the quality of the relationship between professional and parent that determines the likelihood of parental changes in behavior to benefit the care and development of the infant," (Wieder et al, 1992, p. 101).

The challenge to the professional from the collaborative model of helping services is to be ready to deal actively with parental reactions and initiatives. These include conflict, such as anger, confrontation, and disagreement, grieving and expressions of loss. The professional must be ready to handle parental assertiveness, while providing continuing education and support. In the short run, more time may be needed; but in the long run, the parents become much better able to follow through with recommendations, are more accurate reporters of child behavior and progress, and are more empowered to act appropriately for the child's betterment. Their sense of competence and confidence in parenting will additionally be enhanced.

**Encourage the Partnership Between Parent and Child**

The alliance between a parent and professional is not the only partnership in which work is done. The parent and child also must learn to work together, to create and maintain a partnership. Parents frequently miss much of the emotional information their young children give them. This can contribute to poor decisions and ineffective parenting. Failure to read the nonverbal language of a young child may be due to parental anxiety, denial, lack of understanding of child development, or attachment problems. As professionals guide parents to learn and hear the emotional language of young children, parents become more attuned to their children's needs and, thus, grow more responsive to them. Parents learn a great deal from their children, but often need guidance in how to do this.

Building a working alliance with parents and children is best done over time, rather than in single encounters. In a supportive context, parents learn to observe, question, answer questions, report information, and learn from their experiences. Parents also learn to be more aware of and comfortable with the feelings and needs of themselves and others. When the client brings the professional into this process of experiencing, observing, feeling, expressing, sharing, and learning, the working alliance or partnership is set into motion. Professionals need to encourage this process and facilitate parents sharing in it.

**Observations and Questionnaires**

While building a strong working alliance or partnership with families, the professional needs ways to assess the child's emotional health. Effective assessments of children and families consist of multiple methods of data collection across different times on more than one dimension (LaGreca, 1983). No one source of data is sufficient for understanding complex human emotions and behaviors. Thus, interviews, intake materials and/or questionnaires, information from referring persons and observations are combined to construct a comprehensive index of a child's life in the context of his/her family.

Observational skills are vital for a professional service provider. There are numerous ways to observe families. Some are elaborate, structured, and systematic (e.g. the Brazelton Neonatal Behavior Assessment Scale, 1973), while others are more unstructured and informal (LaGreca, 1983). Observational categories are provided in structured or unstructured systems to help the professional observer turn "raw" observational data into usable hypotheses about the client. Then, a systematic plan with specific guidelines or categories suggests what kind of observations need to be made (Hogstel, 1987). Structured routines can require completion of checklists or choice of levels (high or low) on a rating or score sheet. Unstructured routines simply ask the observer to note his/her impressions about certain events or behaviors, such as a child's "free play" or "verbal communications." In all systems, knowledge of normal development is essential (Liptak and Chamberlain, 1983).

The major purposes in observing, of course, are to determine the presence of any possible concerns or problems in the parent-child relationship that show up in observable behavior, and also to discern the presence of parent, child, and family strengths. Does the parent interact positively with the child? Does the child respond to directions? Do they listen to one another? Can the parent(s) ask questions of the professional? Does the parent protect the child from potential harm? Do they play together? What patterns of interaction occur? These (LaGreca, 1983) and other such questions prompt the professional to look for certain "data."

If a professional does not utilize a structured, observational schema, he/she will typically make all observations spontaneously — i.e., in the course of whatever else she/he needs to do. It is important to consider the impact of the context and setting on how people are behaving. The presence of the observer and the procedures done with children and parents have major effects on child and parental behavior (Liptak and Chamberlain, 1983; LaGreca, 1983). While obtaining a developmental history, the professional will observe what happens, who initiates behavior, how persons respond to one another and how they behave. For example, how does the parent react when the child drops a toy into the parent's lap? When conducting a particular diagnostic or intervention procedure, does the child look to his/her parent for help or reassurance? When observations are routine and unstructured, no special time is set aside for the professional to just sit back and observe.
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In weaving observations into a regular course of action, the professional makes mental, or perhaps written, notes. A child's or parent's body posture, eye contact or gaze aversion, sighs and other vocalizations, movements of the hands or feet, and facial gestures are some of the behaviors a professional will observe. In addition, the timing of behavior or gesture, its intensity, its duration, the latency of responses, the order of speaking or interruptions, uses of silence, and patterns of speech are all additional sources of information. The more objective and specific the observations, the more reliable they are in helping to build an accurate picture (Hogstel, 1987).

A parent or child's response to the professional's questions are often telling; does this person seem to feel relaxed, defensive, comfortable? Similarly, a person's responses to positive feedback, suggestions, and teaching are also revealing. Does the parent “take in” information, reject it, question it? The quality or style of a parent in response to the specific activity or behavior of a professional can provide much information about how that parent (or child) conceives of the helping situation. This is crucial information in the early stages of the working alliance. Shame-prone clients, for example, expect to be berated and will respond defensively, no matter how nurturing a professional may act.

Knowing what “raw” data to attend to, and what conceptual categories to refer to when organizing the raw data into thoughts or hypotheses is the work of professional observation. With regard to psychosocial practices, there are two levels of information which guide further work. One consists of observations pertinent to the working relationship or parent-professional partnership. Observations here seek answers to such questions as: Does the parent ask questions? Seem to attend to information given? Show an understanding of this service? Participate in the process as a full partner? Any answers in the negative suggest further work on enhancing the alliance and partnership with the parent.

The second level of information to be gathered through observation pertains to those that add depth and specificity to the professional's understanding of child-parent-family strengths and problems. Here, the professional seeks information on areas considered important to the emotional health and functioning of the child and family. The AIMS System of Practice gives specific guidelines for observing in the areas of parent-child attachments, interaction, mastery, and use of social supports.

Skillful observation enables the professional to choose pathways for intervention in terms of interviewing, further observing and/or responding to issues. Interviewing and observing, then, become reciprocal activities, each guiding the other's points of focus, anchoring interventions.

Questionnaires are another method of assessment. They are generally of two types: standardized, or researched carefully to ascertain their validity and reliability; and informal unstandardized, or measures constructed without benefit of research. The latter are far more plentiful.

There are a variety of uses for surveys or questionnaires. One is to use them to structure the time with families and make certain that specific types of information are gathered. They act as a framework for providers to focus and organize data collection. A second use is to open up channels of communication or dialogue between a parent and professional (Liptak and Chamberlain, 1983). The surveys or questionnaires then provide points of entry for dialogue, or ways to engage parents and establish rapport. Thirdly, parents can learn from questionnaires. Parents can identify what they are doing well, what they wish to change and what they want to discuss with their providers (Liptak and Chamberlain, 1983). The surveys or questionnaires in this way assist parents in organizing their thoughts and questions to then share with the provider.

The AIMS: Developmental Indicators of Emotional Health contain twelve Parent Questionnaires. They are designed to promote dialogue, identify strengths and concerns, and offer parents information on emotional health. As with other assessment methods, these questionnaires are most productive when they are used in conjunction with professional observations and interviews.

The Interview: Issues and Skills

Adding to the rich data gathered from observations and questionnaires, is information from interviews. Whether lasting ten minutes or two hours, a professional's interview of parents and verbal children is an essential feature of child and family work. In the early stages of contact with parent and child, the professional's interview consists of questions designed to gather pertinent history and current information about parental concerns and child's needs. The interview seeks to disclose both strengths and vulnerabilities, concerns or problems in the child's and family's life. This information is needed to guide the use of available time.

Clearly, there are many types of interviews, each defined by different purposes and contexts (Barker, 1990). Information interviews stress the giving of facts or other information. Evaluative interviews may precede still other interviews, those held to monitor a client's progress, or prior to treatment. Evaluative interviews are also intended to assess a family's situation for possible child abuse or jeopardy, or eligibility for services.

The focus here is on general interviews, those that evaluate the child's situation to determine level of need and to establish or monitor the course of a service designed to help a child, and those that entail the helping process itself. Interviewing skills come into play, setting the stage for a productive exchange of information, feelings, and responses between professional and client. Becoming self aware of interview skills and the importance of the interview process in setting the stage for relationship building, establishing a partnership and enhancing dialogue is essential. The basics of interview skills are given in Table 3.3.
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Thus, the interviewer must maintain four levels of focus:
1. gathering information/data on the current situation;
2. understanding its roots and origins;
3. assessing client level of need and capacity to solve problems; and
4. building a strong foundation for the working alliance.

Active Listening

Active listening is a basic skill, important to client or patient satisfaction (Rowland-Morin and Carroll, 1990; Wender, 1983), and the foundation of an interview. It involves body language or physical attention, such as holding one's body alertly, leaning toward the parent, keeping an open, non-defensive posture, facing the other person squarely, and maintaining eye contact. It also involves attending to two levels of information: word-content, and feeling-content (Wender, 1983; Lavigne and Burns, 1981). For example, a father may be describing a child as difficult to deal with, active, and boisterous; this is the word-content, or "cognitive" message unit. But the father may be smiling, chuckling quietly, or perking up as he discusses this, indicating some level of enjoyment in his son's acting up. While the words convey frustration, his body language and gesture convey a different feeling. This "affective" message unit is not one that tells of frustration, but of enjoyment or appreciation. While not all communications convey differing cognitive and affective messages, many do. Active listening requires astute observation.

Awareness of Process

Active and attentive listening is essential, but can still result in circular and unproductive interviews unless the interview is also aware of process. There is a process within the interview itself; it has a beginning, middle and end. Also, in situations where one interview will be followed by another at a later date, there is usually a relationship or connection between one session and the next, a process across two points in time. And, there is a process between the professional and the person being interviewed (Heinrich, 1988; Wender, 1983; LaGreca, 1983), which is the manner in which the relationship is being built.

Establishing a Dialogue

The early phase or beginning stage of any given interview requires skills that relax the parent and/or child for dialogue and define the focus of concern. (Many of these skills were discussed earlier, in the sections on partnership and alliances.) The dominant issue is flagged for discussion, and the purpose of the interview made clear. Ideally, the focus of concern will be determined jointly, after the professional has gleaned the initial reasons for the interview with the parent. The presenting concerns and overall situation are identified. Some refer to these skills as "tracking"
Professional Empathy

An effective interview process hinges on professional empathy (Rosenbaum, 1989; Pfeiffer, 1986; Wender, 1983). The capacity of the professional to establish rapport, create dialogue and thereby develop an alliance between him/herself and the parent/child, as discussed in previous sections of this handbook, is critical. The working alliance or partnership is the basic foundation upon which the interview—the verbal exchange of information—takes place. In one study of physicians, the most common client complaint related to specific aspects of communication, offering information and listening (Hickson et al, 1994). Closely related in the same study was the client perception of a lack of concern or respect for the patient by the physician. Increased skills in the interview process toward relationship building can have great potential impact on this perspective.

An effective interviewer sees the communication between him/herself and a parent on behalf of a young child, as part of a multilayered process. At one layer, the interviewer seeks information about the presenting problem or situation. What is going on under what conditions? When and how is something happening? Who is involved? At the same time, there are simultaneous concerns about the roots or possible causes of the current situation: Why is this going on? What led up to this? Third, the interviewer is thinking about the parent/child’s capacity to solve problems and make use of the helping relationship: Is this person able to give good information? What are this person’s strengths and difficulties? What are the external (environmental, relational) and internal (personality, temperament) resources and limitations of this person? What kind of help or service is needed? Open versus closed-ended questions generally obtain more productive answers.

Finally, the interviewer is acutely aware of the here-and-now interaction between him/herself and the parent or child (Rowland-Morin and Carroll, 1990): How can I structure the dialogue in the remaining time to promote not only a working alliance, but also an optimal accounting of the presenting situation and its history? How do I make the best use of myself? What observations am I making that I want to weave into the verbal dialogue?

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skills, consisting of reading interpersonal cues, emphasizing points, and testing for acceptance or understanding (Rosenbaum, 1989).

The intermediate phase or middle stage of the interview involves a second look at the course of discussion. The professional asks him/herself if he/she has enough information to make some tentative conclusions about a family's and/or child's problems and strengths. Is there an intervention that might help reduce the problem or promote the child/family's strengths? Is there need for more information in order to proceed? In the middle phase, then, the interviewer takes stock and makes appropriate adjustments to round out the picture, check out hypotheses, or clarify issues, so that the interview can move forward towards closure. Some people find that "persuasive skills" are helpful at this stage, skills that involve clarifying needs and gaining commitment for a treatment plan of intervention (Rosenbaum, 1989).

The final phase or end stage of the interview involves pulling together all the sources of information, communicating an understanding of the situation, and discussing with the client what can be done. Here, a provider uses "shaping skills" that consist of reinforcing family strengths, increasing family awareness of needs and solutions, and handling any objections (Rosenbaum, 1989). This phase of the interview is a summary of the focus of concern, data or information gathered and initial planning.

Table 3.4
Interview Stages

| Early Phase/Beginning Stage: establishing rapport/dialogue |
| Intermediate Phase/Middle Stage: reviewing/follow up on the course of discussion |
| Final Phase/End Stage: summarizing information, providing feedback, and initial intervention/action planning |

These stages occur in any interview process, regardless of the length of the interview. As such, awareness of process is relevant to all professionals and all interview situations. Process is a critical element toward establishing rapport and a working relationship with the parent-child-family.

Orientation and Openness to Feelings

Many interviews in helping services sooner or later center on a parent's or child's most intense feelings, often what "hurts" most, as when a child has been abused, or what feels the best, as in a new parent's joy with his/her newborn. The interview process can be halted summarily if the interviewer ignores, criticizes, or shames a person for having these feelings. This is very unlikely to occur if the interviewer
brings empathy to the situation. Feeling empathy and responding empathetically, however, are two different things.

Most human beings who have been sufficiently cared for in their own lives will naturally experience empathy, but empathy can be increased by learning about how different people experience their lives. One cannot necessarily be empathic towards a refugee from a foreign country, for example, without knowing something about what life in that country was like or what conditions were experienced upon arriving in this country. Asking questions with an openness to learning and feeling, will maximize empathic understanding.

Building a Relationship

An interview and the developing relationship will be greatly facilitated by an empathic process and empathic responses in building the relationship. This means that a professional not only feels empathy, but conveys it through nonverbal gestures and communications and appropriate verbal feedback. "I'm sure this was hard for you," "You have really been through a lot lately," and other such comments are examples of simple but effective empathic feedback. The choice of words, however, is not as important as the timing, tone of voice, and nonverbal expressions of concern and caring that accompany the verbal feedback. Such behaviors help providers to obtain better input from clients and get closer to them (Pfeiffer, 1986). It helps to establish a sense of trust and an alliance or partnership with the parent, as discussed in earlier sections.

Judicious Use of Professional and Personal Self

Personal qualities can enhance the interview where the professional relates to a client as one person to another. Use of humor, spontaneous positive remarks (especially about the parents' children), flexibility with materials or assessment methods, and sharing appropriate personal information about one's own life, are some examples of how one's personal "self" can be brought into the interview process. Discussing one's own experience can be helpful if done sparingly and used to teach, explain a point, or help build trust; too much interjection of one's own life can also be intrusive, intimidating, competitive, or self-aggrandizing, and thereby rob the client of valuable time and attention.

Activity level is another dimension about which the professional can make choices. Some parents learn best from a professional who is very active, initiating dialogue, giving lots of feedback, and asking many questions. Other clients are alienated by this level of activity and are best helped when the professional takes a quieter, less active approach. Observations of client reactions can help determine how and when to use one's own style, personality, or personal experiences to facilitate an interview dialogue. One also needs to determine how much information a client needs (Maguire, 1990) in a given context or point of time; again, this can be determined with a client, through discussion and observation.
Related to the identified interpersonal relationship skills needed, are skills involving self-awareness. One area of which professionals need to be aware is attitude, such as personal biases or opinions about people, places, or things. Awareness of one's own personal need to have control of a situation is equally necessary. It is important to be aware of how these attitudes may be evoked by a given interview—either by the presenting problem, or by the qualities of the persons involved. If a professional is unaware of personal biases or certain issues, her/his questioning could easily proceed in inappropriate and unhelpful directions. For example, if one is biased against large families or people of a certain religious background, facing a family with eight children, one might ask, "Why did you have so many children?" It is necessary to filter out one's biases and check one's need to control (Thomas, 1988), in order to maintain a helpful and supportive stance with families. Some questions, as the one in this example, could easily be seen as judgmental, confrontational or accusatory.

Being aware of one's own feelings is helpful in another sense. Sometimes a professional will notice sadness, anger, annoyance or other feelings in him/herself during the course of the interview. It is not infrequent that these feelings are "clues" to what the client might be feeling. Whether the client discloses these feelings in words or not, often, if the provider is overwhelmed or anxious, this maybe a reflection of what the parent is feeling. One's personal reactions and emotional experiences can be a very important source of information about a client, and can thus, lead the way to deeper insights.

Finally, one's "style", or personality type, their learned behavior, can have a direct bearing on the manner in which an interview is conducted (Heinrich, 1988). Being aware of one's strengths and limitations along the lines of introversion/extroversion and other aspects of personality or temperament, the quality of behavior, can enhance a skill-building effort (Heinrich, 1988). Knowing how one is perceived by a client is facilitated by self-awareness and self-knowledge (Wender, 1983).

**Giving Active Feedback**

In all phases of the interview process, a technique commonly called "active feedback" is an essential component of the dialogue. This comes in many forms, but is called "active" because it emphasizes the professional making a decision about what, and how to give feedback. The feedback is not a "knee-jerk," spontaneous or involuntary reaction, but a thoughtful, conscious choice to give information that can facilitate the interview process.

Nonverbal feedback consists of a smile, nod of the head, encouraging or questioning, raising of eyebrows, leaning forward in one's chair, gesturing with hands, and the like. These types of feedback convey information to the other person. Often, this feedback effectively says, "Please continue. You are on the right track." Sometimes it is supportive, such as when conveying the attitude of "I see that this is emotionally difficult." Sometimes it is questioning: "Oh? Are you sure?" Verbal feedback such as "uh-huh," "tell me more," or reflecting back in words what the other has just said, are other forms of feedback chosen to keep the flow of the interview smooth, or to encourage or support the communicative exchange.

In the final phase of a given interview, feedback is often more plentiful, in an attempt to achieve closure and set the stage for any further interviews, or to carry out an interview plan. Feedback about the nature of the problems as they are currently understood requires some summarizing of the issues or ideas about how the problems or concerns came about. Feedback about how to deal with the problems usually involves some education or guidance. Feedback about the interview process itself can reinforce parents' strengths, informing them about how productively they have engaged in collaboration and problem-solving. Feedback specifically about the strengths in the child and parent-child-family relationships, is particularly useful and important to parents, and is a good way to encourage a working alliance with the professional. It also facilitates parental mastery and self-esteem; parental feelings of competence and confidence.

**Following the Content or Track of the Communication**

All interviews center on, or attempt to focus on, a particular content area. Some interviews are primarily investigative, others are oriented towards problem-solving, still others tend towards client self-expression or emotional release, or a combination of these or other goals. Staying on track is important. Being intentional in the interview process is also important.

When interviewing parents, the interviewer can be intentional and stay on track in a number of ways as follows:

1. Stay focused on the child's well-being/needs, in the context of the family.
2. Anchor the conversation in the parent's "core" motivation to do the best he/she can for the child.
3. "Check in" periodically with the parents by summarizing and reflecting back what has just been discussed or decided.
4. Attempt to keep the dialogue to no more than a few issues in any given interview, and refer to these often.
5. Attempt to relate seemingly extraneous comments that parents bring up to the central issues at hand.
6. Summarize and "debrief" at the end of each interview and acknowledge the next steps in the helping process.

These techniques help to keep the boundaries of the work clear. They serve to define a focus, stay centered and move forward in the process. Defining boundaries with a parent is often very challenging, especially for those family situations where there are many competing problems. Sometimes the professional may communicate
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the boundary broadly, such as, "Today we will take a look at the things in your life that are causing you distress." Or the focus may be set narrowly as, "Today we need to examine why Judy is having trouble sleeping through the night and what you have tried to do about it."

Helping parents stay within the boundaries, for the sake of focusing and allowing problem-solving in a limited period of time, is a skill in itself. It is important not to give parents an impression that the professional does not want to know about other things, or that their concerns or thoughts are not valuable unless they are in line with the professional's expectations. Rigid boundaries are rarely helpful. If parents simply cannot stay on course, due to their feeling overwhelmed or burdened by many problems, it is helpful to give them information about when and where their additional concerns can be addressed. In doing so, however, one has to be very clear that the boundaries set by the professional are appropriate. Many times, professionals delimit areas to address and end up neglecting the most important issues; often it is the parent who knows best what to discuss, and professionals have simply not listened well enough. Other times, the parents avoid the most crucial issues. Knowing when to go outside the focus defined for a particular interview, and how to stay within it when there is pressure to expand the focus, is particularly challenging to an interviewer.

Table 3.5 reviews Communication Boosters (Partridge et al, 1993) to assist in the interview process. Some of these have already been covered in detail others are important reminders. Although parents have a role in and responsibility for how the interview process goes, the primary responsibility falls to the professional. It is the professional provider's responsibility to set the tone for the interview and take the lead in facilitating the interview process.

