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**INFANT MENTAL HEALTH PROGRAMS:  
EXPERIMENTING WITH INNOVATIVE MODELS—  
ONE CENTER'S EXPERIENCE WITH NEW  
PROGRAM FUNDING**

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**ABSTRACT:** This article describes one child and family treatment center's process of creating a long-awaited, new infant/child early intervention program. An experimental service model is discussed in the context of the need for empirically validated assessment and intervention for very young clients in high-risk families. Case examples and illustrations of service flow are provided. Some features of this program, such as the fact that it was set up for a seamless transition to a treatment research project, are highlighted.

**RESUMEN:** Este artículo describe un proceso en un centro de tratamiento para el niño y la familia, por medio del cual se crea un programa de intervención en los casos de una larga espera por un hijo/infante. Se discute un modelo experimental de servicio dentro del contexto de la necesidad de una evaluación e intervención empíricamente válida para clientes jóvenes que pertenecen a familias de alto riesgo. Se incluyen ejemplos de casos e ilustraciones del curso del servicio. Se subrayan algunas características de este programa, como por ejemplo el hecho de que el mismo fue puesto en marcha con el fin de tener una transición sin barreras hacia el proyecto de investigación.

**RÉSUMÉ:** Cet article décrit un centre de traitement de l'enfant et de la famille et son procédé afin de créer un nouveau programme d'intervention nourrisson/enfant que l'on attendait depuis longtemps. Un modèle de service expérimental est discuté dans le contexte du besoin d'évaluation et d'intervention empiriquement validées pour de très jeunes clients issus de familles à haut risque. Des exemples de cas, et des illustrations du flot au sein du service sont offerts. Quelques traits caractéristiques de ce programme, tel que le fait qu'il fut établi pour effectuer une transition facile avec un projet de recherche sur le traitement, sont mis en valeur.

**ZUSAMMENFASSUNG:** Dieser Artikel beschreibt den Prozess der Einführung eines lang erwarteten Interventionsprogramms in einem Kind- und Familienbehandlungszentrum. Es wird ein experimentelles Leistungsprofil beschrieben, das die Bedürfnisse eines empirisch überprüfbar Services für sehr junge Klienten

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ten von Hochrisikofamilien erfüllt. Fallbeispiele und Verlauf werden beschrieben. Eigenheiten dieses Programms werden hervorgehoben, etwa dass es für den reibungslosen Übergang zu einem Forschungsprojekt über Therapie geplant war.

抄録：この論文では、長い間待たれていた乳幼児早期介入プログラムを創り出す、一つの子どもと家族治療センターのプロセスを記述する。リスクの高い家族の中の非常に幼いクライアントのための、経験的に認証された評価と介入の必要性という文脈で、実験的なサービスモデルが議論される。症例とサービスの流れの実例が提供される。プログラムは治療研究プロジェクトへの継ぎ目のない移行のために作られたという事実のような、このプログラムのいくつかの特徴が強調された。

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In January 2002 as part of a major province-wide initiative, Aisling Discoveries Child and Family Centre in Toronto, like a number of other children's mental health facilities in Ontario, received long-awaited funding for an all-new treatment program for families of young children under 6 years of age. Our province had decided to act on the recommendations of a well-publicized "Early Years Study" (McCain & Mustard, 1999), authored by two long-time advocates of early intervention. This occasion presented both an opportunity and a challenge to all recipient centers. As the child psychologist and manager to whom this new program was assigned, I will describe where this challenge took us.

#### **SOME BACKGROUND: OUR NEIGHBORHOOD AND FACILITY**

Aisling Discoveries Child and Family Centre is a multiservice child and family agency that provides children's mental health services and programs to support the healthy development of children in the communities of Scarborough and East York in the city of Toronto. These areas of our city welcome a large percentage of new immigrants, and include many low socio-economic neighborhoods. Statistics Canada (2001) census data indicate that about 38% of Scarborough residents report a mother tongue other than English, 50% belong to a visible minority group, and 58% are first generation Canadians. Furthermore, about 24% of all families in this area of the city are headed by a single parent, with more than 40% of adults reporting less than a high-school education. Finally, 24% of families are subsisting below the so-called poverty level, with over 40% declaring household incomes of less than \$Can 40,000 (Statistics Canada, 2001). Clearly, numerous families in this district are dealing with well-known risk factors in children's mental health.