Table 3.5

<table>
<thead>
<tr>
<th>Communication Boosters in the Interview Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Awareness</td>
</tr>
<tr>
<td>• Empathy</td>
</tr>
<tr>
<td>• Sensitivity</td>
</tr>
<tr>
<td>• Understanding</td>
</tr>
<tr>
<td>• Openness</td>
</tr>
<tr>
<td>• Acceptance</td>
</tr>
<tr>
<td>• Validation</td>
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<tr>
<td>• Active Listening</td>
</tr>
<tr>
<td>• Good Questions</td>
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<tr>
<td>• Reflection</td>
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<tr>
<td>• Affirmation</td>
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<tr>
<td>• Positive Attitude</td>
</tr>
<tr>
<td>• Proactive</td>
</tr>
<tr>
<td>• Constructive Feedback</td>
</tr>
<tr>
<td>• Commitment</td>
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<tr>
<td>• Cooperation</td>
</tr>
<tr>
<td>• Collaboration</td>
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<tr>
<td>• Consideration</td>
</tr>
<tr>
<td>• Caring</td>
</tr>
<tr>
<td>• Friendly</td>
</tr>
<tr>
<td>• Flexible</td>
</tr>
<tr>
<td>• Tolerant</td>
</tr>
<tr>
<td>• Patient</td>
</tr>
<tr>
<td>• Informative</td>
</tr>
<tr>
<td>• Supportive</td>
</tr>
<tr>
<td>• Helpful</td>
</tr>
<tr>
<td>• Respectful</td>
</tr>
<tr>
<td>• Honest</td>
</tr>
<tr>
<td>• Realistic</td>
</tr>
<tr>
<td>• Relaxed</td>
</tr>
<tr>
<td>• Knowledgeable</td>
</tr>
<tr>
<td>• Clear Communication—No Jargon</td>
</tr>
<tr>
<td>• Use of Positive Language</td>
</tr>
<tr>
<td>• Inclusion of Strengths</td>
</tr>
<tr>
<td>• Solicitation of Parent's Input</td>
</tr>
<tr>
<td>• Validation of Parent's Perspective</td>
</tr>
<tr>
<td>• Use of Self Disclosure</td>
</tr>
<tr>
<td>• Find Common Ground</td>
</tr>
<tr>
<td>• Clear Boundaries</td>
</tr>
<tr>
<td>• Non-judgmental</td>
</tr>
<tr>
<td>• Non-biased</td>
</tr>
<tr>
<td>• Non-blaming</td>
</tr>
<tr>
<td>• Non-defensive</td>
</tr>
<tr>
<td>• Non-condescending</td>
</tr>
<tr>
<td>• Brainstorm Options</td>
</tr>
<tr>
<td>• Knowledgeable</td>
</tr>
<tr>
<td>• Clarification of Goals</td>
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</tbody>
</table>
The interview process is a complex social interaction. The interviewer who takes time to polish skills in listening, empathy, interpersonal relations, awareness of the interview process, feedback, and staying on track will greatly enhance his or her ability to help parents and their children effectively. These are basic principles of supportive interviews with parents. Employing these principles of practice in the interview process will serve to establish a relationship and development of a partnership with parents, enhancing dialogue. All of which will facilitate the interview process toward understanding the child in the context of the family situation.

Making Use of Interviews and Observations: Synthesis and Interpretation

The interview process, observations, and completed intake materials and other documents all produce a great deal of information or “raw data” about any given case. To transform raw data into meaningful hypotheses that suggest a course of action or intervention plan, the professional must think about the raw data in theoretical or conceptual terms. As has been referenced throughout this handbook, the AIMS: Developmental Indicators of Emotional Health, organizes raw data into meaningful categories: parent-child attachment; family interactions; parental and child feelings of mastery of basic and progressively complex competencies; and the family’s access to and use of social support. These four domains organize data into easily referenced dimensions of emotional health. Ultimately, the professional uses these domains to ask what are the parent-child-family’s strengths, and what are the limitations, concerns or possible problems in these areas? Making use of the multiple sources of information, the professional constructs a clinical profile of strengths and concerns (Mattaini and Kirk, 1991). The clinical profile is then used to determine points of entry and a plan of action.

No matter what conceptual schema is used to categorize raw data, the clinical profile addresses two questions:

1. What strengths exist?
2. Is there a concern, problem or a potential problem?

Answers to these questions are best considered as hypotheses to be verified or altered over time. Generally, the service provider looks at the balance between child, parent and family resources — such as health, support, resilience, education, work, basic necessities and the like — and their liabilities, such as stress, conflict, hardships, lack of necessities and so forth. This balance is important to determine, as many families need their resources shored up. If liabilities outweigh resources, then the provider needs to be alert to possible problems and needs to understand how problems, or potential problems, are handled by the family. In very unbalanced situations, unmet needs will often emerge as priorities for intervention.
In applying the AIMS conceptual framework to the following case — the Cannon family, including twelve-month-old Jenny, who met with an early intervention, family support professional, Brenda Adair — the clinical data is organized into the four areas or domains considered relevant to understanding emotional health. These domains—attachment, interaction, mastery and support—provide a conceptual framework or frame of reference from which to better understand, assess and make interventions toward strengthening emotional health development. These four areas can be simply thought of as follows:

- Attachment: Parent-Child-Family Feelings
- Interaction: Parent-Child-Family Behaviors
- Mastery: Parent-Child-Family Capabilities
- Support: Parent-Child-Family Resources

Observations and other assessment data and information are given in Table 3.6
### Table 3.6

**Clinical Profile: Synthesis of Interview, Observation and Background Data Utilizing A-I-M-S Conceptual Framework**

<table>
<thead>
<tr>
<th>The Cannon Family*</th>
<th>Mother: age 32</th>
<th>Father: age 34</th>
<th>Female Child: age 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>√ Strengths</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Attachment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>√ good level of commitment from mother towards child</td>
<td>&gt; Intense ambivalence in marriage, expressed by parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>√ predominance of positive maternal feelings toward child</td>
<td>&gt; father, says he's “uncomfortable with babies”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>√ child approaches mother when scared, is easily comforted</td>
<td>&gt; pregnancy highly stressful for both parents; may not be resolved</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interaction</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>√ mother smiling, laughing with child</td>
<td>&gt; father quiet, uses few words with child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>√ parents set clear limits when baby crawls near danger</td>
<td>&gt; mother and father do not talk to one another</td>
<td></td>
<td></td>
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<tr>
<td>√ child brings toys to mother, who looks at them and shows child how toys work</td>
<td>&gt; father often tells child to “be still”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>√ father plays warmly with child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mastery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>√ child feeding self</td>
<td>&gt; mother expresses worries about baby’s health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>√ child crawling freely</td>
<td>&gt; father says he is frustrated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>√ child makes lots of sounds, says “da”</td>
<td>&gt; child had hernia surgery at 3 months, parents scared</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt; mother had toxemia in pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt; child not sleeping well, wakes up often screaming</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Support</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>√ good finances, housing</td>
<td>&gt; family very isolated, no family near</td>
<td></td>
<td></td>
</tr>
<tr>
<td>√ both parents ask questions, want help</td>
<td>&gt; family just moved to area</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt; no clear support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The data about this family has been gathered from interviews with use of the AIMS Parent Questionnaire, observations with use of the AIMS Points of Observations, and written materials, such as the AIMS intake forms and the physician's referral notes.*
As this information is catalogued, it becomes clearer where additional attention is needed. In the above case, a picture emerges of a mother and father who had possibly, emotionally traumatic experiences during the pregnancy and infancy (toxemia, surgery); these traumas may be unresolved. The father may feel rejected by the mother, whose sole focus has become the baby. The marriage may have taken a back seat. The professional would seek additional information on parental emotional mastery, or adaptation. The family's supports are questionable, given the family's recent move, with no relatives nearby. At the same time, the child is developing well, the maternal-child attachment is strong, father-child interaction is warm and parents want to ask questions and learn. In this case, the family needs support and empathy regarding a pregnancy trauma, their infant's surgery, and the family's anxiety. The marriage probably needs bolstering, and the father may need to feel more involved. Both parents could benefit from education and guidance about children's sleeping issues. These emerge as some initial goals for intervention, but these ideas are open to change, in collaboration with the parents.

The AIMS reference materials suggest intervention techniques that are especially relevant for particular ages of children or for particular concerns related to attachment, interaction, mastery, and support. The techniques one chooses to apply in any given situation depend on the individual case. Taken into account are an understanding of the nature of the problem, its severity and depth, the family's inner and external resources, and capacity to use help, the child's course of development, the nature and stage of the working alliance between professional and family, and the overall clinical picture and level of need. There is no way to make exact prescriptions for what to do and when (Liptak and Chamberlain, 1983).

The AIMS System of Practice provides guidelines for professionals, generalists, and specialists to follow in working towards the broad goals of improving a child and family's emotional health. These suggestions are not all-inclusive or prescriptive. The AIMS guidelines suggest such techniques as: reassuring; giving suggestions to parents; providing education about child development or the helping process; active listening; validating parents; monitoring child development; facilitating parental problem identification; facilitating problem-solving and coping skills; supporting parents in working through traumas and emotional conflicts; reinforcing strengths and positive changes; role modeling; and identifying feelings. These techniques are appropriately used at each and every level of intervention. All of these techniques are brought to bear in order to improve the attachments, interactions, feelings of mastery and ability to master developmental challenges, and optimal use of social supports.

Measuring Progress and Working Toward Mastery

Chapter III has addressed many components of psychosocial practices in children's services, including the needs of families with young children, the importance of partnerships, basic principles of infant mental health practices, development of working alliances with parents on behalf of their children, observation and interviewing skills, development of a clinical profile, and general psychosocial interventions. There are, of course, many other topics related to psychosocial practices with young children and their families, such as how to conduct in-depth psychosocial evaluations or to deal with specific problems of intervention. Only some general underpinnings of effective psychosocial practices designed to improve emotional health have been addressed. Utilization of such practices maximize any opportunity to promote emotional health. These opportunities present themselves to all professionals in a variety of settings at any time, and at all levels of service.

In addressing psychosocial or emotional health, a professional can easily become overwhelmed by the vast number of goals and objectives, or by the lack of specificity of some goals, or the difficulty of measuring change. Is the child functioning better now? Do the parents feel happier? These questions may point to indicators of progress, but feeling happier or better does not always indicate lasting developmental improvement. In fact, in the arena of emotional health, some improvement may leave individuals feeling worse at times, such as when denial is lifted and parents feel grief or anger. Short-term emotional pain often precedes long-term adaptation, such as when an alcoholic parent finally comes to terms with his/her disease and feels depressed for a period of time. Thus, it is difficult to discern the degree of progress when the primary concerns relate to mental or emotional health. Yet, professionals and parents need to know whether or not progress is being made. How does a professional remain attuned to progress or lack thereof?

The AIMS: Developmental Indicators of Emotional Health is a System of Practice that emphasizes certain dimensions of psychosocial functioning — Attachment, Interaction, Mastery, and Social Support. Charting changes in any of these domains is one way to track progress in any given child and his/her family. For example, when people are moving forward psychologically, they often show evidence of growth by expressing appreciation for family relationships more clearly (attachments), demonstrating their feelings to one another (interaction), having more fun together (interaction), noticing and verbally acknowledging things they do well (interaction and mastery), accepting their own or other's limitations (mastery), taking on risks or new challenges (mastery), or reaching out to other people in new ways (use of support). Positive changes, such as these examples, are likely to be recognized and indicated by "little things." Receiving feedback from a professional who notices these little things is often very encouraging and supportive to parents and children.

Of the four domains of emotional health, the notion of mastery is perhaps the most relevant to ongoing professional monitoring and case management. Mastery is
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The AIMS System of Practice provides guidelines for professionals, generalists, and specialists to follow in working towards the broad goals of improving a child and family's emotional health. These suggestions are not all-inclusive or prescriptive. The AIMS guidelines suggest such techniques as: reassuring; giving suggestions to parents; providing education about child development or the helping process; active listening; validating parents; monitoring child development; facilitating parental problem identification; facilitating problem-solving and coping skills; supporting parents in working through traumas and emotional conflicts; reinforcing strengths and positive changes; role modeling; and identifying feelings. These techniques are appropriately used at each and every level of intervention. All of these techniques are brought to bear in order to improve the attachments, interactions, feelings of mastery and ability to master developmental challenges, and optimal use of social supports.

Measuring Progress and Working Toward Mastery

Chapter III has addressed many components of psychosocial practices in children's services, including the needs of families with young children, the importance of partnerships, basic principles of infant mental health practices, development of working alliances with parents on behalf of their children, observation and interviewing skills, development of a clinical profile, and general psychosocial interventions. There are, of course, many other topics related to psychosocial practices with young children and their families, such as how to conduct in-depth psychosocial evaluations or to deal with specific problems of intervention. Only some general underpinnings of effective psychosocial practices designed to improve emotional health have been addressed. Utilization of such practices maximize any opportunity to promote emotional health. These opportunities present themselves to all professionals in a variety of settings at any time, and at all levels of service.

In addressing psychosocial or emotional health, a professional can easily become overwhelmed by the vast number of goals and objectives, or by the lack of specificity of some goals, or the difficulty of measuring change. Is the child functioning better now? Do the parents feel happier? These questions may point to indicators of progress, but feeling happier or better does not always indicate lasting developmental improvement. In fact, in the arena of emotional health, some improvement may leave individuals feeling worse at times, such as when denial is lifted and parents feel grief or anger. Short-term emotional pain often precedes long-term adaptation, such as when an alcoholic parent finally comes to terms with his/her disease and feels depressed for a period of time. Thus, it is difficult to discern the degree of progress when the primary concerns relate to mental or emotional health. Yet, professionals and parents need to know whether or not progress is being made. How does a professional remain attuned to progress or lack thereof?

The AIMS: Developmental Indicators of Emotional Health is a System of Practice that emphasizes certain dimensions of psychosocial functioning — Attachment, Interaction, Mastery, and Social Support. Charting changes in any of these domains is one way to track progress in any given child and his/her family. For example, when people are moving forward psychologically, they often show evidence of growth by expressing appreciation for family relationships more clearly (attachments), demonstrating their feelings to one another (interaction), having more fun together (interaction), noticing and verbally acknowledging things they do well (interaction and mastery), accepting their own or other's limitations (mastery), taking on risks or new challenges (mastery), or reaching out to other people in new ways (use of support). Positive changes, such as these examples, are likely to be recognized and indicated by "little things." Receiving feedback from a professional who notices these little things is often very encouraging and supportive to parents and children.

Of the four domains of emotional health, the notion of mastery is perhaps the most relevant to ongoing professional monitoring and case management. Mastery is
an overarching goal of all human functioning: one seeks to achieve mastery of basic abilities, of difficult situations, of challenges of all kinds. Achieving mastery of an event, conflict, or challenge, can move a person toward learning other tasks or achieving new goals.

In the case of professional psychosocial practices with families of young children, mastery is pertinent to all persons engaged in the helping process. With regard to the child, some mastery issues include: What developmental tasks is the child attempting to master? Are there obstacles in the way of the child’s capacity to achieve mastery? Is the family providing the child opportunities to achieve mastery, as well as recognizing and supporting its presence? With regard to the family, issues related to mastery include: the parents’ self-concept and self-esteem as parents; their capacity to master the many facets of parenting a particular child; the health of their marriage; the development of a capacity to grow along with the child; and their adaptation to and coping with stress.

Mastery also enters as a significant personal issue, for professionals themselves, when they engage in psychosocial practices to promote emotional health in young children and their families. Many professionals not trained in a mental health discipline frequently experience distress when discussing difficult emotional conflicts with parents and/or children. The fear of “opening up a can of worms” or “Pandora’s Box”, is a commonly expressed concern that can often be used as a reason to avoid addressing psychosocial issues.

The professional not only needs to learn skills in handling strong affect in his/her clients or patients, but also needs to master strong feelings generated in himself/herself when professional-client interactions become emotionally charged. Mastering strong emotions, mastering the ability to set boundaries around one’s role and function, mastering communication skills, including the expression of empathy and clinical use of one’s self, and mastering one’s own emotional conflicts to the degree that one can identify and diagnose psychosocial issues in clients appropriately, are all highly important objectives for professional functioning. Learning these skills takes time, practice, and support from colleagues, agencies, and one’s personal social support system.

A summary of strategies and skills toward increased professional functioning is outlined in Table 3.7. Increasing one’s own sense of mastery in these various skills provides additional opportunities to have positive impact on the lives of young children and their families.

<table>
<thead>
<tr>
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<td>• Listen Actively</td>
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<td>• Identify Strengths</td>
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<td>• Develop Common Mission/Approach</td>
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One never completely masters emotional issues, at least in the same way a gymnast might master a maneuver on the parallel bars or the balance beam. In effect, mastery is a perpetual goal, with degrees of mastery achieved at any given time and circumstance. A professional must remain open to change, information, and feedback from others to facilitate increasing mastery over time. Promoting emotional health in young children and their families hinges on professional practices that are carefully, thoughtfully and intentionally selected, in order to move everyone—child, parent, family, and professional—toward mastery.
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Beyond Individual Practice: Organizational and System Issues

John Hornstein, Ed.D.

What does a provider and his/her organization encounter when working to incorporate the AIMS: Developmental Indicators of Emotional Health into their routine practices? Just as a child exists in a context, so too the professional works in an organizational, cultural and systemic context. Successful use of the AIMS System of Practice may hinge on user's sensitivitly to issues of organizational, cultural and social change. This chapter discusses the impact of these issues on implementation of the AIMS System of Practice.

Strengthening the foundations of emotional well-being in infancy and early childhood involves more than altering individual professional practice to meet the psychosocial needs of young children and their families. To make a true impact in a systematic way, the broader organizational and social contexts in which professionals operate must be considered. The make-up and structure of mental health agencies, pediatric practices, well-child clinics, child care providers, governmental and private agencies—the various systems in which we serve young children and families—must be taken into account in the application of new practices. Furthermore, the awareness and activity of policy makers and the general public must be engaged at a time in which limited public and private resources, both human and financial, are available to apply to competing needs.

Change In Organizations: Two Cases

In considering implementation of the AIMS: Developmental Indicators of Emotional Health in an agency or service system, it is important to recognize that organizational change is a complex process that takes place at a variety of levels. Change occurs at the level of; professional to client, professional to professional, professional to agency, between units within an agency, and between one agency and another, as well as within a larger service system. Each of these levels contains both opportunities for and barriers to change.

Figure 4.1 illustrates a model in which the client of a health, education, or social service is at the center of various levels of the service delivery system. Change at any level elicits change at the other levels, and change at a particular level is most di-
rectly experienced at adjoining levels. For example, the client is most directly affected by change in the behavior of the professionals who work with her. However, the broader political and cultural changes may have a more diffuse, but profound effect over time. In implementing the AIMS System of Practice in a variety of settings, we have found that attention needs to be given to all levels of this system.

**Figure 4.1**

**A Social Systems Model for System Change**  
**As It Relates to Professionals Working with Clients**

This next section discusses these various levels of change in two cases: a pediatric practice and a statewide early intervention program. The process of change in these organizations will be addressed, and strategies identified that are successful in accomplishing the changes necessary to adopt innovative practices for supporting the emotional well-being of young children and their families.

The AIMS System of Practice has been implemented in a variety of organizational and community settings. Four communities in Maine were designated as community development sites and, as such, received technical and resource assistance over a four-year period (from 1987-1991). Field-test sites were also established to further test the AIMS materials. These sites included family and pediatric practices, a hospital-based well-child clinic, a developmental evaluation clinic, a city public health nursing unit and health station, and a state-operated home-based early inter-
vention program. In both the community development sites and the field-test sites, a range of strategies was employed to address factors that presented obstacles to implementing the AIMS System of Practice, as well as to the general mission of supporting the emotional well-being of young children and their families. The following cases are composite case studies of the settings in which the AIMS materials were used.

A pediatric practice decided to use the AIMS materials when a pediatrician from a group practice of three physicians attended an informational session on Project AIMS. He left the session convinced that more attention to psychosocial issues would be of great benefit to the families he served. He decided that he wanted to use the AIMS materials in his practice. The incorporation of a psychosocial component involved a major change for this traditional pediatric practice.

A statewide early intervention program's initiation of use of the AIMS System of Practice was somewhat more complex. Many factors worked in favor of the change. The evolution of the service from a child-centered to a family-centered program and the advent of the Education of the Handicapped Act Amendments of 1986 (P. L. 99-457) influenced the program's search for appropriate psychosocial practices. In addition, local and state representatives of this agency played a part in the overall infant mental health movement in the state of Maine. Hence, there was a commitment to the principles expressed by the AIMS materials prior to any effort to implement the AIMS System of Practice.

The change confronted by this statewide program and its staff was subtler than that for a traditional medical practice. The basic philosophy of family-focused intervention, with an emphasis on the psychosocial domain, had in fact, been accepted. However, despite the fact that this program seemed ready to adopt new practices, institutional barriers and individual professional practice needed to be addressed. That is, the program's procedures and the staff's training and experience reflected a more traditional, child-centered approach to service delivery.

The Process of Organization Change

How is change actually accomplished in an organization when one or several members would like to initiate a new practice? In the case of the pediatric practice, one physician saw inclusion of psychosocial concerns as consistent with the mission of the practice, and persuaded his colleagues of the value of this innovation. Office staff, however, were less convinced. It took the ongoing attention of an outside clinical consultant to assist in initial implementation of the practices and deal with resistant perceptions of addressing mental health issues. Sikes (1989) lists seven principles most important for understanding personal and organizational change. These principles illustrate the process of change that occurred in both the pediatric practice and the statewide early intervention program.
Table 4.1

<table>
<thead>
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<th>The Seven Principles of Skiles</th>
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<td>1. You must understand something thoroughly before you try to change it.</td>
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<td>2. You cannot change just one element of a system.</td>
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<td>3. People resist anything they feel is punishment.</td>
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<td>4. People are reluctant to endure discomfort even for the sake of possible gains.</td>
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<tr>
<td>5. Change always generates stress.</td>
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<tr>
<td>6. Participation in setting goals and devising strategies reduces resistance to change.</td>
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<tr>
<td>7. Behavioral change comes in small steps.</td>
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</table>

The first three of these principles of change are highly relevant to the pediatric practice case study, and the last four will be discussed with regard to the statewide early intervention program. It should be noted, however, that each of these principles applies in various degrees to all organizational change. The influence of one or several may predominate in any particular situation, at any particular point in time.

*Principle 1: You must understand something thoroughly before you try to change it.*

This principle includes an understanding of the roles, responsibilities, and attitudes of all office staff; who key decision-makers are and how decisions are made; expectations of the clientele; and operational procedures of the office. It further includes a sense of the overall mission of the organization.

This last element is critical. In the pediatric practice, if attention to the psychosocial needs of families was not seen as part of the practice's mission by either the physician, the office staff, or the clients, then successful adoption of the AIMS material was unlikely. In this case, one physician was convinced by a presentation that indicated benefits to his clients and provided scientific evidence of the value of this approach. He persuaded the other two physicians. Indeed, much of such change—whether it is physician to physician, educator to educator, or therapist to therapist—can come through dialogue within one's discipline. People often listen better to people they see as similar to themselves.

One strategy that is particularly useful for establishing an innovative practice such as the use of AIMS materials in a service delivery setting, is an examination of the organization's mission by all the stakeholders—in this case, the office staff and representative clients, as well as the physicians. If all involved can support the commonly accepted mission, implementation will be far easier to accomplish.
Principle 2: You cannot change just one element of a system.

The AIMS staff were continually reminded of this principle in all field test and community sites. In the case of the pediatric practice, this idea included consideration that time devoted to use of AIMS materials was time that would not be spent on other activities. There were implications for paper flow, office space, and staff time that had an impact on other office activities. Furthermore, the costs involved also needed to be addressed. Consideration of resources needed to support these additional activities, and how these activities would be integrated into existing activities so that they were cost-efficient, was necessary.

Change in one agency or organization within a community also can affect the whole system of services. For example, increased attention to psychosocial concerns at this pediatric practice resulted in more referrals to early intervention and mental health services, as well as a realignment of roles among service providers in the larger community.

The active participation of staff from the affected early intervention and mental health services, helped to manage both internal and external systems. The presence of a clinical consultant from the mental health center not only facilitated the referral process, but allowed for support to staff in adapting office practices. The use of early intervention staff to implement the AIMS materials, relieved time pressures on office staff and provided a concrete link to the broader array of early intervention services.

Principle 3: People resist anything they feel is punishment.

The office staff of the pediatric practice carried out a large share of the interactions with parents and their children. They often got to know the families better than did the physicians. In some senses, the psychosocial domain had been their responsibility. A change in the way the practice dealt with this domain easily could have been seen as a response to the way it had been dealt with in the past. The attitude of office staff toward adopting new practices and adapting old ones, was related to how they felt they had been doing their jobs. A change in this role easily could have been misinterpreted as “punishment” for inadequately dealing with psychosocial concerns. Furthermore, addition of new responsibilities, whether or not they were related to past performance, could have met with resistance unless they were substituted for duties that were removed.

Staff also may have felt that they were protecting the families. The resistance in this case was clearer. The effort to identify areas of psychosocial concern was seen as intrusive by office staff. Although there was an element of personal resistance to dealing with “mental health,” it may also be that staff who developed supportive relationships with families also wanted to protect the families from the presumed “punishment” of something seen as an intrusion.

The support of the clinical consultant was critical here. This provided staff the opportunity to discuss their changing roles, to better understand the dynamics of in-
teraction with families, and to resolve some of their resistance to adopting these practices. The process of change in systems often reflects the same process in individuals. The pediatric office needed to look at itself and understand the barriers to change in order to adopt new practices. The consultant helped staff identify, understand, and address those barriers. The process of change is also ongoing. Barriers to implementation of innovative psychosocial practice continue within this pediatric practice. However, both staff and consultants are committed to the process of change involved in adopting new psychosocial practices.

To illustrate Sikes' remaining four principles of organizational change, they will be applied to the second case, the statewide early intervention program. This program was primarily home-based and the workers who carried out these programs were early interventionists. That is, they carried out home-based programs in compliance with the recommendations of a variety of therapists. Accordingly, they performed some assessment and case management. These workers came from a variety of disciplines, primarily education and social work.

Well before the onset of training in the use of the AIMS materials, the workers from this program had received a significant amount of training in infant mental health practice, and the agency as a whole had adopted a family-centered philosophy. Yet the process of actually applying the materials and adjusting day-to-day practices, proved to be far more difficult than anyone had anticipated. Certainly, some of this difficulty can be attributed to the effect of the three principles of change already discussed. The remaining four principles can provide additional understanding of the process.

Principle 4: People are reluctant to endure discomfort even for the sake of possible gains.

In general, the workers in the statewide early intervention program were conversant with basic infant mental health philosophy and practice, as well as convinced of the benefits of such an approach. However, reluctance to actually apply the AIMS materials was strong. Follow-up training sessions clearly revealed the discomfort individual workers experienced in addressing psychosocial concerns with families.

This discomfort, for those whose professional lives are not fully defined by psychosocial concerns (e.g., "I am a physical therapist, I deal with legs"), is a significant barrier to implementing the AIMS System of Practice. The workers in the early intervention program clearly felt that carrying out speech therapy recommendations, implementing motor activities, and finding preschool and daycare placements were far more comfortable tasks than discussing the emotional health of the child, relationships with other family members, and the parent's own psychosocial needs. The workers feared delving too deeply into these issues, possibly opening up issues they felt unqualified to deal with or raising their own personal emotional vulnerabilities, and losing focus on other aspects of their work. Yet attending to psychosocial
concerns is a component of their work. Infant mental health, by definition, is a multidisciplinary field. Whether carrying out developmental programming or managing cases, the worker has an impact on the social-emotional world of the child and family. These workers need to be aware of and understand the impact of their action or inaction in relation to each family. Many early interventionists found it difficult to broaden their focus.

Follow-up training and support as well as effective supervision are essential in dealing with such concerns. Of particular importance is providing support for workers attempting something new in which feelings of doubt and possible failure is high. Training and supervision must create an environment in which the worker can take the risk involved in attempting a new practice without fear of reprimand for failure.

Regional follow-up training, combined with group supervision, helped address the above issues. The resultant process of reviewing actual cases, identifying areas of difficulty, and helping to determine courses of action was structured to be productive and supportive for the workers in this program. Helping workers define the limits of their work and responsibility, relieved some discomfort. It is a challenge for workers to continually work through the dilemma of knowing that every interaction with a child and family is, indeed, a psychosocial intervention, while at the same time recognizing the limits of their own expertise. This task requires on-going organizational support.

Some form of group support and external supervision for infant mental health issues has evolved at each of the AIMS community development sites. However, the needs and nature of workers vary greatly, as do the capacity of agencies and local service delivery systems to provide support. In one community, an interagency support group facilitated by a clinical consultant, coupled with existing supervisory structures, which seems to meet this need. In another community, the clinical consultant provides individual supervision for workers regarding infant mental health issues. In each case it is clear that an ongoing mechanism must be in place to support workers' efforts to focus on the psychosocial needs of young children and their families. This mechanism needs to include opportunities to process cases, review successful and unsuccessful strategies, and identify concerns, as well as allow staff to express feelings, recognize their own strengths and understand their contributions to interactions with families.

**Principle 5: Change always generates stress.**

For the early intervention program, introduction of the AIMS materials involved both procedural and personal change. Effects on procedures included changes in intake protocols, assessment methods, agendas for home visits, record keeping, and referral procedures. On a personal level, use of the AIMS materials changed the way
The early interventionists in the sample case, encountered and absorbed stress from families on a daily basis. The added stress of adopting new practices and adapting old ones, could have raised the level of stress above the tolerable threshold already approached in the work environment. Therefore, introduction and implementation of the new practices needs to be carefully managed. Through follow-up training and supervision, the rate of use of the AIMS materials was adjusted to meet the needs of individual workers. Workers were allowed to choose families on their own for initial use of the materials. Follow-up training and supervision were made available on a frequent basis to allow for necessary support and problem solving. After a pilot phase of using the materials, the administrative decision was made to utilize the materials as part of the intake and developmental assessment, thus responding to the workers' procedural questions and further clarifying their roles.

Principle 6: Participation in setting goals and devising strategies reduces resistance to change.

The principle of involving people in decisions that affect them is basic to the AIMS System of Practice. Just as the AIMS system relies on the families involved to determine what their own strengths and concerns are, the use of AIMS materials relies on professional discretion to determine how their practices are to be affected.

In the early intervention program, the AIMS materials were presented to workers prior to the agency's decision to use the materials. The frequency and conditions of usage were based upon meetings with both workers and supervisors. Agency staff felt strongly that follow-up training would be necessary if they were to try to implement the system. Such follow-up training was scheduled with workers at orientation sessions, and agendas were determined with their input. The ultimate policy decision about when and how to use the materials was made in full consultation with the workers who would use them.

Usage of the AIMS System built upon the program's previous involvement with infant mental health. The workers had already participated in an historical process of mission development and goal setting that led to a readiness to accept new methodology in this area. Despite this readiness, adoption of new practices was far more challenging than anticipated. This reflected the operation of all seven principles of
change. Note, as well, that Principle 6 says participation *reduces* resistance to change; it does not eliminate it.

**Principle 7: Behavioral change comes in small steps.**

As noted above, adopting the AIMS System of Practice in the early intervention program involved changing the manner in which workers interacted with families. Each worker approached such an interaction with a mindset and a set of behaviors that were both unique and complex. These behaviors evolved over years of both training and experience. In their practice, some workers came to understand psychosocial issues only after they had addressed motor and language issues. Others discussed psychosocial concerns early in the relationship, but informally over a cup of coffee. These behavioral patterns and styles of interaction could not simply be abandoned and substituted with a "system."

It was important to integrate the AIMS materials into these existing behaviors, perhaps substituting for some, while enhancing others. Prior to using AIMS materials with families, workers needed to develop words to use in presenting the materials. They had to decide during which visit, and at what point in the visit, to introduce the materials. Most importantly, they needed to be able to discuss the content of the materials with family members. Clearly, these changes were easier for those workers who already were committed to devoting a significant portion of their effort to psychosocial concerns. However, all the workers struggled with these changes. When change came, it came in small steps (e.g., finding the right words with which to introduce the forms, or identifying a response on the parent questionnaire to use as a starting point for discussion). It was, again, through supervision and mutual support that many of these small steps were identified. They were tried, they worked or did not work. In both cases, workers’ efforts were supported and new steps identified for future progress.

Understanding Sike’s principles of change can help an organization adopt new practices. Each plays a role in the process of change, and one or a few may affect a particular situation more than others. Tables 4.2, 4.3 and 4.4 list some of the strategies and outcomes utilized by the AIMS project in addressing change at the local, regional and state levels. These strategies apply an understanding of the Sike’s principles of change as related to well-child and early intervention settings.
<table>
<thead>
<tr>
<th>Activity</th>
<th>Strategies Employed</th>
<th>Outcomes</th>
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| • Community Demonstration Sites | • Mental Health Forums, 2-3 hours, facilitated discussions among interagency service providers  
• Identification and support of local clinical consultant  
• Small scale funding ($4,000/site/year)  
• Collaboration with medical community | • Networking on referrals, resource development, awareness raising and training  
• Development of local clinical support groups  
• Emotional health component added to ARENA assessment  
• MSW services offered at 3 pediatric practices in coordination with well-child visits  
• Increased IMH training  
• Funding for therapy for families who fall through the cracks  
• Supervision of psychosocial intern of mental health agency  
• Clinical supervision for direct service workers  
• Mental health consultation to preschool programs  
• Increase in family focus in early intervention services  
• Increased awareness among pediatric office staff of mental health concerns  
• Increased referral to early intervention |
| • Small Scale Field-testing in Medical Practices and Public Health Agencies | • Orientation to AIMS materials  
• Psychosocial practice training  
• Data collection and consultation | • Increased awareness of mental health needs by staff  
• Increased referral for psychological intervention  
• Data on usability and numbers for data analysis |
| • Maine Medical Center Field-test | • Orientation to AIMS materials  
• Training seminars and consultation on psychosocial practices  
• Videotape research  
• Data collection and consultation | • Increased confidence by residents in addressing psychosocial concerns  
• Large amount of data for factor analysis  
• Contribution to revised hospital intake forms  
• Change in pediatric resident behavior related to psychosocial intervention |
<table>
<thead>
<tr>
<th>Activity</th>
<th>Strategies Employed</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Development of Needs Assessment/Planning team | • Collaboration with the State and Regional Level leaders  
• Active participation for MCH, P/CHN Needs Assessment and Planning | • Training in infant Mental Health Practice and the AIMS System of Practice to all Regional MCH, P/CHN  
• Inclusion of Emotional Health Assessment in MCH care |
| Coordination with MCH, P/CHN program | • Identification of training needs  
• Program planning around needs  
• Scheduling of training | • Recommendation for Infant Mental Health and AIMS training to all State and Regions for MCH, PHN  
• Additional focused training to support use of the AIMS System of Practice |
| Collaboration around Training Needs | • Orientation to AIMS System of Practice  
• Presentation of Infant Mental Health and Psychosocial Practice | • Increased awareness of emotional health/psychosocial needs of MCH families by MCH, PHN  
• Implementation of the AIMS System and Infant Mental Health Practice as a routine part of Assessment |
| Professional Support           | • Consultation and follow-up in Implementation of the AIMS System of Practice       | • Regular use of the AIMS System of Practice in Assessment of MCH families by MCH, P/CHN |
Table 4.4
AIMS Systems Level Activities (State)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Strategies Employed</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Participation in Maine's Interdepartmental Coordinating Committee for Preschool Handicapped Children</td>
<td>• Periodic reporting of AIMS activity</td>
<td>• Incorporation of psychosocial practices in Interdepartmental Standards for Early Intervention</td>
</tr>
<tr>
<td></td>
<td>• Active participation in Committee work</td>
<td>• Inclusion of Mental Health within Health Perspective document</td>
</tr>
<tr>
<td>• Collaboration with the Bureau for Children with Special Needs</td>
<td>• Membership on Early Intervention Task Force</td>
<td>• Continued emphasis on serving children at environmental risk</td>
</tr>
<tr>
<td></td>
<td>• Field Testing AIMS: Developmental Indicators with statewide home-based early intervention program</td>
<td>• Definition of eligibility for system services under category of behavioral impairment</td>
</tr>
<tr>
<td>• Involvement with the Maine Association for Infant Mental Health</td>
<td>• Sponsored organizational meeting</td>
<td>• Task Force report which recommends additional Bureau focus on children's mental health and prevention as well as use of a wellness and family focused approach</td>
</tr>
<tr>
<td></td>
<td>• Membership on the Board</td>
<td>• Training for staff in innovative psychosocial practices</td>
</tr>
<tr>
<td></td>
<td>• Training at annual conferences</td>
<td>• Incorporation of AIMS in intake and assessment procedures</td>
</tr>
<tr>
<td>• Clinical Consultation Group</td>
<td>• Monthly supervisory meetings with community site consultants and MMC staff</td>
<td>• MAIMH exists as a network for infant health practitioners, advocate for new and expanded services and training resource</td>
</tr>
<tr>
<td></td>
<td>• Training in the AIMS System and implementation with MCH populations served by P/CHN</td>
<td>• Promotion of AIMS developed practices to statewide audience</td>
</tr>
<tr>
<td>• Training and Implementation Consultation Group</td>
<td></td>
<td>• Supervision on infant mental health issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Network of key system members</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Incorporation of AIMS in assessment of young children and their families</td>
</tr>
</tbody>
</table>

AIMS Concepts as Guiding Professional Practice

The importance of Attachment, Interaction, Mastery, and Social Support does not end at age five. These concepts are of lifelong importance and can be applied directly to the work of health professionals, early interventionists, administrators and policy makers. The interaction between a pediatrician and a mother is more than a report on the medical status of the child. It is a partnership on behalf of the child and family's health. The visit a public health nurse makes to a home is more than the filling out of forms. It is an opportunity to support a family's emotional well-being. The committee meeting among state program staff to develop program policies is more than a bureaucratic task needing to be completed by a certain date. It is an opportunity to affect the emotional well-being of large numbers of families. Bringing
these values to our work and to our professional relationships provides the basis for our work with, and on behalf of young children and their families. Extending the AIMS paradigm to this level provides an analogy that can help us view decision making in a healthier light.

In infancy and early childhood, Attachment refers to the tie between caregiver and child. It implies acceptance, and leads to a sense of security, and of trust. Applied to our professional work, Attachment refers to an investment in the relationship between physician and patient, between members of a service team and between representatives of different agencies working together to manage services for children. At this level we don't talk about deep emotional ties, but we do need to accept divergent styles and opinions. And we must create an atmosphere of trust and cooperation in order to support a family's health, develop a service plan or affect state policy.

Parent-child Interaction refers to a communicative exchange of information. In a family, healthy interactions leave each member feeling some sense of control and connectedness in an environment perceived as generally supportive. The nature of our interactions at the professional level is critical to both effective work with families and to the development of public policy. As with families, Interaction between professionals and families and among professionals need to be reciprocal, allowing, again, for control and connectedness, as well as support. It implies teamwork, enjoyment and feedback. In the case of an early intervention home visit, this means allowing the family to play an equal role in determining the agenda for the visit. In the case of determining the training agenda for the early intervention system, it means identifying training needs and strategies with the recipients of training and soliciting their feedback subsequent to training.

Mastery refers to the parent, child and family's development of a range of skills and abilities. Based upon secure attachment and positive interaction, the child encounters both the physical and social world in a manner that allows for the development of competence and confidence. The child recognizes that he/she can have an impact on the world. Professional competence and confidence can be seen in a similar way. The state agency manager or consultant can passively respond to the requirements of state and federal mandates or, he/she can take the opportunity, the initiative or the risk, to offer new ideas or reject that which dis-empowers the agency's clients. The pediatrician can indeed support the emotional well-being of his patients by mastering techniques that allow for a dialogue which encompasses more than a checklist of physical health.

Support refers to a social network of people, resources, and influences available to families, which enhances healthy parent-child attachment, interaction and mastery of skills. Just as such a network allows family members to develop an increasing sense of empowerment, competence, connectedness, and ability to cope and adapt to life events, so it is that the early intervention, health, and child care systems need to create a professional support network to provide the same. At the level of service
to clients, this may mean that the speech therapist is assisted by the teacher and the pediatrician, toward helping the child achieve mastery in communication. At the level of policy development, this may mean that the Division of Special Education actively supports the establishment of Public Health Nursing positions.

The AIMS central concepts of Attachment, Interaction, Mastery and social Support, can be seen not only as elements of emotional well-being in early childhood, but also as analogies that can provide insight into healthy professional behavior and decision making. As with many ideals, the values they represent are not difficult to accept. The challenge is to apply them to the day-to-day work that we do, to the individual interactions that we have with clients and colleagues, and to the specific decisions we make.

Table 4.5
The AIMS Concepts as a Paradigm for Professional Practice

<table>
<thead>
<tr>
<th>Attachment: Professional Ties</th>
</tr>
</thead>
<tbody>
<tr>
<td>• investment in the provider-parent relationship</td>
</tr>
<tr>
<td>• investment in the team approach to provision of services</td>
</tr>
<tr>
<td>• acceptance of divergent styles</td>
</tr>
<tr>
<td>• atmosphere of trust and cooperation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interaction: Professional Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>• collaboration/communication with parent-child-family</td>
</tr>
<tr>
<td>• collaboration/communication among providers</td>
</tr>
<tr>
<td>• sensitivity and reciprocity</td>
</tr>
<tr>
<td>• teamwork</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mastery: Professional Capabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• accomplishment of parent-professional partnership</td>
</tr>
<tr>
<td>• team approach/relationship building</td>
</tr>
<tr>
<td>• effective communication skills/dialogue</td>
</tr>
<tr>
<td>• problem solving/overcoming barriers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support: Professional Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>• creation/use of provider support network</td>
</tr>
<tr>
<td>• consultation with team members</td>
</tr>
<tr>
<td>• referral to/consultation with other service providers</td>
</tr>
<tr>
<td>• ongoing collaboration with other service providers</td>
</tr>
</tbody>
</table>
Training and Technical Assistance

Of all the strategies applied in achieving the organizational and personal change discussed in the previous sections, the applications of training, technical assistance, and consultation were most pivotal in the adoption of innovative psychosocial practices. Experience in implementing the AIMS System of Practice in a variety of field-test and community development settings has resulted in identification of the four essential components of such training:

1. establishment of the basic conceptual components of emotional well-being and intervention in early childhood (Attachment, Interaction, Mastery, Support);
2. acquisition of specific knowledge and skill in use of the AIMS System of Practice;
3. assistance in adapting usage to current practices; and,
4. support in the process of personal and professional change.

Establishment of the basic conceptual components of the AIMS System of Practice must take place at two levels; those of the individual practitioner as well as those of the organization or system. Training in the AIMS System of Practice begins with a thorough review of the concepts of Attachment, Interaction, Mastery, and Social Support. These concepts as the foundation of emotional health in early childhood, are the basis for all of the AIMS System's assessment and intervention practices. Implementation of the AIMS System for the individual practitioner, requires an understanding of socio-emotional development in infancy and the nature of human relationships in supporting that development. At the organizational level, it requires institutional investment in a family and a wellness approach, as well as investment in multidisciplinary and interagency approaches to serving families.

The acquisition of specific knowledge and skill in use of the AIMS System of Practice is a two-fold process. First is an introduction to the actual materials. This includes an understanding of, and guidance in administering the intake forms, parent questionnaires, and points of observation; interpreting data gained from these materials; and establishing a dialogue with the family. Second is application of the materials to case vignettes. This includes applying the AIMS materials to a case composite or vignette, developing a clinical profile and plan, and proceeds to follow-up training, which discusses use of the materials with actual participant/trainee cases.

The latter step may be the single most important element of the training process. It is at the point of interaction with actual families that the AIMS materials become most relevant. The opportunity for practitioners to discuss the nature of these interactions, the effect of use of the materials on the interaction with the family, and the implications for further interactions is critical in enabling the practitioner to become conversant in use of the materials. This discussion process can be carried out through individual supervision of the practitioner, or within a group of users in which the case review can benefit many at once.
Assistance in adapting usage of the materials to current practices again takes place at both the individual and systemic levels. At the individual level, technical assistance is necessary to help the practitioner "fit" these new practices into their usual/routine way of working with young children and their families. Some previously used practices may need to be discarded and others altered. Schedules may need to be adjusted, reimbursement mechanisms explored, existing paperwork revised. In each of these examples, the assistance of someone who has experienced such adaptation, can make the difference between successful implementation and frustration or abandonment.

A strategy that was particularly successful in two of the four AIMS community sites at the interagency level, was offering mental health forums for local professionals involved in work with children/families who have emotional health issues. These forums were jointly planned by local service providers and Project AIMS staff. The forums reflected the unique characteristics of each community and were intended to serve the following purposes:

- To develop opportunities for early interventionists to meet and become better acquainted with mental health providers in their area.
- To encourage wider professional networking.
- To offer opportunities for peer counseling.
- To establish such forums on an ongoing, local basis.
- To potentially expand the base of local treatment resources.
- To learn more about the educational/support needs of professionals, in order to improve the AIMS training and products.

This range of purposes was addressed in various degrees at each of the sites. In one instance, networking became the major focus. At another site, a smaller support group of service providers from five agencies evolved from the original forum format. At a third, the forum provided the opportunity for providers to work together to plan development of new resources. In each instance, the effect of the initial forums was to allow components of the service system to work together, as a whole, in adopting innovative psychosocial practices.