Our center offers many different types of assistance, from community-based prevention programs to intensive treatment programs. Home visiting for new parents, school and child-care consultation, intensive behavior intervention, family counseling, sexual abuse treatment, and a residential program are but a few of the services that are offered free of charge to families with children from birth to 12 years of age.

#### **PARAMETERS FOR THE NEW PROGRAM**

First, in setting up this new program, we needed to operate within clear parameters set by our funder, the Ontario Ministry for Community, Family and Children's Services. The mandate was to create a comprehensive, strength-based and highly accessible program for children—

birth to 6 years old—who were experiencing identifiable difficulties. It was clear that this was not to be a prevention program but rather a focused early intervention initiative.

Next, and no less importantly, the goals for our new program, eventually named *Infant Child Treatment (ICT)*, needed to be in line with the Centre’s philosophy. Thus, the ICT service had to strive to strengthen the healthy social and emotional development of infants and children in partnership with their families and communities, to offer family-focused, multidisciplinary mental health assessment and treatment services, and to ensure that all services were inclusive and easily accessible to families living in our target district. The menu of services needed to be appropriate for all stakeholders in our very multicultural and diverse community. Services had to be provided in a language understood by the family, either in the center, home, or community at a time convenient for the family, evenings and weekends included. Much like for all our other programs, we also saw the necessity for an offering of relatively short-term assessment and intervention to address issues of sustainability. As well, to create continuity of service through the child and family’s developmental phases was deemed important for a smooth transition from “infant treatment” to “preschool intervention,” if required. Finally, there had to be a strong commitment to so-called “evidence-based” practice and to continuous evaluation of the effectiveness of interventions provided. As a psychologist, and an active member of a provincial committee concerned with the question of knowledge transfer in children’s mental health, I lobbied for the use of empirically validated assessments and interventions as well as the inclusion of a research and evaluation component. Regrettably, but not surprisingly, no financial support was built into the funding formula for that latter element of the program; this would have to be obtained through alternate sources.

### TARGET POPULATION

Based on mandate, informal needs assessments, and focus of calls received through the agency’s intake department as well as the nature of referrals made by the agency’s own home-visiting program, the client population eligible for this team’s services was defined as follows: We would be responsive to any family whose child under 6 years was experiencing problems with one or several of the following: (a) feeding, sleeping, separation; (b) being comforted; (c) managing emotions; (d) relationships with parents, siblings, caregivers; (e) making friends, playing; (f) transitions and routines; and (g) child care and school.

Involvement in our program also would, naturally, be prescribed for any child at possible risk for maltreatment, emotional and/or physical, as assessed during the initial intake call by any agency staff involved in providing other services to the family or by referring community partners. Referrals would be encouraged and received from: parents themselves, child-care facilities, schools, public health staff, child-welfare agencies, hospitals, physicians in private practice, and other mental health agencies.

### THE NEW TEAM AND SERVICES OFFERED

The fact that this was a brand new, high-profile initiative allowed us to build the ICT team by selecting a group of experienced and motivated child mental health professionals who were ready for a challenge. The team, once assembled, consisted of seven full- and part-time clinicians (an equivalent of four full-time staff members) with a background in child and youth work, infant mental health, early childhood education, social work, and psychology. The composition of the team meant that we would be able to offer a great variety of expert support, including regularly scheduled, multidisciplinary assessments of families’ needs. In the start-up phase, we would have the luxury, at times, of assembling most of our team for particularly

challenging observations and assessments that might lead to recommendations for a range of interventions including traditional, individualized family counseling, and behavior management; however, there was consensus that at the heart of this team's work should be innovative, empirically validated and culturally sensitive parent-child interaction assessment and treatment. Furthermore, based on the overwhelming empirical evidence on the effectiveness of such programs, the team was committed to offering a variety of parenting-education programs as well as consultation to community settings such as child-care centers. Our aim was for a fully ecological model of child treatment.