Support in the process of personal and professional change must be available if practitioners are to successfully integrate new practices into their work. Use of the AIMS materials as a new practice invariably brings up points of resistance, such as personal psychosocial history, and professional boundaries. Successful change requires ongoing supervisory and collegial support. Table 4.6 summarizes the various training, technical assistance, and consultation strategies utilized by the AIMS staff in addressing these needs.
Table 4.6
A Summary of AIMS Integration of Change

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Format</th>
<th>Needs Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Mental Health Forums</td>
<td>1/2-day presentation and discussion</td>
<td>• building an interagency, multidisciplinary network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• a common language and goals</td>
</tr>
<tr>
<td>Orientation Training</td>
<td>2-day in-service for potential users</td>
<td>• establishing basic concepts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• acquiring skill in use of materials</td>
</tr>
<tr>
<td>Follow-up Training</td>
<td>1/2-day sessions for users</td>
<td>• integrating materials into practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• continuing skill development</td>
</tr>
<tr>
<td>Clinical Consultation</td>
<td>Periodic on-site visits</td>
<td>• removing organizational barriers to usage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• providing support in the process of change</td>
</tr>
</tbody>
</table>

In summary, application of a range of training and technical assistance strategies is necessary in the adoption of innovative psychosocial practices such as the AIMS System of Practice. It should be noted that these strategies are not a substitute for ongoing supervision and administrative support to professionals in the fields of health and early intervention. The strategies described will be far more successful in service delivery settings that provide a context conducive to healthy professional growth and development.

Public Policy and Advocacy

The mission of strengthening the foundations of emotional health in early childhood is advanced not only through improving professional practice, but also by affecting broader public policy. In its conception, the AIMS Project was designed as an element within the state of Maine’s early intervention system. As such, it has had the opportunity to affect public policy through linkage with key decision-making bodies within the state system. The following examples of such linkage illustrate of how public policy can indeed be affected to better meet the emotional health needs of young children.

Advocacy with a state legislature can lead to a direct impact on mental health services for children. In 1988, AIMS staff worked closely with local representatives to the State Legislature on a bill to allocate funds for infant mental health pilot or demonstration programs. As a result, $40,000 was appropriated to be administered by the Bureau for Children with Special Needs for direct treatment, training, and family support. This bill marked the first time in the history of the state that mental health funds were appropriated specifically for services to infants, young children, and their families.

Under P. L. 99-457, the Education of the Handicapped Act Amendments of 1986, each state is required to establish an interagency coordinating council to oversee its
early intervention effort. For the duration of Project AIMS, this role has been carried out by the Interdepartmental Coordinating Committee for Preschool Handicapped Children (ICCPHC) for the state of Maine. Throughout its history, the AIMS project maintained close coordination with this committee, and has kept issues pertaining to children's mental health needs on its agenda.

A specific example of collaboration with ICCPHC, is AIMS' involvement in the development of interagency standards for service delivery. The Interdepartmental Standards for Family-Focused Early Intervention are rules that govern the operation of state-supported early intervention services. AIMS participation in the development of these standards assured that psychosocial concerns are addressed in assessment, program planning, and intervention procedures; that both prevention and treatment are addressed; and that families are truly partners in making decisions about services for children with special needs.

Along with participating in the State's interagency effort, AIMS has maintained strong linkages with specific agencies that serve children. Notable in this regard is the State's Bureau for Children with Special Needs (BCSN), whose home-based early intervention program served as an AIMS field-test site. AIMS staff also participated in a task force on early intervention whose responsibilities included making recommendations for future overall Bureau policy. The task force report made recommendations to the Bureau as follows:

- Adopt a wellness- and family-focused perspective;
- Take primary responsibility for mental health services for children from birth to five years old, and;
- Increase efforts towards primary prevention through staff education and public awareness.

Public policy and advocacy activities need not be limited to efforts within government institutions. In the project's second year, AIMS sponsored an organizational meeting that resulted in creation of the Maine Association for Infant Mental Health. As a viable and self-supporting organization, the Association is active at a number of levels that foster its mission of strengthening the foundations of emotional health in early childhood. Specifically, the Association disseminates training materials in infant mental health, holds annual conferences, carries out various training events, serves as a network for infant mental health practitioners, publishes a newsletter, and advocates development of new and expanded private and public resources. As a private, non-profit organization, it can serve its overall mission without the restrictions of a time-limited project or governmental entity.

The importance of emotional well-being in early childhood is a value not always well-represented in American society. Material acquisition and personal achievement often seem to express the values of our culture more than caring for others and feeling good about ourselves. The roots of these values are established in early child-

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hood. Attachment, Interaction, Mastery and social Support, as components of emotional well-being in early childhood, represent more than a means to help children develop and grow. They also represent a value system that society needs to embrace.

Certainly, growth in professional practice and change in agencies, organizations, and governmental institutions affect the development of greater societal attitudes. But the awareness of the larger public itself, must also be considered. In recent years, newspapers, magazines, and even television and radio have given more coverage to topics relating specifically to emotional health in early childhood. However, relative to advertisements for junk food or professional sports statistics, the amount of coverage is small. The news media will respond to increased efforts of professionals to reinforce the importance of emotional health in early childhood. A case in point is the “Stand for Children” rally at the Lincoln Memorial, Washington, D.C. in June of 1996.

Opportunities to affect public awareness do arise each day. In our effort to use the powers of mass media, we should not neglect the power of day-to-day human interaction. Such seemingly minor events as the trip to the supermarket, the wait in the doctor's office, and the neighborhood picnic, offer countless opportunities to discuss and express the values of Attachment, Interaction, Mastery and social Support. Professionals who are committed to the well-being of children and families, must embrace every chance to make a positive difference.
Study of the AIMS System of Practice—
Usability, Practitioner Change and Psychometrics


How useful is the AIMS System of Practice to practitioners in
the field and how is their practice impacted? Study of the AIMS
System of Practice has been ongoing since the tool was devel-
oped including a pilot study, field-testing, pre- post-test study
for practitioner change and psychometric study. This chapter
discusses these studies in the context of usability of the AIMS
System of Practice, change in Practitioners who have been
trained in use of the AIMS System and psychometric study to
date of the System.

Study of the AIMS System of Practice has been a complex and multifaceted un-
dertaking. This is due, in part, to the system's multiple purposes— a) as a clinical
tool used to establish a dialogue toward early intervention on emotional health with
families, b) as an assessment of emotional health and development, and c) as a
means of training professionals in early emotional health. Each of these purposes, in
turn, is directed toward particular outcomes. As an intervention system, use of AIMS
yields effects on the child and family, the practice of individual professionals, and
the institution in which the practitioner operates. As an assessment instrument, the
AIMS: Indicators of Emotional Health includes not only separate parent self-report in-
struments for each of its twelve ages but also intake materials (demographic data and
a family concerns indicator), observation forms and reference materials for more fo-
cussed interviews and brief interventions. And, as a means of training health, social
service and early education professionals in psychosocial practices it effects both the
professional's understanding of emotional health as well as specific skills in working
with families. As a result of this complex array of elements, several discrete areas
have been selected for study including usability, practitioner change, systems
change, and the psychometric properties of the assessment instrument.

The selection of these areas of focus was based upon a developmental process
for the system itself, and the nature of project funding. The initial focus on usability
was essential to the development process, and is directly related to tool development
and dissemination for the purpose of use in clinical practice. The system's use as a
practical means of supporting healthy emotional development in families of young
children was the highest priority of the system's developers.
Subsequent to original materials development, initial field testing, and dissemination, AIMS project activities were directed largely to training. Three separate training grants1 were funded after the initial development period. As a result, evaluation of these efforts led to study of the effect AIMS training had on practitioners.

Since the initial process of instrument development, the project has included an effort to establish the reliability and validity of the AIMS: Indicators of Emotional Health. Psychometric study of the AIMS tool as an assessment instrument was initiated as the parent questionnaires were being completed. The original funding for AIMS, however, only included funds for collection and descriptive analysis of field-test data. More recently, additional data independent from AIMS funded projects has been added to the pool of field-test data yielding sufficient samples for more substantive psychometric analysis.

An area central to the AIMS mission, but not yet sufficiently studied is that of direct effects on children and families. The effects of interventions based upon the use of the AIMS System on the emotional well being of children, parenting capacity, and on the overall health and development of children require thorough examination. To this point AIMS has not received funding for such research. As the AIMS staff continue to develop research sites, and as programs around the country continue to use AIMS as part of their interventions and evaluate its effects, we expect to establish a more substantive body of evidence for the effects of using AIMS on children and families.

To date, then, the focus of study on the AIMS System of Practice has addressed usability, practitioner change, and initial psychometric analysis. The specific research questions that have guided this study are as follows:

**Usability**
- Can the AIMS System of Practice be efficiently integrated into pediatric well-child practice?
- How do parents respond to application of the AIMS System of Practice in well-child settings?

**Practitioner Change**
- Does training in the AIMS System of Practice affect practitioner's interactions with families?
- In what ways does training in the AIMS System of Practice effect practitioners' understanding of emotional health in early childhood?

**Psychometric**
- Do the AIMS: Indicators of Emotional Health reliably assess attachment, interaction, mastery, and support?
- Is the four-factor structure of the AIMS: Indicators of Emotional Health supported by the data?

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1 Two grants funded by the Federal Division of Maternal and Child Health supported the training of community and public health, maternal and child health nurses and one funded through the State's Part H training initiative supported the training of early interventionists.
Usability

The first area to be studied was usability. The purpose was to examine how the AIMS materials could be used in direct practice with families in various settings. The goals of the usability studies were to determine both how pediatricians and other practitioners could effectively integrate the system into their practice, and how families responded to the AIMS System of Practice. The information gained by this early study of AIMS was used to further refine the materials as well as to inform the developers and future users about how to best use the system. The results of these studies are fully described in the Pilot Study Report (Marsh, 1990) and the Bureau for Children with Special Needs Field-Test Report (Hornstein, 1991), and the Expanded Field Test Report (Marsh, 1992), (USM Publications).

Method

Sample. In 1988, during the development phase of the project, five sites in Maine were selected to integrate the AIMS System of Practice into existing service delivery. These sites consisted of three private pediatric practices, one public health well-child nursing clinic, and a social service parent center. One pediatric site was in an urban area with the four remaining sites serving rural areas. In addition to getting provider feedback from each site, the project also accomplished a small study of parent response to the AIMS materials for each site. In order to broaden the sample, a second level of study was also conducted. Parents identified by practitioners on the development team were asked to complete the AIMS: Indicators of Emotional Health, and respond to a survey. Further, a focused group of pediatricians and family-practice physicians from an urban area was conducted. And in 1990 the usability studies were supplemented when field-testing was conducted with Bureau for Young Children with Special Needs (BCSN) staff throughout the State of Maine, and again in 1991 and 1992 when six additional sites were added as expanded field test sites for data collection toward usability. Those sites included two private family practice offices and a hospital outpatient clinic all in Portland, as well as two City of Portland Health stations utilizing Pediatric Nurse Practitioners, to a developmental evaluation clinic in Waterville.

A total of 72 practitioners participated in usability studies data collection. The five pilot study sites used the AIMS materials at 223 well child and social service visits. Seven physicians participated in a focused-group discussion panel. 36 BCSN child development workers and therapists used materials with 112 families. And, 39 parents participated in interviews and surveys. The expanded field test sites utilized the AIMS materials with 1304 families across the twelve developmental ages of the forms.
Table 5.1

Number of Subjects in AIMS Usability Studies

<table>
<thead>
<tr>
<th>Study</th>
<th># parent participants</th>
<th># parents surveyed</th>
<th># of practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot study</td>
<td>223</td>
<td>39</td>
<td>41</td>
</tr>
<tr>
<td>Focused group</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>BCSN Field Test</td>
<td>112</td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>Expanded Field Test</td>
<td>1304</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>Total subjects</td>
<td>1639</td>
<td>39</td>
<td>108</td>
</tr>
</tbody>
</table>

Procedures: Each of the site staff were trained in the use of the AIMS System of Practice during 1-day training. This training included an orientation to the materials, and discussion of how AIMS could be integrated into their specific practice settings. In addition, BCSN staff developed sample case profiles and discussed the implications of AIMS for families of children with special needs.

The procedure outlined for use of the materials in pediatric practices was as follows: parents completed the AIMS forms in the waiting area prior to their scheduled appointments or, having received the materials by mail, bringing them completed to the scheduled visit. The materials would then be reviewed by office staff and forwarded to the provider who was to see the parent/child. The provider would then review the family concerns indicator and the parent questionnaire for strengths and concerns. These areas would then be used as points of entry for discussion with the parent/child. The supplemental psychosocial materials (Points of Observation, Suggested Interview Questions, Focused Interview and Brief Interventions) would be used in conjunction with the assessment materials as references for these discussions.

In the case of the BCSN sites, the materials were integrated into the home-visiting program with the family concerns indicator and the parent questionnaire being filled out during a home visit. Procedures for review and discussion were essentially the same as for the health care providers.

After the five pilot sites implemented the AIMS System of Practice both providers and parents were interviewed. Feedback from BCSN child development workers and therapists and the expanded field test sites was elicited during follow-up training sessions.

Results

Practitioners. Practitioner's responses to usage of the AIMS system were predominantly positive but varied. Pilot study users were unanimous in their perception that AIMS was successful at providing information about family relationships, family identified issues, the child’s impact on the family, and family stressors. Both pilot site and
BCSN field-test users also found that the system provided an effective and positive way of getting at family mental health issues. Furthermore, they felt that the instrument supported family strengths and validated their own clinical impressions.

The two issues of most concern were the amount of time required for administration, and the difficulty of integrating AIMS into existing procedures. The time and cost that the perceived additional materials would add to well-child visits was a significant barrier to use at the pilot sites and was reflected by the physician's panel. Time was not a large issue for the early interventionists. Since they conduct relatively frequent home visits more time is available. However, both pilot study sites and BCSN staff saw integration into existing procedures as a barrier. The pediatric practices saw their procedures as already complex, and their environments hectic. The BCSN staff were challenged by the complexity of integrating the AIMS focus with those of developmental programming for children and case management with parents as they were attempting to comply with new federal and state regulations governing their work with families. For some workers the use of the AIMS system was seen not as a means to achieve such compliance, but rather, as an additional demand.

A final concern was related to the readiness of providers to address psychosocial issues, which may have been reflected in the previous concerns of time and cost. The physician's panel pointed out that physician's training is inadequate in preparing practitioners to address psychosocial concerns. That AIMS could serve as a means to address this shortcoming was acknowledged. However, in working with both pilot-study users and BCSN staff AIMS consultants noted the role that personal resistance played in the adoption of the AIMS System of Practice. Some practitioners, despite acknowledging the appropriateness of addressing psychosocial concerns, have personal difficulty entering into discussions relating to emotional health. It was stated that they are afraid of opening “Pandora's Box” related to emotional health concerns.

Parents. Feedback from parents through structured interviews and written surveys indicated that the AIMS: Indicators of Emotional Health can play a positive role both in helping parents reflect on their parenting and in establishing a relationship with their service providers. In response to the parent questionnaires, parents indicated that they were receptive to completing the forms as they were a way for them to reflect upon themselves as parents both in relation to the particular child and in relation to support and resources. Typically, they felt reaffirmed and supported by responding to the questionnaires. They additionally felt validated in their knowledge of their child.

In response to the relationship to providers, parents indicated that completion of the forms helped them identify concerns to discuss with their service providers so that they were more prepared for use of that time. A secondary benefit was their interpretation that use of the AIMS Indicators represented a true concern for their child's well being by their provider. In contrast to the practitioner's responses, parents indicated that they were glad to take the time necessary to complete the forms.
The average time parents' spent completing the forms was 20 minutes. They did indicate that when they completed the forms they expected the practitioner to address the issues raised, however they also felt use was valuable even when the practitioner did not directly review the questionnaire with them.

Parental criticism of the AIMS forms and use of them by their providers was minimal. A few parents felt that some items were redundant, and that it was difficult to answer some of the questions within the Likert scale provided (very often, often, sometimes, rarely, never). Other parents felt that relationships with siblings, fitting into the family and childcare required more emphasis. Overall parent response was positive with parents at the site asking to complete the parent questionnaire, even after the study was concluded.

Table 5.2 summarizes findings on use of the AIMS system from the usability studies and more current feedback from additional providers.

**Practitioner Change**

At its heart, AIMS is a strategy for changing how our society supports families of young children. Research on parent perceptions of the adequacy of well-child health care (Sharp et al, 1992); of relationships with special education providers (Leff & Walitzer, 1992); and on relations between child care providers and parents (Shpancer, 1997), shows the need for more effective strategies on the part of professionals in establishing partnerships with families. A focus on emotional health is central to such partnerships (Greenspan, 1997). Hence, AIMS has focused much of its research on the effect use of AIMS has on practitioners from the various disciplines that work with young children and their families.

The study of practitioner change as a result of training in the use of the AIMS System of Practice has occurred in several stages as increasing numbers of practitioners have been trained. All of this study is characterized by pre- and post-training testing. The first phase of this testing took the form of a formal research model carried out with pediatric residents at Maine Medical Center in Portland, Maine during the field-test phase of the project (Maine Medical Center Research Study Summary, Marsh, 1991). Subsequent training with public and community health, maternal child health nurses as well as with early interventionists, utilized a written pre- and post-test methodology to examine change in practitioner's responses to a hypothetical practice case.
Table 5.2

Usability Study Findings Summary

**Parents**
- enjoy filling out the parent questionnaires
- do not feel that completing the parent questionnaires are too time consuming
- helps them reflect on parenting - bringing up aspects of parenting not consciously considered and affirming parenting capacities
- feel more prepared for the time with their provider
- feel that use of the indicators by the professionals represents a commitment toward them, their child, and their family

**Physicians**
- find information useful, but administration can be too time consuming for traditional practice
- when office staff and/or additional resources are available, the additional dimension is seen as very useful
- express some fear about broadening the domain for which they are responsible, due to lack of training and resources to meet psychosocial needs
- use of materials increases ability to address psychosocial concerns during well-child care
- awareness engendered by use and training results in qualitative changes in well-child care interactions (e.g. responsiveness to parental cues, body position, interactions with parent and child)
- provides words and a method to incorporate emotional health assessment and intervention into routine well-child care

**Early Interventionists**
- helps organize information - offers multiple entry points for discussion, clarifies options, identifies issues, identifies parental priorities
- use of the system results in increased awareness of family strengths
- provides a method for assessment and individual plan development
- helps establish a connection with the parent/child/family
- raises questions about the role of the early interventionist (developmental programming/family support/case management)

**Mental Health Clinicians**
- helps organize information - as with early intervention, but often with more interpretation of family dynamics
- confirms clinical impressions
- offers multiple sources of data about the parent/child/family
- provides a means for discussing diverse perspectives on family issues when forms are filled out by more than one family member

**Trainers**
- contains an important and often neglected body of information in a philosophically satisfying and usable form
- able to be used in practice or as didactic training material
- provides a framework for discussing emotional health
- encourages case discussions, peer reflection and collaboration
Phase I Method

Sample. The sample for the pediatric resident study consisted of 14 residents at Maine Medical Center. Five first-year residents, five second-year residents, and four third-year residents participated; eight men and six women. The residents were videotaped in the Maine Medical Center Outpatient Department Pediatric Well-Child Continuity Clinic. The clinic serves low-income families from the Greater Portland area.

Procedure. Residents were divided into two groups (A & B) with a relatively equal distribution of year of residency and gender. All residents from both groups were first videotaped conducting regularly scheduled well-child visits with young children as a baseline. Subsequent to this baseline filming, Group A was trained in the AIMS System of Practice. This training included an introduction to emotional health in early childhood, an orientation to use of the AIMS materials, and incorporation of psychosocial practices into well-child visits. A week after the training, one-month after the first filming, a second filming of all residents from both groups again providing regularly scheduled well child care was carried out. After completion of the second filming, group B received the same AIMS training as group A had. One week after the Group B training, a third and final filming of all residents providing regular well child care took place. All videotapings were done behind a two-way mirror to make it less obtrusive. Both parents and residents were aware of the filming process at the time it occurred, but no changes in the routine provision of the care were made. Only a hidden microphone was in the room with the resident and families. Parents were informed that AIMS was being used both to help the practitioner better understand the family and for research purposes. Confidentiality was guaranteed. Results of the study were for research and training use only. Permission from families was received prior to filming by way of signed consent forms.

Videotape analysis consisted of coding the tapes using a coding scheme developed by project staff (Marsh & Devine, 1991) to assess the extent to which psychosocial concerns are addressed in well-child visits. Categories coded included: a) opening the interview/rapport building, b) conveying empathy, responsiveness, adaptability, c) gathering information around social/emotional issues, and d) giving positive feedback. Each category consisted of 6 or 7 behavioral indicators for the category. Categories were rated on a 1 - 5 scale with the highest possible rating as a score of 20. Coding was carried out separately by two coders who observed the videotapes separately. Scores were determined by calculating the average ratings in each category by each observer. Interrater reliability for the coders was .86.
Phase I Results

Ratings for the Maine Medical Center resident study indicated that 62% of the resident group showed a change in the quality of their interactions with families after training in the AIMS System of Practice. Eight pediatric residents had an average increase of 3 points in their scores immediately after training. This total reflects 2 residents from group A and all 6 from group B. Of these 2 were third year residents, 4 were second year residents and 2 were first year residents. Two residents (both from group A) showed no change in their global rating by an average of 2 to 3 points immediately after training. These, again, were all group A residents.

The mean total scores for residents before training was 12.08 and after training 13.42. A Student's t-test was applied to the data to test for a pre- and post-test difference. A significant difference was found p < .5. Figure 5.1 shows study results by subscale scores. The largest differences were found on subscale #3, “Gathering information on social/emotional issues” (p < .05). The smallest difference was for “Giving positive feedback” with pre and post difference not achieving statistical significance.

Phase II Method

Whereas Phase I study consisted of assessing behavioral change on the part of practitioners, Phase II consisted of whether training had an effect on the thinking of practitioners. Hence, a more qualitative method was applied.