A decision was made to dedicate 2 hours each week to a team meeting which, at least in the beginning phase, would serve as the vehicle for case assignment, and group supervision. While initially met with some skepticism at the center, this dedication of a relatively large amount of time to team meetings would prove extremely productive in scaffolding the new service model, and subsequently received much support. Given that one of our team members doubled as intake worker and was able to present waitlist cases weekly, work assignment could proceed smoothly, avoiding unnecessary delays for clients. When the usual initial recommendation for participation in a parenting group program was deemed inappropriate by intake staff, cases would be distributed to individual therapists taking into consideration staff workload, specialization, and current interests. Every 4 weeks, team time would be taken up by team assessment activities. Dedicated group-assessment times would allow for therapist dyads to interview a family with particularly complex concerns, with the rest of the ICT team observing behind a one-way mirror and offering consultation during a scheduled break in the session. Generally, one of the two therapists involved in the interview would then take on the case for intervention, ensuring minimal disruption for the family. In rare, complex cases or cases that might place the therapist at risk for vicarious trauma, two clinicians might team up to provide the often necessarily multifaceted intervention. In addition to a weekly educational component (e.g., discussion of new articles in the field, review of reliability procedures for instruments used), group supervision, and peer consultation, regularly scheduled individual-case supervision with the team manager also would be made available to team members on a biweekly basis, as necessary. In the beginning, issues brought to supervision frequently tended to focus on case-management challenges and the implementation of the team model; increasingly, there would be an emphasis on process issues, including transference and countertransference concerns as arising from the work with our families.

#### **MEETING THE CHALLENGE: BUILDING A FUNCTIONAL MODEL THROUGH THE SELECTION OF ASSESSMENT AND TREATMENT MODALITIES**

The *raison d'être* for this new team clearly was the basic assumption that early intervention is paramount in optimizing life chances, and that, when it occurs in or before the preschool years, it is more effective and more likely to prevent chronic dysfunction (Briesmeister & Schaefer, 1998; Guralnick, 1997; Landy, 2002; McCain & Mustard, 1999). We now believe that the period from 0 to 6 years may be the most influential in the life cycle for brain development and subsequent learning, behavior, and health (Alaggia, 2001; McCain & Mustard, 1999). We also are more convinced than ever that the quality of parenting behavior during that time can have a significant impact on later development—social, emotional, and physical (Landy, 2002).

It was our goal to design a program that was well grounded in theory and based on empirically evident effectiveness for both individualized and group treatment. Furthermore, any such intervention model also would have to meet the needs of a challenging client group:

a parent population that falls into a moderate-to-high-risk category. Despite the carefully assembled criteria for referral, parents still mostly come to us with worries about their infant's or child's "bad behavior." These concerns are in line with those of the majority of parents of the center's older clients, children over 6 years, as conduct problems remain the most prominent reason for referral. These complaints, of course, most often occur in the context of inordinate parental stress, frequently caused by dire economic circumstances, poor parental mental health, and/or family violence. Despite the assessors' and therapists' commitment to an ecological approach, the referred child's behavior is still often seen by parents as an intrinsic, child-owned problem. As has been demonstrated (e.g., Bugental & Happaney, 2000), parents who have low perceived control over behavioral events in general may develop faulty attributions with respect to their child's disruptive behaviors. Negative attributions, in turn, influence the quality of parent-child interaction and perpetuate a cycle of negative behavior and deterioration, chronicity, and potential maltreatment (Bugental, 2002). Furthermore, recent investigations increasingly point to a significant relationship between negative cognitive styles and childhood emotional maltreatment (Gibb, Butler, & Beck, 2003). Not surprisingly, then, models based on cognitive representations of power in caregiving relationships are gaining in popularity for children's mental health and child-welfare professionals, as erroneous parental attributions are increasingly seen as possible predictors of child abuse (Azar, 1988; Bugental, Blue, & Cruz-cosa, 1989). Physical child abuse, with an estimated incidence of 2.25 cases per 1,000 children in Canada, with incidences higher in high-risk communities (Troeme & Wolfe, 1998), carries dangerous implications for the child's ongoing development and chances for a productive life (Karr-Morse & Wiley, 1997). Thankfully, there is mounting evidence that programs based on parental-empowerment models have demonstrated effectiveness over time (Thomas et al., 1999).