Sample. The sample for this study included 41 state employed public health, maternal and child health nurses who completed pre- and post-tests around training in use of the AIMS System of Practice in 1994. The State of Maine Division of Public Health Nursing made the decision to train all its Maternal and Child Health nurses so that AIMS could be included in the assessment and evaluation protocol for home visits of families with young children. Trainings were carried out at three regional sites – Houlton, Bangor, and Augusta, which represented the statewide Public Health, Maternal and Child Health Nursing System.

Procedure. Training consisted of presentation and explanation of the four conceptual areas underlying the system; presentation, description and instruction in the use of the AIMS materials, discussion of a sample case composite and profile development with a plan of action and discussion of implementation issues specific to the participants' work settings. Prior to the training, participants completed a pre-test utilizing a sample case of completed AIMS materials. Subsequent to the initial training, nurses were asked to implement the materials in their work with families of young children. This experience was used in the follow-up training sessions to discuss implementation issues and use of the system. At the close of the follow-up training, participants completed a post-test utilizing the same sample case as in the pre-test and responded to the same set of questions.
The pre- and post-tests consisted of a vignette that describes the family of an 18-month-old child such as might be obtained through a referral, along with completed AIMS materials (Family Information, Family Concerns Indicator, an 18 month Parent Questionnaire and an 18 month Points of Observation). Trainees were asked to respond to the case vignette in narrative form via a set of seven questions which follow.

1. Think about what may be going on for this family. What strengths do you discern?
2. What concerns do you discern based on the parent's response to the questionnaire?
3. What would you try to observe to verify or confirm these hunches?
4. What questions might you ask in an interview to round out the clinical picture you gathered using the questionnaire?
5. Frame one or two objectives that might be appropriate in establishing a program plan with this family.
6. What strategies might be used to accomplish these objectives?
7. How would progress toward these objectives be evaluated?
**Analysis.** Pre- and post-test responses to the case study were analyzed both quantitatively and qualitatively. First, pre- and post-tests were paired by subject. Next, the number of responses per question was enumerated. And, finally, inductive content analysis via patterns of word usage, length of responses, and response content was carried out.

**Phase II Results**

Results of pre- and post-testing with 41 public health nurses in Maine who were AIMS trained are multifold. First, training in the use of the AIMS system is related to an increase in the ability of practitioners to describe both strengths and concerns in families. This tendency was a quantifiable increase for both strengths and weaknesses and a qualitative result in that post-test descriptions of family capacities showed greater detail. A second finding was that the responses displayed a more open-ended and exploratory attitude toward the family. Post-test descriptions tended to be less judgmental in language and requests for additional information were authentic inquiries vs. confirmation of previously held assessments.

A third finding indicated a moderately greater tendency to view emotional health as a dyadic phenomenon. That is, in framing possible objectives for the family post-test there was a tendency to come up with strategies that view the "mother and child" issues in tandem as opposed to as distinct developmental issues that reside solely in one or other member of the dyad. A fourth finding indicated a change in perception on the nature of the practitioner-parent relationship. Post-test responses showed a greater sense of partnership in identifying objectives, strategies, and means of progress evaluation. Responses also indicated a greater focus on the quality and importance of the relationship itself.

Contrary to expectations, there was no clear increase in focus on emotional health issues. Topics like attachment or social support were not likely to be more apparent in post-test responses. Thus it seems that the effect of AIMS is related more to the "how" of practice than to the "how much".

**Psychometric Study**

The AIMS: Indicators of Emotional Health are simultaneously interventions and assessments. Practitioners use them simultaneously to establish a relationship with families as well as a means to provide data on the emotional health of families. This dual purpose resulted in instrument design that was not driven primarily by psychometric qualities. Certain properties of the instrument, such as the number and phrasing of items were chosen not to strengthen the tool's capacity to discriminate between children or families but rather to serve as a means of impacting the emotional lives of families.
A second concern that needs to preface a discussion of the instrument's psychometric properties is that it is actually many instruments. Items are different at each developmental age. What describes attachment at 4 months may not describe attachment at 4 years. Hence, the reliability of items and the overall scale must be examined at each age of which there are twelve in the AIMS System. Furthermore, since the tool has different components (intake materials, parent questionnaires, guidelines for practice) each component part needs to be assessed.

To date the focus of psychometric analysis has been exclusively on the parent questionnaires. These are the only components that can be easily scored, and, more importantly, they are the core of the AIMS system. They were the primary focus of the instrument developers, and as parent report measures they provide a particularly relevant source of information on the child and family’s emotional health. In this regard, they reflect the use of parents as primary informants on the psychosocial development of young children in the tradition of instruments such as the Child Behavior Checklist (Achenbach, 1983) and the Vineland Adaptive Behavior Scale (Sparrow et al, 1984). However, in contrast to those highly prevalent instruments, the AIMS Indicators are wellness and family focused.

Instrument construction was a thorough process that included an emphasis on content validity. A detailed description of the instrument construction process is available in the AIMS User's Manual (Partridge et al, 1996). The scale went through repeated iterations guided by a multidisciplinary development team utilizing the literature on attachment, interaction, mastery and social support and being mindful of literacy and comprehension as this was to be completed by parents and families, not professionals. Review by national experts and pilot-testing were also used to refine the instrument. Psychometric analysis, however, was not used to guide item selection.

Method

Sample. There are several sources for the parent questionnaire data used for psychometric analysis. The AIMS field test resulted in the collection of approximately 525 forms across the twelve ages. Data collection among childcare agencies yielded an additional 166 forms for typically developing children aged 2, 3 and 4 years old. And, data from the Spurwink child development clinic yielded data on children with special needs aged 2, 3 and 4 years.

The portion of the sample used for psychometric study to date includes 6 month, 1-year, 2-year, 3-year, and 4-year samples. This was done through two separate studies. The first study focussing on the 6 and 12 month parent questionnaires utilized only data from the AIMS field test. The second study focused on the 2, 3, and 4-year-old questionnaires and included the childcare and Spurwink special needs data. Summary background information for the samples for both studies is included in Table 5.3.
Table 5.3
Percentages of Typical and Special Needs Respondents to the AIMS 2, 3, and 4 year-old Parent Questionnaire by Background Variables (n=585)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>Typical</th>
<th>Special Needs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>53%</td>
<td>67%</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>47%</td>
<td>33%</td>
<td>38%</td>
</tr>
<tr>
<td>AFDC</td>
<td>receive</td>
<td>18%</td>
<td>32%</td>
<td>27%</td>
</tr>
<tr>
<td>Maternal Education</td>
<td>Less than 12</td>
<td>10%</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>24%</td>
<td>42%</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>Greater than 12</td>
<td>67%</td>
<td>32%</td>
<td>45%</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>Caucasian</td>
<td>89%</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>African-American</td>
<td>4%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>Hispanic</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>Am Indian</td>
<td>1%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>3%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Siblings</td>
<td>0</td>
<td>34%</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>43%</td>
<td>40%</td>
<td>41%</td>
</tr>
<tr>
<td></td>
<td>2 or more</td>
<td>24%</td>
<td>40%</td>
<td>34%</td>
</tr>
</tbody>
</table>

As can be seen in Table 5.3, the samples are not as racially diverse as across the country as a whole, but more so than the overall population in Maine. This is a result of the sample being drawn, in large part, from the Portland area. Also, two of the childcare programs serve a large portion of children from military bases, which essentially draw people from throughout the country. Economically, the samples tend toward lower than average income. This resulted, in part, from the AIMS field-test data coming largely from public health clinics, and children served by the Spurwink clinic coming, in part, through Maine Department of Human Services referral.

Procedure. Field-test site staff were trained in use of the AIMS system prior to use in a similar manner as described for the public health nurses. Subjects were all typical clients of the service provided and the AIMS forms were integrated into well-child exams, early intervention home visits, and other routine contacts. Parents were informed that AIMS was being used both to help the practitioner better understand the family and for research purposes, as in the resident research study. Confidentiality was guaranteed. A similar process was used in the childcare sites with the exception that all the sites did not opt for staff training. In the case of the Spurwink data, AIMS forms are included as part of the intake package that parents are required to complete prior to a developmental evaluation. AIMS scores and background data on the sample were collected through manual review of the case files.
Analyses. After the initial field-test phase of the project descriptive statistics were generated for the data at each of the twelve ages. Subsequent data analysis was conducted primarily via confirmatory factor analysis. Confirmatory factor analysis is preferable to the traditionally used exploratory factor analysis when the construction of a scale is based upon a clearly defined theoretical foundation (Floyd & Widaman, 1996). Separate single factor analyses, attachment-interaction-mastery-support, were carried out in establishing the internal reliability of AIMS items. Subsequent to examination of item reliability, Cronbach's alpha statistics were estimated for the scale at 2, 3, and 4 years for the entire scale and the four subscales – Attachment, Interaction, Mastery and Social support. In examining the construct validity of the instrument, four-factor confirmatory factor models were tested to determine the relationship between the factors and to support the contention that these four factors are independent contributors to emotional health at each age.

Results

Initial examination of field-test data indicated that the items varied in the distribution of responses at each age. Some items were very strongly skewed toward positive responses and others showed a more normal distribution over the 5 point-Likert scale. At that point the decision was made not to exclude items exhibiting non-normal score distributions. This choice was made in the belief that there is clinical utility to items that do not, in fact, discriminate between subjects. Given this decision, later analyses of the instrument focus on the subset of well-functioning items. Single factor analyses were carried out at each age tested 6 months, 12 months, 2 years, 3 years and 4 years. Internal reliability estimates were calculated at each age. A set of twenty items, five for each factor, was selected for use in further analyses at each age.

Overall scale and subscale reliability statistics (Cronbach's alpha) are shown in Table 5.4. These results show that the scale as a whole predominantly meets the standard of .80 for a screening instrument (Wittmer, Doll, & Strain, 1996). However, the subscales do not routinely reach that level.

Table 5.4

<table>
<thead>
<tr>
<th>Scale</th>
<th>2 year</th>
<th>3 year</th>
<th>4 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIMS</td>
<td>.86</td>
<td>.85</td>
<td>.79</td>
</tr>
<tr>
<td>Attachment</td>
<td>.66</td>
<td>.52</td>
<td>.57</td>
</tr>
<tr>
<td>Interaction</td>
<td>.86</td>
<td>.71</td>
<td>.64</td>
</tr>
<tr>
<td>Mastery</td>
<td>.66</td>
<td>.75</td>
<td>.58</td>
</tr>
<tr>
<td>Support</td>
<td>.55</td>
<td>.75</td>
<td>.80</td>
</tr>
</tbody>
</table>
Four factor confirmatory factor models were tested at all ages, and at all ages four-factor models fit the data better than a model positing a single, overall emotional health, factor. The four-factor models, however, do not fit the data closely. Review of factor-factor correlations for the four-factor models (Table 5.5) indicates that the strongest relationship exists between interaction and mastery at three of the four ages. And, social support is almost uniformly less related to the other three factors.

**Table 5.5**

**Correlations between AIMS Factors in the Four-Factor Model of Emotional Health at 6 months, 2, 3, and 4 years**

<table>
<thead>
<tr>
<th></th>
<th>Attachment</th>
<th>Interact.</th>
<th>Mastery</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 mo.</td>
<td>Interaction</td>
<td>.844</td>
<td>.656</td>
</tr>
<tr>
<td></td>
<td>Mastery</td>
<td>.656</td>
<td>.875</td>
</tr>
<tr>
<td></td>
<td>Support</td>
<td>.118</td>
<td>.109</td>
</tr>
<tr>
<td>2 yr.</td>
<td>Interaction</td>
<td>.562</td>
<td>.776</td>
</tr>
<tr>
<td></td>
<td>Mastery</td>
<td>.513</td>
<td>.436</td>
</tr>
<tr>
<td></td>
<td>Support</td>
<td>.460</td>
<td>.330</td>
</tr>
<tr>
<td>3 yr.</td>
<td>Interaction</td>
<td>.666</td>
<td>.474</td>
</tr>
<tr>
<td></td>
<td>Mastery</td>
<td>.986</td>
<td>.300</td>
</tr>
<tr>
<td></td>
<td>Support</td>
<td>.278</td>
<td></td>
</tr>
<tr>
<td>4 yr.</td>
<td>Interaction</td>
<td>.520</td>
<td>.979</td>
</tr>
<tr>
<td></td>
<td>Mastery</td>
<td>.343</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support</td>
<td>.547</td>
<td></td>
</tr>
</tbody>
</table>

Between-group analyses comparing item-factor correlations of responses from parents of children with special needs indicate both similarities and differences between groups. Mean item scores are typically higher in the special needs group. However, the items that figure largest for some factors differ between groups. For example, on the scale for two-year-olds the attachment item "I feel proud of my child doing things on his/her own" exhibits a item-factor correlation of .67 for typical children and .38 for children with special needs. Whereas the item "I like being a parent even though it can be tough" exhibits a item-factor correlation of .54 for typical children and .71 for children with special needs.

In sum, psychometric analysis of the AIMS instrument at five ages indicates satisfactory levels of internal consistency reliability for the purpose of screening. Examination of construct validity indicates that the four-factors—attachment, interaction, mastery, and social support—provide a better representation of the data than single factor models for emotional health. However, in themselves, they do not sufficiently characterize the complexity of emotional health in early childhood as independent indicators. Taken together, as the tool was designed and intended for use, the four factors of attachment, interaction, mastery and support hold up. That the pattern of
factor-factor correlation seems to hold over different ages does lend support to an underlying factor structure that is represented by the four constructs. Variation in item-factor correlations between groups of typical children and those with special needs provides initial evidence that the AIMS measure offers the capacity to develop a picture of the unique structure of emotional health under a variety of circumstances that may affect emotional development. The AIMS System of Practice with the four constructs or domains of Attachment, Interaction, Mastery and social Support does seem to provide a reliable frame of reference with which to assess and intervene in the emotional health and development of young children in the context of their families.

Discussion

Study of the AIMS: Indicators of Emotional Health has demonstrated its usability, its effect on practitioners (and parents) and its technical soundness as a screening instrument. Each of these areas of study has indicated the multiple benefits as well as the limitations of the system.

Based upon the study of usability, the major benefits are that the system provides parents and practitioners with a meaningful mechanism to support communication around issues of emotional health and development. It provides a means for practitioners to join with parents and validates the important role parents play in the care of their child. It provides a methodology for assessing and intervening in emotional health issues, as well as evaluation over time. It gives parents information and it gives practitioners a framework through which they can better understand parent, child and family concerns. The limitations in terms of usability are that in some settings the procedures can add to time demands. Also, practitioner resistance to inclusion of emotional health in their medical or educational practice plays a role in whether they can effectively utilize the AIMS System.

Based upon the study of practitioner change, the major benefits are that use of the system helps practitioners see family strengths as well as improve their capacity to establish productive relationships or partnerships with parents through enhancing dialogue from the multiple points of entry the tool provides. The tool additionally gives providers a language with which to better understand and describe the emotional life of young families. However, a surprising result of the study of practitioner changes after training in use of the AIMS System of Practice was that it did not necessarily lead to a greater focus on emotional health issues in spite of enhancing the parent-practitioner relationship. The practitioner him/herself remain a variable in how the tool can assist in focusing on emotional health issues.

Psychometric study of the AIMS: Indicators of Emotional Health demonstrated that, for the ages examined, the instrument provides satisfactory reliability (internal consistency) for a screening instrument. Further, it is apparent from between-group comparisons that the Indicators provide a richly textured picture of
emotional health in early childhood and a base for assessment and intervention. However, results of psychometric study also indicate that caution should be taken in interpreting the four subscales as valid independent factors, for which they were not intended at the outset of the tool development.

Further study of the instrument’s ability to discriminate between typically developing children and those at-risk for emotional and behavioral problems is indicated. As a wellness measure, the primary intent of the instrument is to help practitioners join parents in considering, being more aware of and supporting the emotional health and development of their children. However, given the instrument’s overall reliability and the complex picture that the items provide it is likely that the instrument could help in the early identification of children at emotional risk.

In sum, the AIMS System of Practice should be seen simultaneously as an intervention and as an assessment methodology. It provides a means through which the emotional health of the young family can be understood in the context of forming a relationship or partnership with the family. It is through this partnership with parents that the practitioner can have the greatest potential impact on strengthening the foundations of emotional health of the young child. In an era in which children are increasingly both the victims and perpetrators of social dysfunction, attention to the emotional health of the youngest members of our society is essential. The AIMS System of Practice provides one approach to joining parents in the construction of emotionally healthy children.
A Word of Encouragement

The Authors

Over the course of the first five years of working on Project AIMS, as well as the four years subsequent to the development of the AIMS System of Practice, we have learned almost as much about the professionals we introduced to the AIMS materials, as about the families they are seeking to help. We have come to understand how professionals feel about integrating psychosocial practices into their usual activities, and what barriers or problems they encounter in so doing.

For professionals who have had previous training in mental health fields, such as social work, psychology, psychiatry, psychiatric nursing or counseling, learning to incorporate the AIMS materials is often a matter of utilizing familiar skills but from a new vantage point, or with heightened awareness or attentiveness to new sources of information about young children and their families. For professionals who do not have specific training in mental health, such as those from traditional health care, education or early intervention fields, attempting to incorporate the AIMS materials into ongoing practices can expose a number of barriers to effective psychosocial practices. We have found that it helps to identify these challenges, acknowledge them, and plan for ways to deal with them.

Incorporating psychosocial practices into delivery of service or care, for many professionals, represents a change in their basic routine or usual activities. Any such change can incur difficulties or barriers to successful implementation. We have discussed a number of barriers to change throughout this handbook. They include professional barriers, such as; professional’s lack of training, knowledge, or confidence in addressing emotional health and family issues; a dearth of supervision or consultative support for his/her efforts; and lack of knowledge about or access to community infant mental health and family resources available to families with young children.

There are also personal barriers, such as; dealing with these kinds of client issues can stimulate uncomfortable introspection about one’s own immediate family and childhood experience. Professionals may also feel discomfort at delving into emotional issues with clients, either because they fear opening a floodgate of parental emotions for which they may not be able, much as they desire, to ameliorate or prescribe a quick “cure”; or they find such new awareness, knowledge or responsibility too great a burden.

And there are system barriers as well, such as: too little or no support for this work, no reimbursement for time spent and/or inadequate understanding about the importance of this work. Conducting psychosocial assessments and brief psychosocial interventions takes time, which may not be fully compensated financially. This kind of care may also not be sanctioned or supported by the system in which the
professional works. Practitioners often feel pressure to stay with their usual practice or priorities, such as physical well-being, leaving no time for incorporating additional priorities, such as psychosocial well-being.

In addition to their professional, personal and/or system barriers, professionals may feel they have to work to overcome resistance to psychosocial practice in some of the families they treat. They may feel that some families are uncomfortable or unfamiliar with the practice of psychosocial/emotional care. Practitioners may fear losing clients because of a new approach or a changed professional image, not realizing how much families do want to open up to a willing listener. In actuality, the incidence of reported family or parental resistance to service providers’ use of the AIMS materials has been very small. Parents have actually reported feeling more “cared for” by the professional who takes the time and makes the effort to include psychosocial/emotional care in their delivery of service.

It is never easy to take on new challenges. It takes some time to be successful. We do not expect professionals to become experts in infant mental health practice. It is not our goal to train all professionals to become infant mental health clinicians. Nor do we expect practitioners in any one field to drastically overhaul their practices in order to utilize the AIMS materials. In fact, we have painstakingly designed the AIMS materials and training to facilitate integration and use by professionals within their existing practices. Our goal has been an attempt to fill the gap in delivery of care to incorporate psychosocial aspects by providing a methodology to accomplish this. This methodology and training helps deal with some of the various barriers presented.

There are additional ways to cope with these barriers. We have learned from parents, and try to help professionals understand, that even a few sentences of professional support can go a long way toward having a positive impact on parents and families. The range of AIMS interventions professionals can use with families also provides great flexibility, so the professional can utilize those with which they are most comfortable. Change can also come in small increments, from increased professional awareness of psychosocial issues, to expanded knowledge, to application in practice; each resulting in behavioral changes and increased skills. And once the professional adopts these practices, networks with other professionals, receives organizational sanction and support, as well as supervision and consultation, barriers to this work can be reduced or eliminated.

In short, the task is not insurmountable—and the rewards are great. Investment in early intervention can lead to crucial improvements in young children’s overall health and well-being, and their futures. Assessment and early intervention helps serve young children and their families through prevention of relationship problems, school or work difficulties, and a broad range of other social maladies. We share in common the fact that we have chosen the helping professions for a fundamental reason: to use our abilities to help others. Every one of us can help in our own unique way. We may not be able to work miracles overnight, but like any other preventive intervention, our efforts now can pay off many-fold in the future.
About the Authors

Susan E. Partridge, L.C.S.W., Ph.D., acted as Principal Investigator for the Project. She was also the Project Director for its first three years and a Research Associate at the Muskie Institute. Susan currently is a private practice clinician in Portland working with families and young children. She has two spirited daughters, 18-year-old Mara, and 13-year-old Juliana.

John Hornstein, Ed.D., acted as Project Director for two years subsequent to Susan, as well as a Research Associate at the Muskie Institute. John currently teaches at UNH, and is on staff with T. Barry Brazelton's Touchpoints Project in Boston. John is the father of a 21-year-old daughter, Allison, currently attending Bard College.

Jayne D.B. Marsh, M.S.N., M.P.A., acted as Director of the Project through 1999 and served as Editor for this second edition. She was also a Research Associate at the Muskie Institute. Jayne currently provides consultation and training around Assessment, AIMS, Infant Mental Health and Early Intervention through Developing Child (www.developingchild.org). She is also an Adjunct Faculty member at USM and UMA at Lewiston-Auburn College. Jayne is the mother of spirited son, Travis, age 18, and spunky son, Austin, age 13.

Deborah Devine, Psy.D., was a Consultant on the Project and a Research Associate at the Muskie Institute. Debi is currently a private clinician working with families and young children. She is the mother of a very active daughter, Tory, who is 10 and Maia, age 2.
Bibliography


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Feedback on the AIMS: Developmental Indicators of Emotional Health

Albert Einstein College of Medicine, Early Childhood Center, Bronx, NY

The AIMS materials ...[have been]... extremely useful in identifying issues that might have lead to more ingrained problems for parents, and parent-infant interactions, had they not been identified and addressed at such an early stage.

AIMS provides us with a tool with which to assess and track areas of critical importance [to infant mental health]- Attachment, parent-child Interaction, Mastery for both the child and caregiver, and Social Support, and to provide supportive interventions that improve outcomes for children and families.

AIMS... makes such a unique and necessary contribution to the care and well-being of infants and young children.

Dartmouth-Hitchcock Medical Center, Department of Pediatrics

[The AIMS System of practice]... will enable us to prepare our residents by way of a specific curriculum of skills and information... in the evaluation of the emotional health of infants and children within families and early intervention when indicated.

Boston City Hospital, Boston University School of Medicine, Department of Pediatrics

There is definitely a need for more knowledge and tools to assist primary care and child care providers in assessing and responding to the emotional health care needs of children 0-5 years and their families. We would welcome [AIMS] training... around emotional health and early intervention as we also see it as the key to emotional well-being and development in early childhood.

Maine Medical Center, Family Practice, Portland, Maine

The AIMS Tool has a track record in making a difference in the confidence, knowledge and skill of... residents.

State of Vermont, Department of Social and Rehabilitation Services, Child Care Services

The AIMS System of Practice ... offers the advanced information and tools to support the knowledge... and sensitivity [needed] in working with families... [toward] the healthy development of young children... that would be welcomed by many early childhood professionals.
Appendix B

The AIMS Developmental Indicators of Emotional Health

Intake Forms: Family Information
Family Concerns

Parent Questionnaires
(Samples): 2 months
18 months
4 years

Points of Observation
(Samples): 2 months
18 months
4 years

Guidelines for
Psychosocial Practice: Focused Interview Questions
Brief Interventions
## AIMS: Developmental Indicators of Emotional Health

**(Attachment — Interaction — Mastery — Support)**

### FAMILY INFORMATION

<table>
<thead>
<tr>
<th>A. IDENTIFICATION</th>
<th>Date: _____ / _____ / _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Child:</td>
<td>Home Telephone:</td>
</tr>
<tr>
<td>first</td>
<td></td>
</tr>
<tr>
<td>middle</td>
<td></td>
</tr>
<tr>
<td>last</td>
<td></td>
</tr>
<tr>
<td>(nickname)</td>
<td></td>
</tr>
<tr>
<td>Child's Current Age:</td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Name of Mother:</td>
<td>Name of Father:</td>
</tr>
<tr>
<td>Mother's Address:</td>
<td>Father's Address:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>With whom does child live? (Check all that apply.)</td>
<td>Mother</td>
</tr>
<tr>
<td></td>
<td>Other, specify</td>
</tr>
<tr>
<td>Billing Address</td>
<td>Address</td>
</tr>
<tr>
<td>of Responsible Party:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Zip</td>
<td></td>
</tr>
<tr>
<td>Medicaid #</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group No.</td>
</tr>
<tr>
<td>Ethnicity of Child:</td>
<td>(optional)</td>
</tr>
<tr>
<td>Current marital status of parents:</td>
<td>Married</td>
</tr>
<tr>
<td>Total number of people living in home:</td>
<td>Number of adults</td>
</tr>
<tr>
<td>Have there been any changes in the past year of people moving in and out of your home?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### B. EMPLOYMENT

<table>
<thead>
<tr>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>employer</td>
<td>address</td>
</tr>
<tr>
<td>employer</td>
<td>address</td>
</tr>
</tbody>
</table>

### C. EDUCATION

<table>
<thead>
<tr>
<th>Highest grade completed — Mother:</th>
<th>Highest grade completed — Father:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Less than 12th</td>
<td>□ Less than 12th</td>
</tr>
<tr>
<td>□ high school graduate</td>
<td>□ high school graduate</td>
</tr>
<tr>
<td>□ higher than 12th</td>
<td>□ higher than 12th</td>
</tr>
<tr>
<td>Currently enrolled in school?</td>
<td>Currently enrolled in school?</td>
</tr>
<tr>
<td>□ yes</td>
<td>□ yes</td>
</tr>
<tr>
<td>□ no</td>
<td>□ no</td>
</tr>
</tbody>
</table>

### D. TRANSPORTATION

<table>
<thead>
<tr>
<th>Do you have reliable transportation?</th>
<th>□ yes</th>
<th>□ no</th>
</tr>
</thead>
</table>

### E. SERVICES

<table>
<thead>
<tr>
<th>Child/Family Services</th>
<th>Economic Services</th>
<th>Health/Rehabilitation</th>
<th>Other Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Adoption Services</td>
<td>□ AFDC</td>
<td>□ Drug/Alcohol Services</td>
<td></td>
</tr>
<tr>
<td>□ Child Day Care (foster Care, preschool)</td>
<td>□ Food Stamps</td>
<td>□ Family Planning</td>
<td></td>
</tr>
<tr>
<td>□ Employment Services</td>
<td>□ SSI</td>
<td>□ Psychotherapy/Family Counseling</td>
<td></td>
</tr>
<tr>
<td>□ Legal Services</td>
<td>□ Other:</td>
<td>□ Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
<td>□ Therapy (e.g., speech, PT/OT)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ WIC</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Other</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Over, please)
F. BIRTH HISTORY INFORMATION:

1. PREGNANCY, LABOR AND DELIVERY

Pregnancy (Provide as much information as you have available.)

(Check if adopted □)

Age at adoption ___________ □ No problems □ Alcohol or Drug Use
□ Bleeding □ Prematurity, How early?
□ Infection □ Other

Was the timing of this pregnancy good for you? □ Yes □ No
Did you receive regular medical care during this pregnancy? □ Yes □ No
What month of the pregnancy did you start to see a medical provider?

Where was the child born? ____________________________

Hospital ____________________________ Town

Child’s birthweight: ____________________________

Circumstances at birth:

Labor and Delivery:
□ Vaginal delivery
□ Cesarean delivery
□ Premature
□ Breech
□ Twin (1st born, 2nd born)
□ Other:

Newborn Status:
□ Healthy, no problem
□ Jaundice
□ Low birth weight
□ Breathing problems, how long?
□ Ventilator, how long?
□ Surgery:

Hospital Stay: Child: _______ days  Mother: _______ days

2. OTHER PREGNANCIES: How many? ____________

Problems: □ Yes □ No

If yes: □ Before this child □ After this child

Type of experience: □ Abortion □ Miscarriage □ Stillborn □ Premature
□ Other:

3. EARLY LIFE WITH CHILD (birth to six months):

Sleeping: □ No problems □ Problems
If problems, describe: ____________________________

Feeding: □ Breastfed □ Bottle fed
□ No problems □ Problems
If problems, what kind: □ Sucking □ Swallowing
□ Eating problems (Fussy eater, excessive spitting of food, allergies)
□ Other:

How would you describe your baby during infancy?
□ Quiet □ Irritable □ Hard to deal with □ Average □ Overactive
□ Other: ____________________________

4. LATER LIFE WITH CHILD (six months to five years)

How Would You Describe Your Child Now?
□ Quiet □ Irritable □ Hard to deal with □ Average □ Overactive □ Aggressive
□ Other: ____________________________

This information will be kept private. Thank you.
FAMILY CONCERNS INDICATOR

Name of child: ____________________________
Name of parent: __________________________
Date: __________________________

Families often have to deal with many different stresses and challenges. Have any of the following occurred to you or anyone in your family? Is this of current concern to you or anyone in your family? If "yes", please indicate with a check (✓) next to the item under the appropriate column.

<table>
<thead>
<tr>
<th>Occurred Within My Family</th>
<th>Of Concern At This Time</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHYSICAL WELL-BEING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Problems/Disabilities</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Serious or Ongoing Illness</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Learning Difficulties including reading or school</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Speech/Language-Hearing Problems</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Accidents</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>SOCIAL SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Problems</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Problems with Social Services or Schools</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Difficulties with Childcare Help or Services</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>FAMILY LIFE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage or Relationship Troubles</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Children Living Outside of Family Home</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Few Friends or Close Family Members</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Financial Problems or Difficulties</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Emotional/Mental Health Problems</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Behavior Problems</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Family Violence (physical/emotional)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Problems with Alcohol or Drugs</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Concerns About Safety</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Housing Difficulties</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Transportation Difficulties</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Frequent or Long Separations</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>LIFE CHANGE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorce or Change of Marital Status</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>New Child in Family/Recent Pregnancy</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Change of Residence</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Job/Work Difficulties/Change of Employment</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Unfortunate Life Events (fire, theft, etc.)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Death</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>OTHER CONCERNS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify: ____________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9/20/89 This information will be kept private. Thank you.
© copyright, Project AIMS
### A. Family Feelings of Attachment

This part covers ways that family members feel about one another.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very Often</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My baby's other parent feels our baby is wonderful.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I think my baby is good.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. My baby looks at me when I hold him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. My baby snuggles close to me when I hold him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I believe my baby likes to keep me up at night.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. My baby stops crying when I hold him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I feel this baby is the baby I wanted.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I believe my baby feels I am special.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I worry that my baby is like me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Our baby adds to our family's closeness.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### B. Family Behaviors and Interactions

This part covers the ways you, your child, and your family play, work and talk together.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very Often</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My baby and I enjoy bath time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. My baby smiles at me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. My baby makes sounds when I talk to him/her.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. My baby tells me he/she is happy by the sound of his/her cry.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I worry if my baby will be spoiled if I pick him/her up too much.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I hold my baby during feedings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I smile at and talk to my baby.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. My baby and other parent hold and talk to our baby.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. My baby is happiest when he/she is all alone.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. My baby's other parent and I talk problems out without hard feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### C. Family Abilities and Feelings of Mastery

This part covers the way you, your child and your family develop, learn skills and solve family problems.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very Often</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel good about feeding my baby.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Our family knows how to calm our baby.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I am able to find time for myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. My baby's other parent helps me to be a good parent for our new baby.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I wonder if I will ever get used to having a baby.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. My baby is able to let me know what he/she likes and does not like.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Our family is able to cope with a new baby.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. My baby has regular times for eating and sleeping.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I believe that infants should learn right from the start that life is tough.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I think about how to take best for our baby.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### D. Family Resources and Supports

This part covers the kind of help and supports you and your family have.

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<tr>
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<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. People help me out when I need a break.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I like to talk about my new baby with his/her grandparents.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. My friends call or visit me and my baby.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I feel our family can make ends meet.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. People think I should be a perfect parent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. People care how I am doing as a parent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I feel it is alright for me to ask the doctor, minister or others for information or help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I get good ideas about taking care of babies from magazines, books or TV.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I find it very hard to get out of the house.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Relatives spend enough time with my other children.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
### A. Family Feelings of Attachment

This part covers ways that family members feel about one another.

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<tr>
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<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>I enjoy watching my child do things on his/her own.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child wants to be close to me when he/she is sick or hurt.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child looks to me when in a strange place.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child enjoys giving hugs and kisses.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel my child wants to make me angry.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child loves to see his/her other parent after they have been apart for a while</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child loves to be with his/her grandparents, aunts and uncles.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It makes me feel good to see my child growing and learning.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I wish my child needed me more.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Our family is happy with each other.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It makes me happy to see my child after we have been away from each other</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Family members love our child even when he/she has a tantrum</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child leaves my side to do things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### B. Family Behaviors and Interactions

This part covers the ways you, your child, and your family play, work and talk together.

<table>
<thead>
<tr>
<th>Statement</th>
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<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our family spends time together.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I let my child know when he/she has done something well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child tries to do what other people do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child brings me toys so that we can play together.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It is hard for me to say &quot;no&quot; to my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child and I laugh together.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>We look at family pictures with our child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I give my child something else to do when I need to stop him/her from doing something</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child is old enough to play outside by him/herself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child lets me know what he/she likes or dislikes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child's other parent understands what our child is trying to say.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### C. Family Abilities and Feelings of Mastery

This part covers the way you, your child and your family develop, learn skills and solve family problems.

<table>
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<tr>
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<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>I accept my child telling me &quot;no&quot; without getting upset.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child wants to do things on his/her own.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am happy with how my child's other parent cares for our child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child is able to look at picture stories for a short time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child seems unhappy for long parts of the day or night.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am able to keep my child safe.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>We talk about how to raise our child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Other children in our family can cope with this child's constant activity</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I get confused about the best way to parent my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child is curious about things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My child climbs on things to get what he/she wants.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Family members share feelings with each other.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
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### D. Family Resources and Supports

This part covers the kind of help and supports you and your family have.

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<th>Statement</th>
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<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do things by myself outside the home.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I can count on others when I ask for their help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Relatives let me know they think I am a good parent.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel okay getting the services my child needs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I worry that people outside our family will not care about my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Other people give me good ideas about family and child care.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I keep up with my old friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Relatives care about how my child is doing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I hate to ask for help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Our family feels our home is a good place to be.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
### A. Family Feelings of Attachment

This part covers ways that family members feel about one another.

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<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My child shows me things that make him/her proud.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. My child trusts me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. My child cares when other children are sad or upset.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Everyone in our family feels like they belong to it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I worry my child wants to hurt others in the family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. It is okay for my child to show or say what his/her feelings are.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I like to see my child growing to be his/her own person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. My child likes to spend time with adult family friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I make the same mistakes with my child that my parents made with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. My child's other parent feels sad or upset when our child's feelings are hurt.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
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### B. Family Behaviors and Interactions

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<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My child lets others know what he/she needs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. My child and I do the same thing every night before bedtime to help him/her settle down.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. My child and I choose together what we want to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. My child and I talk about things like sharing toys, waiting turns and getting along with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I feel unable to stop my child from fighting with me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. When my family gets together we share stories or pictures.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Family members enjoy answering my child's questions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. Our family goes together to bedtimes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. My child finds it hard to sleep in his/her own bed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. My child plays well with his/her brothers and sisters.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I ask my child about his/her feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
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### C. Family Abilities and Feelings of Mastery

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</tr>
</thead>
<tbody>
<tr>
<td>1. I keep my patience when my child tries to get his/her own way.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. My child sticks with things that are hard for him/her to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. My child likes to tell about things that he/she has done.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. My child does things for him/herself (like dressing, brushing teeth, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I feel that my child worries too much.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. My child plays 'make believe.'</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. My child's other parent and I help each other when we are upset with our child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. My child is proud of what he/she does.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. My child is a leader.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. My child helps me and his/her other parent spend time together.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I feel I have done a good job teaching my child right from wrong.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### D. Family Resources and Supports

This part covers the kind of help and supports you and your family have.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very Often</th>
<th>Often</th>
<th>Sometime</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Our family and relatives help each other through bad times.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Our relatives like to hear about my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I am able to get the services my child needs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. People I work with care about our family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. My child's needs tie me down.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I have good child care I can depend on.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. My child has friends he/she plays with.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I can count on my friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I think our family needs a better place to live.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. My child's grandparents are active in our child's life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
### INTERVIEW QUESTIONS

**Response to Questionnaire:**

Do you want to talk about anything from the AIMS questionnaire?

**Parental Adjustment and Well-being:**
1. How are you feeling?
2. Are you getting enough sleep?
3. How much time do you have for yourself?
4. Are you getting help with your baby?
5. Are you comfortable with your baby and friends?
6. Is there anything else that you would like to talk about today?

**Basic Care and Relationships with Baby:**
1. How are things going with your baby?
2. How are you feeling about the baby and the baby doing with each other?
3. Do you have any special worries about your baby? Your family?
4. How does your family feel about the baby?

### POINTS OF OBSERVATION

#### Strengths

**ATTACHMENT**
- parent is at ease when holding baby
- parent describes baby in positive terms
- baby is able to be comforted by parent
- parent shows concern over baby's crying or distress

**INTERACTION**
- baby molds to parent's body
- parent able to calm baby down when distressed
- baby appears alert, socially involved
- parent's stimulation of baby is appropriate
- parent and baby give eye contact
- parent seeks to protect baby from possible harm (e.g., covers when cold, comforts after shot, guards baby from falling off table)

**MASTERY**
- parent appears confident in role as parent
- parent is able to perform basic child care tasks (e.g., putting on clothing, diapering)
- parent is prepared for baby's needs (e.g., brings bottle, rattle, diaper)

**SUPPORT**
- parent asks for help or information
- parent is responsive to information, advice or other forms of help
- parent appears rested and healthy
- family appears and/or reports having adequate housing, transportation, finances and child care

#### Concerns

**ATTACHMENT**
- parent appears stiff or awkward when holding baby
- parent is unable to describe baby or uses primarily negative terms
- baby remains distressed despite parental efforts
- parent does not appear to "hear" or react to baby's cries

**INTERACTION**
- baby recoils, arches, or stiffens when held by parent
- parent is unable to calm baby
- baby appears lethargic, apathetic, socially uninvolved
- parent appears intrusive, over-stimulating, or under-reactive toward baby
- no eye contact between parent and baby
- parent appears unaware of possible harm

**MASTERY**
- parent appears more anxious, depressed or overwhelmed than expected
- parent is not able to perform basic child care skills
- parent is ill-prepared for meeting baby's needs

**SUPPORT**
- parent appears hesitant or unable to ask for help or information
- parent rejects offers of help
- parent appears overwhelmed, tired, stressed or unhealthy
- family appears and/or reports to have inadequate housing, transportation, finances and child care

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### AIMS: Developmental Indicators of Emotional Health

#### 18 MONTHS

### Guidelines for Psychosocial Practice

#### Interview Questions

**Response to Questionnaire:**
- Do you want to talk about anything from the AIMS questionnaire?

**Parental Adjustment and Well-being:**
1. How are things going at home with you, your child, and your family?
2. How do you feel about the things your child is doing now?
3. Is there anything on your mind that you would like to talk about today?

**Parent’s Sense of Child’s Well-being:**
1. What new things is your child doing?
2. Does your child enjoy trying out his/her new abilities?
3. Does your child seem happy most of the time?

**Family Adjustment and Well-being:**
- Do you and the child’s other parent talk about discipline and limit setting?
- How do other family members get along with your child these days?
- How are you and your child’s other parent getting along?

### Points of Observation

#### Strengths

<table>
<thead>
<tr>
<th>Attachment</th>
</tr>
</thead>
<tbody>
<tr>
<td>child tolerates periods of separation from parent</td>
</tr>
<tr>
<td>parent and child show pleasure in each other’s company</td>
</tr>
<tr>
<td>parent appears to enjoy child</td>
</tr>
<tr>
<td>parent behaves and talks about child in generally positive ways</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>parent responds to child’s needs or requests for comfort and care</td>
</tr>
<tr>
<td>child uses words and phrases to communicate with parent or others</td>
</tr>
<tr>
<td>child asks parent to help</td>
</tr>
<tr>
<td>child appears interested in adults and children around him/her</td>
</tr>
<tr>
<td>parent sets reasonable limits on child’s behavior, when necessary</td>
</tr>
<tr>
<td>child responds to parent’s limit-setting</td>
</tr>
<tr>
<td>older sibling responds positively to child</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mastery</th>
</tr>
</thead>
<tbody>
<tr>
<td>child uses 10-20 words</td>
</tr>
<tr>
<td>parent allows child to be curious</td>
</tr>
<tr>
<td>parent appears capable of handling child’s temper outbursts</td>
</tr>
<tr>
<td>child shows age-appropriate assertiveness (says “no”, protests, wants own way, etc.)</td>
</tr>
<tr>
<td>child’s behavior shows purpose; appears to know what he/she wants and how to get it</td>
</tr>
<tr>
<td>parent appears to enjoy being a parent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>parent asks for help or information</td>
</tr>
<tr>
<td>parent is responsive to information, advice or other forms of help</td>
</tr>
<tr>
<td>parent appears rested and healthy</td>
</tr>
<tr>
<td>family appears and/or reports having adequate housing, transportation, finances, and child care</td>
</tr>
</tbody>
</table>

### Concerns

<table>
<thead>
<tr>
<th>Attachment</th>
</tr>
</thead>
<tbody>
<tr>
<td>child clings excessively to parent</td>
</tr>
<tr>
<td>parent and child engage in constant conflict or struggle</td>
</tr>
<tr>
<td>parent appears angry with or distant towards child</td>
</tr>
<tr>
<td>parent talks critically of and behaves negatively toward child</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>parent ignores or rejects child’s needs or requests for comfort and care</td>
</tr>
<tr>
<td>child shows little or no verbal communication skills</td>
</tr>
<tr>
<td>child does not ask parent to help</td>
</tr>
<tr>
<td>child appears uninterested or avoids social contact with others</td>
</tr>
<tr>
<td>parent sets no limits or limits which are too harsh</td>
</tr>
<tr>
<td>child ignores parent’s limit-setting</td>
</tr>
<tr>
<td>older sibling appears angry with child</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mastery</th>
</tr>
</thead>
<tbody>
<tr>
<td>child does not use words</td>
</tr>
<tr>
<td>parent unnecessarily restricts child’s exploration</td>
</tr>
<tr>
<td>parent appears scared, overwhelmed by or punitive toward child’s temper outbursts</td>
</tr>
<tr>
<td>child appears excessively angry, insistent, compliant or passive</td>
</tr>
<tr>
<td>child’s behavior appears random or disorganized</td>
</tr>
<tr>
<td>parent shows distress over his/her role or feelings as a parent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>parent appears hesitant or unable to ask for help or information</td>
</tr>
<tr>
<td>parent rejects offers of help</td>
</tr>
<tr>
<td>parent appears overwhelmed, tired, stressed or unhealthy</td>
</tr>
<tr>
<td>family appears and/or reports to have inadequate housing, transportation, finances, and child care</td>
</tr>
</tbody>
</table>

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### AIMS: Developmental Indicators of Emotional Health

#### 4 YEARS

### Guidelines for Psychosocial Practice

#### INTERVIEW QUESTIONS

**Response to Questionnaire:**
Do you want to talk about anything from the AIMS questionnaire?

**Child Adjustment:** (Address these questions to the child.)
1. How old are you? When is your birthday?
2. What is your favorite television show? What toy do you like best?
3. Who do you like to play with?
4. What do you like to do? Do you play by yourself sometimes?
5. Do you have any brothers or sisters? Tell me about them.
6. Do you go to a babysitter? School? How do you like it?
7. Do you ever get mad? What things make you mad? What do you do?

**Parental Adjustment and Well-being:**
1. How are things going at home with you, your child, and your family?
2. What is your life like now that your child is four?
3. Is there anything on your mind that you would like to talk about today?

**Parent's Sense of Child's Well-being:**
1. What major changes have you seen in your child over the past year?
2. Does your child behave differently with another parent than with you? How?
3. How well does your child play with other children?
4. Do people enjoy spending time with your child?