Without a doubt, then, we would build into our model of evaluation and treatment a parental attributions component as well as some form of risk assessment. The choice for an attributions assessment and intervention turned out to be an easy one as the *Parent Attribution Test* (Bugental, 1998; Bugental, Johnston, New, & Silvester, 1998) and Bugental's *Cognitive Approach to Child Abuse Prevention* (Bugental, Lin, Rainey, Kotkotovic, & O'Hara, 2002) so clearly stand out in this area. This author offers a simple, time-limited approach to changing parental attributions for their child's conduct by challenging erroneous beliefs and encouraging caregivers to generate alternative explanations for disruptive behavior. We adapted this cognitive intervention for use with several types of videotaped interactions. A free-play situation or a more structured feeding or teaching time (NCAST; Barnard & Kelley, 1990) was used for children 3 years and under. Those older than 3 years and their mothers would be involved in a structured, staged play assessment [the *Parent-Child Interaction Assessment* (PCIA); Hologrocki, Kaminski, & Frieswyk, 1999; 2002]. For both infants and preschoolers, the interaction would be viewed (sometimes repeatedly) by parent and therapist, and parents were invited to offer interpretations of their child's actions and reactions on tape. Attributions, when inappropriately negative, would then be challenged and alternatives elicited. Clearly, this would become the intervention of choice when there appeared to be any risk for maltreatment. For the evaluation of risk, we chose Abidin's (1995, 1997) *Parenting Stress Index* and Milner, Gold, Ayoub, and Jacewitz's (1984) *Child Abuse Potential Inventory*—arguably two of the most frequently used measures in the research literature.

As compelling as the cognitive approach is, we knew that some complementary conceptualizations of dysfunctional child behavior would have to be integral to our ecological treatment model as well. First, any cognitive or behavioral intervention had to be preceded by a thorough, multifaceted assessment to rule out physical and developmental concerns. Psycho-

logical and psychiatric consultation are available at our center for this purpose, and as will be demonstrated through the two case examples at the end of the next section, the staff does make good use of these additional services as components of their multidisciplinary assessments.

No program for very young clients could very well forego a component based on attachment theory, given the indisputable importance of healthy attachment relationships for child mental health (Main & Solomon, 1990) as well as the increasing numbers of reports linking disordered attachment relationships to child psychopathology (e.g., Lyons-Ruth, 1996). Not surprisingly, with our parent group, negative attributions were often observed as embedded in dysfunctional attachment relationships (e.g., the disorganized attachment described by Lyons-Ruth, 2000, and Main & Solomon, 1990). Luckily for us, promising new assessment and treatment measures were just beginning to emerge. Lyons-Ruth's (2000) *Atypical Maternal Behavior Instrument for Assessment and Classification* (AMBIANCE) is a powerful, well-validated tool for the identification of parent-child relationships at risk for attachment disorganization and poor developmental outcomes. This coding system allows for an analysis of short play interactions, in view of isolating specific problematic maternal behaviors. Maternal frightened and frightening behaviors in particular have been shown to predict disorganized attachment (Lyons-Ruth, Bronfman, & Parsons, 1999) and could become a clinical focus, once identified.

Treatment, then, was designed based on the consistent finding that short-term, focused interventions are effective in improving attachment relationship problems. McDonough's (2000) *Interaction Guidance* intervention has garnered attention, followed by Benoit's (2002) *Modified Interaction Guidance*, which is designed to deal specifically with the often intractable disorganized attachment relationships that are not responsive to *Interaction Guidance* alone. Both approaches revolve, once again, around the videorecording of short (10- to 20-min) parent-infant interactions, and the subsequent powerful strength-focused, collaborative analysis of the recording by parent and therapist. These methods are shown to increase parental sensitivity (Benoit, 2002). Often used in the family's home, the video analysis and playback allows the therapist to review with the parent any or all parts of the parent-child interaction, purposely focusing on moments of appropriate responding and sensitivity, and reinforcing this desirable behavior. In the case of *Modified Interaction Guidance*, an additional component is added to this strictly reinforcement-oriented feedback, in that one objectionable parental behavior also is addressed during each session. Specific maternal behavior markers, as identified by coding with the AMBIANCE, are brought to the parent's attention and clearly labeled undesirable. This is done matter-of-factly, and always embedded in the otherwise positive and praising process of the feedback session. Guided by our knowledgeable and experienced infant mental health therapist, we chose to include both types of interaction guidance in our repertoire of individual interventions. The AMBIANCE coding system would become the assessment upon which interventions were based, and also would become our source of evaluation for critical atypical maternal behaviors in more formal research and evaluation activities.