**Family Adjustment and Well-being:**
1. What does your child like to do most with the family?
2. Who in your family does your child prefer being with?
3. How does your child get along with other family members?

#### POINTS OF OBSERVATION

### Strengths

**ATTACHMENT**
- Child tolerates periods of separation from parent
- Parent behaves and talks about child in generally positive ways
- Parent and child show pleasure in each other's company
- Child intermittently looks at or talks with parent while exploring
- Parent expresses pride in child's development

**INTERACTION**
- Child appears interested in adults and children around him/her
- Parent responds to child's needs or requests for comfort and care
- Parent sets reasonable limits on child's behavior, when necessary
- Child responds to parent's limit-setting
- Parent and child pay attention to each other's feelings and behaviors

**MASTERY**
- Parent encourages child's exploration and independence
- Parent appears capable of handling child's temper outbursts
- Child shows age-appropriate assertiveness
- Child appears to have good feelings about him/her
- Child talks clearly

**SUPPORT**
- Parent asks for help or information
- Parent is responsive to information, advice or other forms of help
- Parent appears rested and healthy
- Family appears and/or reports having adequate housing, transportation, finances and child care

### Concerns

**ATTACHMENT**
- Child clings excessively to parent
- Parent talks critically of and behaves negatively toward child
- Parent and child engage in frequent conflict or struggle
- Child does not look at or talk with parent while exploring, or refuses to leave parent's side
- Parent expresses disappointment or shows lack of interest in child's development

**INTERACTION**
- Child appears uninterested or avoids social contact with others
- Parent ignores or rejects child's needs or requests for comfort and care
- Parent sets no limits or sets limits which are too harsh
- Child ignores parent's limit-setting
- Parent and child remain distant and avoid emotional contact

**MASTERY**
- Parent resists or struggles with child's exploration and striving for independence
- Parent appears scared, overwhelmed by or punitive toward child's temper outbursts
- Child appears excessively angry, insistent, compliant or passive
- Child is self-abusive or withdrawn
- Child's speech is difficult to understand

**SUPPORT**
- Parent appears hesitant or unable to ask for help or information
- Parent rejects offers of help
- Parent appears overwhelmed, tired, stressed or unhealthy
- Family appears and/or reports to have inadequate housing, transportation, finances and child care

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## AIMS: Developmental Indicators of Emotional Health

### Guidelines for Psychosocial Practice: Focused Interview Questions

The following are Focused Interview Questions to Pursue Concerns or Obtain More Information About ATTACHMENT

### Any Age Child (0 - 5 years)
1. How would you describe your child at this age? Tell me what he/she is like.
2. Do you feel close to your baby/child? Do other family members feel close to the baby/child?
3. Do you worry about how you or anyone in the family feels about the baby/child?
4. How do you feel when you are away from your baby/child? How do you think your baby/child feels?
5. What things about your baby/child do you find most enjoyable? Least enjoyable?
6. Does the rest of the family enjoy this baby/child?
7. What is it like to be with your baby/child for hours at a time?

### Early Infancy Stage (2 weeks - 4 months)
1. How did you feel when you first saw your baby?
2. Are you troubled by anything that happened during your pregnancy or delivery?
3. Is the baby different from what you had imagined? In what ways?
4. Is it easy or hard to know what your baby wants?
5. How does your baby respond to being comforted by you?
6. Do you think your baby feels close to you?

### Infancy Stage (6 months - 1 year)
1. Is it easy or hard to know what your baby wants?
2. How does your baby respond to being comforted by you?
3. Do you think your baby feels close to you?
4. Does your baby seem to prefer you to others?
5. How does your baby's brother(s) and sister(s) get along with him/her?

### Toddler Stage (15 months - 2 years)
1. Is your child becoming sensitive to other family members' feelings? In what ways?
2. Does your child seem more independent than he/she used to? How does this affect you?
3. How do you feel you and your child are getting along?
4. How do your child's brother(s) and sister(s) get along with him/her?
5. Do you think your child's need for you is changing? How?
6. Are your expectations of your child changing? How?
7. Does your child feel secure in the family?

### Preschool Stage (3 years - 5 years)
1. Is it easy for your child to come to you with any questions?
2. Is your child becoming sensitive to other family members' feelings? In what ways?
3. How do you deal with your child's greater independence and those times when he/she has ideas different than yours?
4. How do you feel you and your child are getting along?
5. How do your child's brother(s) and sister(s) get along with him/her?
6. Does your child feel secure in the family?
7. Do you think your child's need for you is changing? How?
8. Are your expectations of your child changing? How?
### Any Age Child (0 - 5 years)

1. How does your baby/child let you know what he/she needs?
2. How does your baby/child tell you what he/she feels?
3. Do you and your baby/child have special routines for eating, naps, bath or bedtime that you both enjoy?
4. Do family members talk with one another about their interests and/or worries?

### Early Infancy Stage (2 weeks - 4 months)

1. When your baby gets fussy, what things work best to soothe him/her?
2. How are feedings going?
3. How do you get your baby to sleep?
4. Do you have time to enjoy your baby?
5. Do you and your baby enjoy "talking" together?
6. How involved is the baby's other parent in the baby's life?

### Infancy Stage (6 months - 1 year)

1. What do you do when your baby is irritable?
2. How are feedings going?
3. How do you get your baby to sleep?
4. Do you have time to enjoy your baby?
5. What do you and your baby most enjoy doing together? With other family members?
6. Do you and your baby enjoy "talking" together?
7. How involved is the baby's other parent in the baby's life?
8. What limit setting method do you use? How do they work with your child?
9. What do you and other family members do to help your child cope with frustration?
10. Does your baby laugh with you?
11. What games do you and your baby play?
12. Is your baby showing interest in other children?
13. How does your baby react to strangers?
14. What does your baby do when you show excitement about what he/she has done?

### Toddler Stage (15 months - 2 years)

1. Do you enjoy watching your child explore?
2. What do you and your child most enjoy doing together? With other family members?
3. Do you and your child enjoy "talking" together?
4. Does your child's other parent play an active role in your child's life? How?
5. What limit setting method do you use? How do they work with your child?
6. Do you see signs that your child is struggling with independence? Tell me about these struggles.
7. What do you and other family members do to encourage your child to do things on his/her own.
8. What do you do when your child gets angry or loses his/her temper?
9. Does your child enjoy being with other children? Are there opportunities for him/her to do so?
10. Does your child show you he/she cares or is aware of how you feel?
11. Does your child use some words to say what he/she wants?
12. If you ask your child simple questions, how does he/she answer you?

### Preschool Stage (3 years - 5 years)

1. What do you and your child most enjoy doing together? With other family members?
2. Does your child's other parent play an active role in your child's life? How?
3. What limit setting methods do you use? How do they work with your child?
4. Are you using any family rules with your child? What are they? How are they working?
5. Do you see signs that your child is struggling with independence? Tell me about these struggles.
6. What do you and other family members do to encourage your child to do things on his/her own.
7. What do you do when your child gets angry or loses his/her temper?
8. Does your child enjoy being with other children? Are there opportunities for him/her to do so?
9. What activities does your child like to do with other children?
10. Does your child show you he/she cares or is aware of how you feel?
11. Are you and your child usually able to avoid power struggles?

Continued on Reverse.
<table>
<thead>
<tr>
<th>Toddler Stage</th>
<th>Preschool Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(15 months - 2 years)</strong></td>
<td><strong>(3 years - 5 years)</strong></td>
</tr>
<tr>
<td>13. How do you and others in the family deal with your child's constant activity?</td>
<td>12. Do you and your child spend time talking together?</td>
</tr>
<tr>
<td>14. Are you and your child usually able to avoid power struggles?</td>
<td>13. Do you find it easy to be with your child?</td>
</tr>
<tr>
<td>15. How do you and your child work out problems?</td>
<td>14. Do you encourage your child's curiosity about things?</td>
</tr>
<tr>
<td>16. Can you and your child take turns when talking?</td>
<td>15. What do you do to help your child feel good about him/herself?</td>
</tr>
<tr>
<td>17. Does your child enjoy reading with you?</td>
<td>16. How do you and other family members help your child express his/her feelings?</td>
</tr>
<tr>
<td>18. How do you handle all of your child's questions?</td>
<td>17. Does your child participate in family traditions such as holidays and birthdays?</td>
</tr>
<tr>
<td>19. How does your child play with his/her brothers and sisters?</td>
<td>18. Do you invite your child to participate in family decisions?</td>
</tr>
<tr>
<td>21. Is it okay for your child to disagree with you or any other family members?</td>
<td>22. Does your child enjoy reading with you?</td>
</tr>
<tr>
<td>23. How do you and your child work out problems?</td>
<td>24. Is it okay for your child to disagree with you or any other family members?</td>
</tr>
</tbody>
</table>
**Focused Interview Questions**

The following are Focused Interview Questions to Pursue Concerns or Obtain More Information About MASTERY

### Any Age Child (0 - 5 years)

<table>
<thead>
<tr>
<th>Early Infancy Stage (2 weeks - 4 months)</th>
<th>Infancy Stage (6 months - 1 year)</th>
<th>Toddler Stage (15 months - 2 years)</th>
<th>Preschool Level (3 years - 5 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What things are most rewarding about being a parent? Most challenging? How do you cope with these challenges?</td>
<td>1. Is it easy or hard for you to figure out what your baby needs?</td>
<td>1. How does the child's other parent feel about being a parent?</td>
<td>1. Does your child feel proud of his/her new abilities and want you to praise him/her?</td>
</tr>
<tr>
<td>2. Do you and your baby's other parent talk about how to care for the baby?</td>
<td>2. Are you recovering from pregnancy and child birth?</td>
<td>2. Does your child feel proud of his/her new abilities and want you to praise him/her?</td>
<td>2. What kinds of routines has your family been able to create? Do all members of the family feel okay about these routines?</td>
</tr>
<tr>
<td>3. What things are you feeling confident about as a parent?</td>
<td>3. How does the baby's other parent feel about being a parent?</td>
<td>3. What kinds of routines has your family been able to create? Do all members of the family feel okay about these routines?</td>
<td>3. Does your child have temper tantrums? What happens? How do you feel? What is helpful?</td>
</tr>
<tr>
<td>4. What kinds of emotions do you see in your baby/child these days?</td>
<td>4. Does your baby feel proud of his/her new abilities and want you to praise him/her?</td>
<td>4. How does your child show his/her distress when he/she separates from you? How do you handle it?</td>
<td>4. Do you feel successful in setting clear and specific limits?</td>
</tr>
<tr>
<td>5. What kinds of responses do you have to your child's emotional outbursts? What are the other parent's responses?</td>
<td>5. What kinds of routines has your family been able to create? Do all members of the family feel okay about these routines?</td>
<td>5. What do you do when your child misbehaves?</td>
<td>5. What do you do when your child misbehaves?</td>
</tr>
<tr>
<td>8. Do you and your baby/child have fun together?</td>
<td>8. Do you feel successful in setting clear and specific limits?</td>
<td>8. Does your child show any interest in pretend play? Describe the play.</td>
<td>8. What can your child do for him/herself? How does this make you feel?</td>
</tr>
<tr>
<td>11. How does your baby settle him/herself down after being upset?</td>
<td>11. How are you handling your child's increasing mobility around the house?</td>
<td>11. How has your family adjusted to the more independent behavior of your child?</td>
<td>11. Is your child interested in other children? Does he/she have playmates?</td>
</tr>
<tr>
<td>12. Do family members understand your child's speech?</td>
<td></td>
<td></td>
<td>12. Do family members understand your child's speech?</td>
</tr>
</tbody>
</table>

Continued on Reverse.
| Toddler Stage  
(15 months - 2 years) | Preschool Level  
(3 years - 5 years) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Is your child able to spend any time playing alone?</td>
<td>13. How long is your child able to concentrate on an activity? Are you concerned about how long your child can attend to an activity?</td>
</tr>
<tr>
<td>13. How does your child settle him/herself down after being upset?</td>
<td></td>
</tr>
<tr>
<td>15. Do family members understand your child's speech?</td>
<td>15. How do you think your child feels about him/herself?</td>
</tr>
<tr>
<td>16. How long is your child able to concentrate on an activity? Are you concerned about how long your child can attend to an activity?</td>
<td>16. Does your child have little jobs to do? Does he/she like to do them?</td>
</tr>
<tr>
<td>17. Is your child able to follow directions?</td>
<td>17. Is your child able to take turns in talking and playing with others?</td>
</tr>
<tr>
<td>18. Is your child able to take turns in talking and playing with others?</td>
<td>19. Does your child show interest in learning? Is he/she ready for school?</td>
</tr>
<tr>
<td>19. Does your child show interest in learning? Is he/she ready for school?</td>
<td>20. Is your child able to “hold his/her own” with other kids?</td>
</tr>
<tr>
<td>20. Is your child able to “hold his/her own” with other kids?</td>
<td></td>
</tr>
</tbody>
</table>
AIMS: Developmental Indicators of Emotional Health

Guidelines for Psychosocial Practice: Focused Interview Questions

The following are Focused Interview Questions to Pursue Concerns or Obtain More Information About SOCIAL SUPPORT

Any Age Child
(0 - 5 years)

1. Are you getting help from the baby's other parent? Other family members? Friends?
2. Are you getting emotional support from your baby's other parent? Your own parents? Family? Friends?
3. Are you able to take care of your needs? Skills? Resources?
4. Are you getting enough rest?
5. Do you feel okay about asking for what you need?
6. Do you have someone reliable to care for your child when you need to go out?
7. Do you have the basic things that your family needs to get by (food, clothing, finances, shelter and transportation)?
8. Do the important people in your life tell you or make you feel like you are doing a good job as a parent?
9. Do you find time for yourself? Do you find time for other important relationships?
10. Do others share the tasks and responsibilities of parenting and housekeeping with you?
11. How helpful is the advice you get about raising your child? Can you tell others how to be more supportive to you?
12. Do you have enough fun with your friends?
13. Does your child turn to others for help and comfort?
14. Does your child have friends he/she plays with?
### Brief Interventions to Strengthen Attachment

#### Any Age Child (0-5 years)

<table>
<thead>
<tr>
<th>Early Infancy Stage (2 weeks - 4 months)</th>
<th>Infancy Stage (6 months - 1 year)</th>
<th>Toddler Stage (15 months - 2 years)</th>
<th>Preschool Stage (3 - 5 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Comment on specific qualities of the infant, pointing out to parent the baby’s capabilities (alertness, tracking, imitation, signs of interest).</td>
<td>1. Point out how important (irreplaceable) parent is to this baby.</td>
<td>1. Point out how important parent continues to be to the child, as the child becomes more self-sufficient.</td>
<td>1. Point out how important parent continues to be to the child, as the child becomes more self-sufficient.</td>
</tr>
<tr>
<td>2. Congratulate parent on the birth.</td>
<td>2. Point out that parent already knows and understands a lot about her/his baby.</td>
<td>2. Point out ways in which parent knows child’s unique style or temperament.</td>
<td>2. Point out ways in which parent accepts the child’s unique style or temperament.</td>
</tr>
<tr>
<td>3. Acknowledge the first several months as a special &quot;getting acquainted&quot; time for baby and parent.</td>
<td>3. Reassure parent that it is normal to find parenting confusing, difficult and challenging at times.</td>
<td>3. Explain that it is normal for parent to feel frustration and some angry feelings with their growing child.</td>
<td>3. Explain that it is normal for parent to feel frustration and some angry feelings with their growing child.</td>
</tr>
<tr>
<td>4. Confirm parent’s positive feelings about baby; acknowledge the normalcy of some negative or ambivalent feelings.</td>
<td>4. Reassure that it is okay for babies to have strong preferences for certain people.</td>
<td>4. Help parent understand that she/he may experience a sense of loss as her/his child becomes more independent.</td>
<td>4. Help parent understand that she/he may experience a sense of loss as her/his child becomes more independent.</td>
</tr>
<tr>
<td>5. Point out that babies who feel securely attached to someone are able to confidently explore the world.</td>
<td>5. Point out that babies who feel securely attached to someone are able to confidently explore the world.</td>
<td>5. Share your observations about the child’s social and communication skills and compliment parent.</td>
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</tr>
<tr>
<td>6. Explain that baby’s fear of strangers or difficulty letting parent leave her/him is a sign of a strong attachment to parent; explain such separation anxiety is normal.</td>
<td>6. Reassure that it is okay for children to have strong preferences for certain people.</td>
<td>6. Explain that parent may see a broader range of behaviors as her/his child interacts with other children.</td>
<td>6. Explain that parent may see a broader range of behaviors as her/his child interacts with other children.</td>
</tr>
<tr>
<td>7. Congratulate parent on getting through the first few months.</td>
<td>7. Point out that children who feel securely attached to someone are able to confidently explore the world.</td>
<td>7. Point out how child’s increased independence and security will help in transition to school.</td>
<td>7. Point out how child’s increased independence and security will help in transition to school.</td>
</tr>
<tr>
<td>8. Congratulate parent on arrival of child’s first birthday.</td>
<td>8. Explain that child’s fear of strangers or difficulty letting parent leave her/him is a sign of a strong attachment to parent; explain such separation anxiety is normal.</td>
<td>8. Explain that some children have difficulty leaving home and adjusting to school schedule.</td>
<td>8. Explain that some children have difficulty leaving home and adjusting to school schedule.</td>
</tr>
<tr>
<td>9. Comment on how proud the parent must be to see the baby/child doing so well.</td>
<td>9. Congratulate parent on the birth.</td>
<td>9. Encourage parent to be supportive and assist her/his child with this transition to school.</td>
<td>9. Encourage parent to be supportive and assist her/his child with this transition to school.</td>
</tr>
</tbody>
</table>

**AIMS: Developmental Indicators of Emotional Health Guidelines for Psychosocial Practice**
**AIMS: Developmental Indicators of Emotional Health**

**Guidelines for Psychosocial Practice**

The following are Brief Interventions Which Can Help

<table>
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<tr>
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<tbody>
<tr>
<td>1. Point out that parent seems to be under stress; clarify the issue and suggest ways of lessening the stress.</td>
<td>1. Ask if parent has found it difficult to adjust to the baby.</td>
<td>1. Ask if the baby is more difficult to care for than anticipated.</td>
<td>1. Acknowledge the challenge of dealing with a preschooler’s independence and assertiveness.</td>
<td>1. Discuss with parent her/his feelings about child starting school and/or growing up.</td>
</tr>
<tr>
<td>2. Ask if parent is finding it difficult to be the kind of parent she/he wants to be.</td>
<td>2. Suggest that it is normal for parents of newborns to need some time to get themselves and the baby settled.</td>
<td>2. Encourage parent to frequently hold baby, talk to the baby, and watch carefully to learn more about baby as an individual.</td>
<td>2. Discuss with parent her/his feelings about child starting school and/or growing up.</td>
<td></td>
</tr>
<tr>
<td>3. After pointing out things that are going well, ask whether there may be a problem with how the parent feels about the baby/child. Acknowledge the parent’s feelings and support her/him in working toward resolution.</td>
<td>3. Discuss the importance of getting to know her/his unique baby (e.g., temperament and style of communicating).</td>
<td>3. Explain that most new parents feel some difficult emotions; determine if parent still feels more or less overwhelmed now compared to a few months ago.</td>
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<td></td>
</tr>
<tr>
<td>4. State that there are ways to help parents deal with difficult feelings about children or families. Talk about these feelings and provide support. Encourage parent to seek ways of sharing their difficult feelings with helpful adults.</td>
<td>4. Allow parent to discuss her/his feelings; discern unusual postpartum depression, extraordinary family stress, unresolved birth trauma or extremely negative perceptions of infant.</td>
<td></td>
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<tr>
<td>5. Explain that current or previous life stresses can often affect relationships with children.</td>
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<tr>
<td>6. Consider making a referral for further evaluation/services.</td>
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</tr>
</tbody>
</table>
## AIMS: Developmental Indicators of Emotional Health

### Guidelines for Psychosocial Practice

**BRIEF INTERVENTIONS TO FACILITATE INTERACTION**

### Any Age Child (0-5 years)

1. Point out when parent's expectations are developmentally appropriate.
2. Point out when parent listens and responds well to the child's communications.
3. Talk with parent about normal child development in a reassuring way.
4. Assume that parent wants to be an effective parent; convey this in your comments.
5. All parents can learn to be good parents. It does not necessarily come naturally. Convey this in your comments.
6. Discuss how children's behavior impacts parents and vice versa.
7. Encourage the parent to communicate at child's developmental level.

### Early Infancy Stage (2 weeks - 4 months)

1. Encourage parents to read and view materials on child development to learn more about their own baby's temperament and capabilities.
2. Discuss how parents and baby interact at this developmental age. Comment on how these early interactions teach the baby about relationships.
3. Interpret baby's behavior; suggest what baby might be communicating by certain behavior.
4. Explain that infants usually need a lot of holding and warm contact at this period and that this will not spoil them.
5. Talk to parent about the importance of respecting the baby's feelings, especially at times when baby is crying from frustration or anger.
6. Comment on the different styles that mothers and fathers often use with their baby; one parent may stimulate while the other may calm and console.
7. Reassure that parents will not always feel confident in the early weeks that they know what the baby needs. This early period is a time when confidence is being established.

### Infancy Stage (6 months - 1 year)

1. Interpret baby's behavior; suggest what baby might be communicating by certain behavior.
2. Ask what parent's wishes are for child. Point out the parent's interactions which help the baby to reach these goals.
3. Encourage parent to frequently hold and talk to baby and learn about the baby as an individual.
4. Provide information about baby's unique temperament and the "fit" between parent's and child's personalities.
5. Talk to parent about the importance of respecting the baby's feelings, especially at times when baby is crying from frustration or anger.
6. Encourage parent to provide times of undivided attention to baby. This helps the baby to lower his/her demands on the parent.

### Toddler Stage (15 months - 2 years)

1. Ask what parent's wishes are for child. Point out the parent's interactions which help the baby to reach these goals.
2. Point out the importance of listening to what the child is communicating about his/her feelings during a tantrum or outburst.
3. Discuss the importance of consistent, clear and age-appropriate limits on child's behavior.
4. Remind parent that praise and positive reinforcement work, and that children generally want to please their parents.
5. Encourage parent to communicate to the child their own feelings and expectations.
6. Explain that children need to test limits and rules in order to learn about themselves and their world.
7. Encourage parent to find ways for child to play safely without parent's constant attention.
8. Help parents to understand the stress felt by older sibling living with a toddler.
9. Remind parent that toddlers cannot be expected to behave perfectly all the time.
10. Educate and support parent's efforts to deal with child's increasing autonomy.

### Preschool Stage (3 - 5 years)

1. Point out the importance of listening to what the child is communicating about his/her feelings during a tantrum or outburst.
2. Reassure parent that limit-setting can be frustrating. Discuss the importance of consistent, clear and firm limits.
3. Remind parent that praise and positive reinforcement work, and that children generally want to please their parents.
4. Encourage parent to communicate to the child their own feelings and expectations.
5. Explain that children need to test limits and rules in order to learn about themselves and their world.
6. Explain that parents need to help children learn to play with others.
7. Encourage parents to give children choices.
8. Educate and support parent's efforts to deal with child's increasing autonomy.
9. Encourage parent to talk with his/her child.
# Brief Interventions

## AIMS: Developmental Indicators of Emotional Health

### Guidelines for Psychosocial Practice

The following are Brief Interventions Which Can Help

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<tr>
<td>1. Point out that it is important to balance the child's needs with those of the parent and the whole family.</td>
<td>1. Acknowledge that parents want positive interactions with their baby.</td>
<td>1. Acknowledge that parents want positive interactions with their baby.</td>
<td>1. Reassure that most parents find young children demanding and challenging at times.</td>
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</tr>
<tr>
<td>2. Acknowledge parent's feelings. Explain that it is normal for parents to have strong and mixed feelings. Encourage parent to find healthy ways to express her/himself.</td>
<td>2. Explain the importance of recognizing and responding to the child's frustrations, to help the child learn effective problem-solving.</td>
<td>3. Suggest that calmness and an accepting attitude are most helpful when dealing with children's behavior.</td>
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<td>3. Suggest that calmness and an accepting attitude are most helpful when dealing with children's behavior.</td>
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<tr>
<td>3. Reassure that most parents benefit from learning more effective ways of talking to, teaching, or setting limits with their child. Brainstorm ways of meeting needs and searching for solutions to particular situations.</td>
<td>4. Talk with parent about any concerns or power struggles he/she might be having with his/her preschooler.</td>
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<tr>
<td>5. Maintain a positive and supportive attitude with the parent and the child.</td>
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</tbody>
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## AIMS: Developmental Indicators of Emotional Health

### Guidelines for Psychosocial Practice:

### BRIEF INTERVENTIONS TO ENHANCE MASTERY

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<tbody>
<tr>
<td>1. Point out ways parent is doing an effective job.</td>
<td>1. Encourage parent to appreciate his/her baby’s unique style and pace of development.</td>
<td>1. Encourage parent to appreciate his/her baby’s unique style and pace of development.</td>
<td>1. Discuss parent’s perceptions of his/her own skills and strengths as parent.</td>
<td>1. Discuss parent’s perceptions of his/her own skills and strengths as parent.</td>
</tr>
<tr>
<td>2. Comment on how well the child is doing. Comment the parent and encourage him/her to have pride in his/her parenting.</td>
<td>2. Point out how parent’s skills have grown and confidence increased.</td>
<td>2. Point out how parent’s skills have grown and confidence increased.</td>
<td>2. Remind parent that toddlerhood can be a time of rapid changes; both the child and the parent will discover new knowledge and feelings.</td>
<td>2. Help parent recognize that it takes time for his/her child to develop internal emotional and behavioral control.</td>
</tr>
<tr>
<td>3. Reassure parent that there is no one right way of doing things. Point out that it takes time to learn what works effectively with his/her child’s style and unique needs.</td>
<td>3. Reassure parent about challenges he/she will face as child enters new stages. Discuss stages of child development.</td>
<td>3. Help parent recognize that it takes time for his/her child to develop internal emotional and behavioral control.</td>
<td>3. Point out the importance of continuing a balance between the child’s need for independence and the parent’s need to ensure safety.</td>
<td>3. Point out the importance of continuing a balance between the child’s need for independence and the parent’s need to ensure safety.</td>
</tr>
<tr>
<td>4. Explain that parenting is a process that requires patience and flexibility with self and child; point out how parent shows this.</td>
<td>4. Point out the importance of continuing a balance between the child’s need for independence and the parent’s need to ensure safety.</td>
<td>4. Talk with child about how well he/she is doing.</td>
<td>4. Talk with child about how well he/she is doing.</td>
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</tr>
<tr>
<td>5. Reassure parent about challenges he/she will face as child enters new stages. Discuss stages of child development.</td>
<td>5. Point out that toddlers are not able to understand the concept of sharing and parents will have to play a mediating role.</td>
<td>5. Help parent recognize the patterns and understand the meanings of child’s outbursts.</td>
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**AIMS: Developmental Indicators of Emotional Health**

**Guidelines for Psychosocial Practice**

The following are Brief Interventions Which Can Help

## Brief Interventions

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<tbody>
<tr>
<td>1. Identify with parent the overwhelming pressures of having a newborn.</td>
<td>1. Ask if parent is feeling overwhelmed. 2. Ask if there are areas in which the parent wants to gain more confidence and feel more competent with his/her parenting.</td>
<td>1. Ask parent if there are power struggles with his/her child. Encourage parent to explore his/her own feelings about these struggles.</td>
<td>1. Ask if there are areas in which the parent wants to gain more confidence and feel more competent with his/her parenting.</td>
</tr>
<tr>
<td>2. Ask if parent is feeling overwhelmed.</td>
<td>2. Ask if there are areas in which the parent wants to gain more confidence and feel more competent with his/her parenting.</td>
<td>2. Ask parent if there are power struggles with his/her child. Encourage parent to explore his/her own feelings about these struggles.</td>
<td>2. Ask if there are areas in which the parent wants to gain more confidence and feel more competent with his/her parenting.</td>
</tr>
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</table>

### Any Age Child (0-5 years)

1. Explore parent's need with parent and suggest possible solutions to resolve difficulties in a gradual, step-by-step manner.

2. Ask parent how she/he is feeling. If evident, point out obstacles to parental self-esteem or other coping resources. Explore ways parent can feel better about herself.

3. Suggest reading materials or other sources of information for parent to learn more about child development and/or parenting.

4. Suggest ways to resolve particular problems, taking one step at a time. Encourage parent to keep in touch and schedule a follow-up visit.

5. Explain that experiences from parents' own background often influence their feelings and behaviors toward their child(ren); encourage parent to talk about those feelings.

6. Consider making a referral for further evaluation/services.

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8/17/90

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Guidelines for Psychosocial Practice

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<table>
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<tr>
<th>To Promote Use of Social Supports</th>
<th>To Discuss Concerns about Social Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Any Age Child</strong> (0 - 5 Years)</td>
<td><strong>Any Age Child</strong> (0 - 5 Years)</td>
</tr>
<tr>
<td>1. Suggest community or professional services or benefits which might fill a need.</td>
<td>1. Acknowledge any apparent sense of isolation and explore ways to overcome this.</td>
</tr>
<tr>
<td>2. Suggest readings or other helpful materials about stress and the importance of getting social support.</td>
<td>2. Talk about the impact of stress on family life; encourage parent or family members to get the support and/or help they need from family, friends or professionals.</td>
</tr>
<tr>
<td>3. Encourage parents to get emotional support from other parents, friends, or family.</td>
<td>3. Discuss strategies other families have found helpful in dealing with difficulties.</td>
</tr>
<tr>
<td>4. Encourage parent to share feelings with close friends and family.</td>
<td>4. Help parent not see her/his situation as failure and look at getting outside help as a support.</td>
</tr>
<tr>
<td>5. Reassure parent that every family needs outside help once in a while.</td>
<td>5. Consider making a referral for extended evaluation/services.</td>
</tr>
<tr>
<td>6. Encourage parent to take care of own personal needs, including recreation, hobbies, and social activities. Help parent find ways to set aside some time each day for this activity.</td>
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</tbody>
</table>
Screening and Assessment Instruments
Reviewed by Project AIMS
Screening and Assessment Instruments Reviewed by Project AIMS

April, 1988

ACQ Behavior Checklist
Abuse and Neglect Indicators and Index
Adult-Adolescent Parenting Index
Attachment Assessment Form
Bayley Scales of Infant Development (1969)
Birth to Three Developmental Scale
Borgess Interaction Assessment
Brazelton Neonatal Behavior Assessment Scale (1973)
Brigance Diagnostic Inventory of Early Development (1978)
Broussard Neonatal Perception Inventory (1971)
Carey Infant Temperament Questionnaire (1977)
Carey Toddler Temperament Questionnaire (1978)
Carolina Record on Individual Behavior (CRIB)
Child Abuse Potential Inventory Form (CAP)
Child Abuse/Neglect Risk List for Infants and Toddlers
Child Behavior Checklist
Child Development Scale
Child Expectation Scale
Child Rearing and Education Instrument
Child Well Being Scales
Childrearing Scale
Communicative Evaluation Chart, from Infancy to Five Years
Coopersmith Self Esteem Inventory
Coping Questionnaire
Denver Developmental Screening Test (1973)
Denver Developmental Screening Test Revised (1981)
Denver Prescreening Developmental Questionnaire (PDQ)
Developmental Activities Screening Inventories (DASI-II)
Developmental Therapy Objectives Rating Form
Early Coping Inventory
Early Learning Accomplishment Profile (Early-LAP) (1978)
Eco-analysis of Family Functioning (1985)
Environmental Prelanguage Battery (EP3)
Family APGAR
Family Adaptability Cohesion Evaluation Scale (FACES)
Family Adaptability and Cohesion Evaluation Scales (FACES III)
Family Assessment Device (FAD)
Family Assessment Scale
Family Assessment Scales (1985)
Family Awareness Scale
Family Centered Assessment (1985)
Family Crisis Oriented Personal Scales (F-COPES)
Family Functioning Rating Scale
Family Needs Scale
Family Problem List
Family Relations Indicator
Family Resource Scale
Family Responsibility Checklist
Family Support Scale
Family and Community Functioning
First Year Parent Interview
Flint Infant Security Scale (1983)
Greenspan Emotional Health Checklist:
Hawaiian Early Learning Profile (HELP) (1979)
Health and Well Being Index
High Priority Infant Program Home Visit Worksheet (North Carolina)
Home Observation for Measurement of the Environment (HOME) (1978)
Home Screening Questionnaire (HSQ) (1981)
Humanics National Child Assessment Form
ISIS Reciprocal Category System. (1970)
Index of Parental Attitudes
Infant Monitoring Questionnaire for At Risk Infants
Infant Rapid Screen (IRS)
Instrument for Systemic Assessment of Parent Attachment Behaviors
Interaction Rating Scale (IRS) (1980)
Inventory of Parents Experiences
Inventory of Social Support
Kent Infant Development Scale (KIDS) (1980)
Lexington Developmental Scales
Life Satisfaction Scale
Maine 0-3 Preventive Intervention Risk Screening and Family Assessment (1986)
Massie-Campbell Scale of Mother-Infant Attachment Indicators During Stress (AIDS) (1977)
Maternal Developmental Expectations and Childrearing Attitudes Scale (MDECAS) (1980)
Maternal Effectiveness Scale
Minnesota Child Development Inventory (MCDI) (1974)
Minnesota Infant Development Inventory (MIDI) (1980)
Mother-Child Interaction Coding Schema (1977)
NCAST Teaching and Feeding Scales (1978)
Objectives/Problems Checklist for Infancy Programs (Tableman)
Observation Scale for Assessing Family Empowerment
Observation of Parent-child Interaction
Parent Assessment of Needs (PAN) (1986)
Parent Behavior Progression (PBP)
Parent Child Observation Guides (Ounce of Prevention)
Parent Questionnaire
Parent Self-Awareness Scale
Parent as Teacher
Parental Questionnaire of Infant Temperament
Parenting Stress Index (PSI)
Perceived Social Support Measures
Peri-natal Anxieties and Attitudes Scale (PAAS) (1980)
Personal Network Matrix
Personal Well Being Index
Preschool Attainment Record (PAR)
Preschool Behavior Checklist
Preschool Behavior Rating Scale (1980)
Receptive-Expressive Emergent Language Scale (REEL)
Resource Scale for Teenage Mothers
Revised Attachment-Separation-Individuation (ASI)
Rochester Adaptive Behavior Inventory (PABI)
SEED
Self Report Family Instrument
Self-Rating Depression Scale (1974)
Sensory Motor Questionnaire
Social Support Inventories
Stress, Support and Family Functioning Interview Schedule
Support Functions Scale
Syracuse Scales of Infant Development and Home Observation
Test of Early Socioemotional Development (TOESED)
Texas Preschool Screening Inventory (TPSI)
Toddler Care Questionnaire
Uniform Performance Assessment System (UPAS)
Uzgiris and Hunt Scales Of Infant Psychological Development (1980)
Vineland Adaptive Behavior Scales
Vineland Social Maturity Scale
Yale Inventories of Development
### Selected Assessments Addressing Early Social and Emotional Development

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<thead>
<tr>
<th>Assessment/Ordering Information</th>
<th>Age Range/Type</th>
<th>Dimensions</th>
<th>Procedures</th>
<th>Comments/Who can administer</th>
</tr>
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</table>
| **AIMS: Developmental Indicators of Emotional Health**  
Project AIMS  
Human Services Developmental Institute  
University of Southern Maine  
96 Palomar Street  
Portland, ME 04103  
(207) 780-4430 | 2 wks - 5 yrs  
Questionnaire Interview Observation | 1) Attachment  
2) Interaction  
3) Mastery  
4) Support | 1) Intake Forms:  
Family Information form (background)  
Family Concerns Indicator (stress inventory)  
2) Parent Questionnaires  
3) General questions and points of observation guidelines  
4) Focus interview questions and brief interventions | AIMS is a system of practice to aide professionals to:  
1) identify strengths in four areas of emotional health,  
2) to identify possible concerns in the development and emotional health of children,  
3) to facilitate dialogue between parents and professional service providers to promote emotional health.  
References: Partridge (1990) |
| **Bayley Infant Behavior Record**  
Bayley Scales of Infant Development  
The Psychological Corporation  
555 Academic Court  
San Antonio, TX 78204  
1-800-233-5682 | Birth - 2 1/2 yrs.  
Observational screening | The Bayley Infant Behavior Record is part of the Bayley Scales. The IBR is rated through the observation made during the administration of the Bayley Scales. Areas include:  
1) Attitudes  
2) Interests  
3) Emotions  
4) Energy  
5) Activity  
6) Whether the child approaches or withdraws from stimulation | A component of the Bayley; it can be used as a psychosocial screening instrument to identify children at risk.  
(See description of the Carolina Record of Individual Behavior CRIB, which is an adaptation and extension of the IBR.)  
References: Mosane, Kalmanson, Flick, Glazewski, & Sillari (1990) |
| **Borgess Interaction Assessment**  
Michigan Department of Mental Health Prevention, Demonstration and Services Research Division  
Lewis Cass Building - 3rd Floor  
Lansing, MI 48913  
(517) 373-5627  
(Training program $130.00) | Post-partum  
Screening checklist | The BIA has 3 parts:  
1) Situational factors covering infant's vulnerability, experiences of the mother which may impair attachment, potential stressors which could impair nurturance.  
2) Observation of interactions after delivery (7 items) covering exploratory, physical, verbal and visual, paralleling and nurturing responses.  
3) Observation of interactions during the hospital stay (12 items). | Post-partum observational rating scale of mother-infant interaction to identify infants at risk for:  
- child abuse/neglect  
- social adjustment problems  
- emotional difficulties  
- cognitive delays  
Can be administered by trained personnel such as nurses, social workers, and other infant health professionals. Videotape training package available.  
Validated as predictive of parent-infant interaction at one year; used in Michigan for in-hospital screening and referral.  
References: Weatherston & Tableman (1989) |
<table>
<thead>
<tr>
<th>Assessment/Ordering Information</th>
<th>Age/Range/Type</th>
<th>Dimensions</th>
<th>Procedures</th>
<th>Comments/Who can administer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carolina Record of Infant Behavior (CRIB)</td>
<td>birth - 24 mos. or any child functioning within the sensorimotor level</td>
<td>The CRIB measures: 1) activity/arousal level. 2) social orientation, participation, fearfulness, endurance, communication-expressive, communication-receptive, object orientation, and consolability. 3) activity, reactivity, goal directedness, response to frustration, attention span, responsiveness to caretaker, postural tone, responsiveness to examiner. 5) preverbal communication, rhythmic habit patterns, play/self-recognition/attachment.</td>
<td>The CRIB may be completed in one of two ways: 1) It can be completed immediately following the administration of a developmental assessment instrument. 2) It may also be completed immediately following an extensive period (minimum 60 min.) of observation and/or interaction with the child in a setting permitting a display of various behaviors. Behaviors must be observed rather than inferred.</td>
<td>The CRIB was designed to be used by individuals involved in the provision of service to young children. It may be completed by anyone who has familiarized themselves with the CRIB. It is recommended that persons document interrater reliability with a training video tape or with another person who has established reliability as a rater.</td>
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<tr>
<td>Early Coping Inventory</td>
<td>4 mos.-36 mos.</td>
<td>1) Sensorimotor organization 2) Reactive behavior 3) Self-initiated behavior</td>
<td>Observation instrument that assess coping-related behaviors that a child uses to manage the routines, opportunities, challenges, and frustrations encountered in daily living. A five-point rating scale is used.</td>
<td>Authors note that repeated observations in different situations are needed before rating a child and that the specific behaviors a child uses in a coping effort may vary at different stages of development. Assists in looking at what infant brings to the mother-infant interaction. References: Williamson &amp; Zetlin (1990)</td>
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<tr>
<td>The Five P's Variety Pre-Schooler's Workshop</td>
<td>Children with learning, language and behavior problems functioning between 6 and 60 months</td>
<td>Six categories of behaviors are assessed: 1) classroom adjustment 2) self help (toileting and hygiene, mealtime behaviors, dressing) 3) language (communication competence, receptive language, expressive language) 4) social (emerging self, relationship to adults, relationships to children)</td>
<td>All scales with the exception of the Classroom Adjustment Scale are completed by the teacher and the parent in their respective settings. Parents and teachers independently complete their ratings on the scales over a two to four week observation period in the fall and spring (six-month interval). Behaviors are rated as: Y=yes S=sometimes N=no</td>
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References: Williamson & Zetlin (1990)
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</thead>
<tbody>
<tr>
<td>HOME Observation for Measurement of the Environment</td>
<td>Birth - 3yrs</td>
<td>Designed to sample the quantity and quality of social, emotional and cognitive support available to young children in their homes. Birth - 3yrs: 1) emotional and verbal responsivity of mother 2) avoidance of restriction and punishment 3) organization of physical and temporal punishment 4) provision of appropriate play material 5) maternal involvement with child 6) opportunities for variety in daily stimulation.</td>
<td>Detailed instructions for administration are given in the manual and little subjective judgement is required for evaluation. Probably can be administered by a wide variety of personnel.</td>
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<tr>
<td>Michigan Infant History and Needs Assessment Form</td>
<td>Infancy (no age given)</td>
<td>Information from questions and observations focusing on: 1) Infant 2) Parent as caregiver 3) Parent-infant relationship 4) Environment 5) Family context 6) Family therapies/issues 7) Parental history 8) Family culture</td>
<td>A series of questions that are intended to guide the interventionist in her work with families. Answers to the questions come through observations, specific information may also be requested of the parent.</td>
<td>More of a clinical practice guide than an assessment.</td>
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<tr>
<td>MICS Mother/Infant Communication Screening</td>
<td>Infancy</td>
<td>1) Language and Synchrony 2) Distress 3) Feeding 4) Play/Neutral State 5) Rest</td>
<td>Observational screening designed to identify mother-infant dyads at risk for disorders of communication. A referral score on MICS only indicates need for additional assessment, preventative programs, and/or for early intervention.</td>
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<tr>
<td>NCAST Teaching and Feeding Scales</td>
<td>Parent;</td>
<td>1) Sensitivity to cues 2) Response to distress 3) Social-emotional growth fostering</td>
<td>Structured observation of feeding and teaching episodes between mother and infant.</td>
<td>Persons must be trained by NCAST to be certified in using these scales. Training involves observation of behaviors and gaining reliability in the use of the scales.</td>
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<tr>
<td>Nursing Child Assessment Satellite Training</td>
<td>Parent:</td>
<td>4) Clarity of cues 5) Responsiveness to parent</td>
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<td>Symptom Checklist (continued)</td>
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<td>traditional developmental tests in conjunction with observational tools that assess sustained attention, parent-child interactions and sensory processing and reactivity. In this case, the Symptom Checklist is useful in validating clinical observations.</td>
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<tr>
<td>Vineland Adaptive Behavior Scales</td>
<td>Birth - Adulthood</td>
<td>Domains: 1) Communication 2) Socialization (interpersonal relationships, play and leisure time, coping skills) 3) Daily living skills (personal, domestic, community) 4) Motor skills (gross and fine) Optional maladaptive behavior domain (for those 5 years and older) is included on the survey and expanded forms.</td>
<td>There are three versions of the test: Survey Form, Expanded Form and Classroom Form.</td>
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<tr>
<td>American Guidance Service</td>
<td>REVISED</td>
<td></td>
<td></td>
<td>The purpose of this assessment is to assess overlevels of functioning, areas of strength and limitations, monitor progress following program changes, and develop long and short term goals.</td>
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<td>Publisher's Building</td>
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<td>Circle Pines, MN 55014-1796</td>
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<td>Wisconsin Behavior Rating Scale</td>
<td>Birth - 3 years (standardization based on persons who were profoundly mentally disabled functioning in the birth-3 range)</td>
<td>Provides a measure of adaptive behavior for developmental levels from birth to 3 years. Subscales: 1) gross motor 2) fine motor 3) expressive language 4) receptive language 5) play skills 6) socialization 7) domestic activities 8) eating 9) toileting 10) dressing 11) grooming</td>
<td>The scale is completed by a professional familiar with client's behaviors. Direct testing is not necessary.</td>
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<td>Central Wisconsin Center for the Developmentally Disabled</td>
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<td>317 Kнутson Drive</td>
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<td>Madison, WI 53704</td>
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