Finally, there would be a need for excellent parent education group programs—the “bread and butter” of chronically underfunded mental health centers. Niccols (2001) had just developed and validated *Right From the Start*, the first psychoeducational parenting program based on the principles of attachment theory. Our proximity to the Hamilton Health Sciences Centre allowed the team easy access to training, resulting in our program's adoption as a parent group intervention for families with children 0 to 3 years old. Further, choosing a group curriculum for parents of our 3- to 6-year-olds proved the easiest task of all, with the by-then widespread availability of *The Incredible Years* program (Webster-Stratton, 2000), possibly the best-researched and most effective group intervention available to date for families struggling with disruptive behavior problems (Webster-Stratton & Hammond, 1997). *The Incredible Years* had

the additional advantage of addressing discipline not with the traditional “time-out” strategies but rather by focusing on relationship issues, an approach more in line with our general attachment orientation.

Clearly, the focus of both the *Right from the Start* and the *Incredible Years* groups is on the necessity for parental sensitivity to their child’s attachment and other relational needs, and the crucial role that “building relationship” plays in the quality of parent–child interactions and, ultimately, the child’s “behavior.” In either group program, a parent would attend weekly 1½- to 2-hr themed sessions with 4 to 16 other parents for 6 to 14 weeks. Topics of discussion might include basic developmental information, children’s affective and relational needs, common behavioral concerns, and recommended strategies. In-session exercises are based on video vignettes, and include small group exercises and role play. Homework further completes the learning experience.

Both group programs incorporate themes such as play, attachment, and cognitive and risk-reduction features, and seemed to be tailor-made for our ICT program goals. It was decided that any family that called the center would be encouraged to first participate in a group parenting program; if this proved unsatisfactory, they would be offered an individual assessment.

The term “model” suggests program content that is based on empirically validated theory, or a combination of theories; “functional,” on the other hand, implies that program structure will be feasible and will show a reasonable fit with the culture of the host organization. With this functional program model, we were hoping to reach effectiveness with theoretically grounded assessments and interventions that had shown good efficacy (see Figure 1 for a summary of the functional model).

### CHOOSING THE VEHICLES FOR PROVIDING THEORETICALLY GROUNDED ASSESSMENT AND TREATMENT

With basic theoretical directions and group programs in place, we now needed to proceed with the remaining selection of “vehicles” for our individualized assessments and intervention-planning tools. Ultimately, we settled on two fairly unusual instruments: a well-respected and documented parent–infant interaction instrument, the *NCAST Parent Child Interaction Program* (Barnard, 1994; Barnard & Kelly, 1990), for our clients aged 0 to 3 years. The PCI evaluation tool relies on the observation and rating of the parent–child dyad in one of two situations: a feeding or a teaching episode. This measure would allow us to first evaluate the general adequacy of parenting with our young clients 3 years and under (and thus also provide a measure of risk) as well as the relative contributions of parent and infant to the problematic relationship before proceeding to the use of this tool to gather additional information on risk, attachment difficulties, and parental attributions. All ICT team members agreed to the 5-day training, and all attained reliability for this measure. For our older (3- to 6-year-old) client group, we sought out a virtually unknown but highly compelling play-assessment framework: the *Parent–Child Interaction Assessment-II* (PCIA-II) developed at the Menninger Clinic by Holigrocki et al. (1999; 2002). We decided that this structured, videotaped activity would allow us to observe and code a variety of parent–child behaviors along our organizing dimensions (risk, attachment, and attribution) using a series of themed, predictable play situations, including scenarios specifically designed to activate attachment behaviors. As well, this structure would provide us with ideal videotaped material to analyze and share with the parent(s), allowing the latter to comment, question, and offer explanations for situations arising in the play and thus allowing us very immediate access to parental attributions.

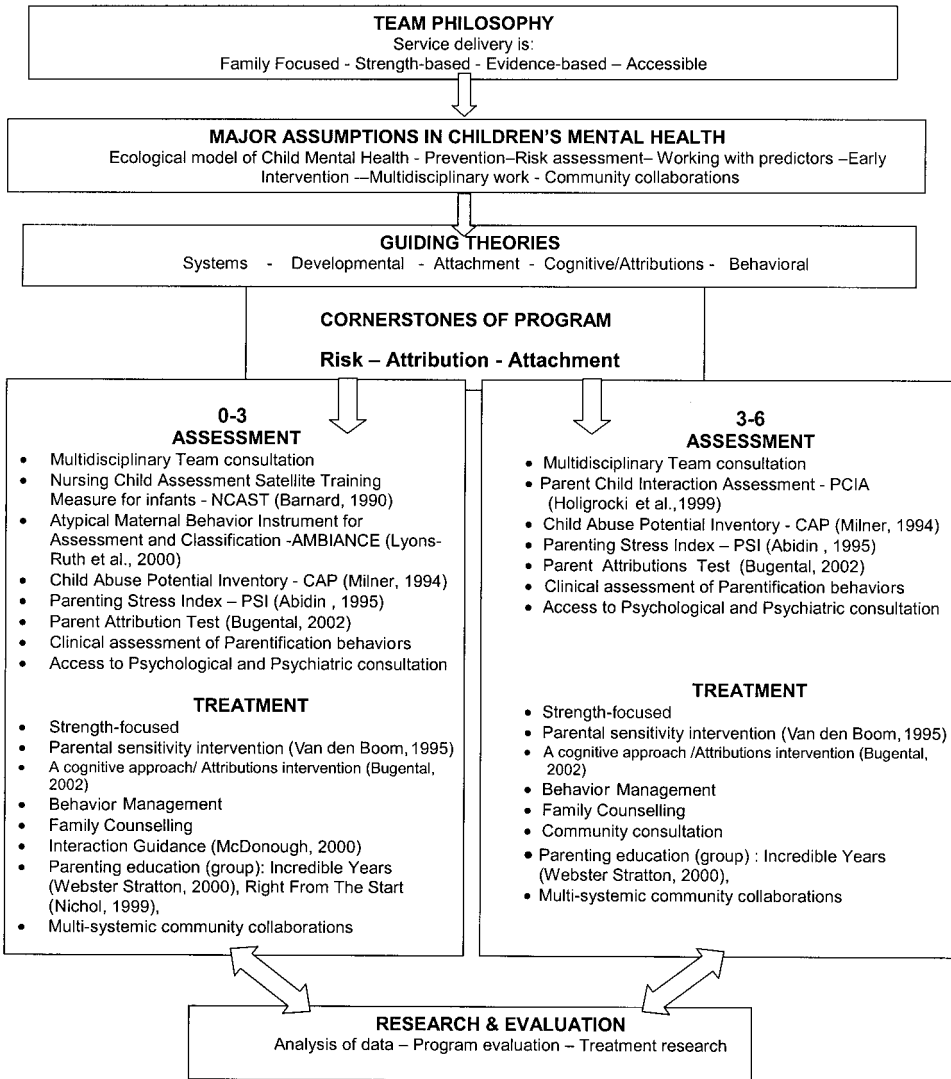


FIGURE 1. Aisling Discoveries Infant Child Treatment team functional working model.

**PUTTING THE PROGRAM MODEL TO WORK**

By May 2002, the program was beginning to take shape, with three apparent cornerstones; namely, an emphasis on risk, cognition, and attachment (see Figure 1 for a summary of all features of this model).

When a family called to request assistance, a flowchart process with many choice points was now activated (see Figure 2). Urgency and potential risk were first clinically assessed by an intake social worker, and a provisional decision made about an optimal first assessment and/or treatment modality (e.g., group parenting program, infant-parent interaction assessment, behavior consultation, family counseling). For example, a father might call with concerns about his 5-year-old child’s maltreatment of a younger sibling; after an extensive intake phone interview that involves an initial assessment of family functioning, degree of stress, and risk level, the recommendation might be that both parents enroll in an upcoming parenting

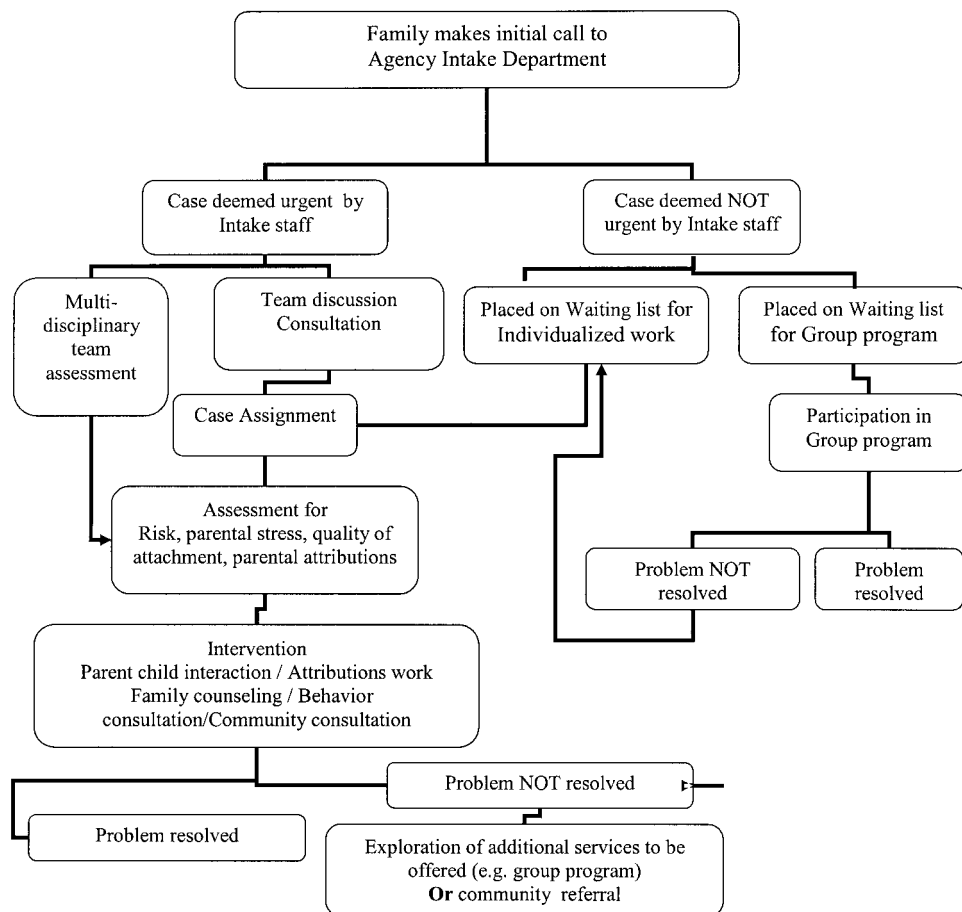


FIGURE 2. Infant Child Treatment team service flow.

program that would be the first step in addressing the large majority of the family’s concerns, with the understanding that after the program, parents and their group leaders would reevaluate the need for further, more intensive and individualized help. Conversely, a mother might call to request a group program to help her learn how to better discipline her very active 3-year-old, but the circumstances of this family, along with highly emotionally charged information shared with the intake worker, might prompt the latter to become concerned about the stress level of the parent and the possible risk for family violence. This case would then be presented at the next ICT team meeting, likely with a request for a multidisciplinary-team assessment.

Most families who called the center with behavior-management concerns were first encouraged to participate in a group parenting program; if this proved insufficient, they would be offered an individual consultation or placed on a waitlist if the service request appeared straightforward. Close to half of all families who participated in groups felt that their needs had been adequately met and did not request further individual intervention. The hope was that many families would emerge from the 12- to 16-session group program with a sense a shared problem solving and new confidence in their ability to manage their relationship with their child. The remaining clients then received tailored behavior-management support or interaction/family counseling.

If not thought to be in immediate need of assistance, a family was placed on a waitlist, to be assigned to the next appropriate group program or, conversely, to the next available staff member. If the case was deemed urgent, it was presented at the next ICT team meeting. There, if the situation was thought to be inordinately complex, a comprehensive team assessment would be scheduled. Alternatively, a team member would be assigned as primary therapist and service coordinator for the case. Next, either the team or the lone clinician would conduct a clinical assessment using ICT's framework and areas of focus—the attachment relationship, parental attributions, and ultimately, the degree of risk for maltreatment (neglect and abuse)—but also for breakdown of the family system or any element thereof. These focal points were always considered within a developmental perspective, with close attention paid to parental strategies and coping skills. The broad environmental context, taking into consideration, for example, the role of child-care setting, and other community services and available supports, also received critical attention.

Based on the evaluation, treatment goals were formulated in partnership with the family. Intervention would primarily be focused on improving parental sensitivity and the attachment relationship as well as altering dysfunctional attributions. Most importantly, change objectives would be scaffolded with psychoeducation that covered basic (but sometimes crucial) developmental information as well as proven strategies for behavior management. When family-system issues also were salient, family counseling was offered either simultaneously or at a later date. Families might be followed for two sessions or for 2 years, with most assessment and intervention activities (save for group programs) available to them at the center or at their home (see Figure 2 for a description of service flow).

## CASE EXAMPLES<sup>1</sup>

### *Case 1*

L. was an 11-month-old girl referred by a community pediatrician because of eating problems. L.'s mother called the intake department in a near panic, quite obviously very worried about her daughter's apparent refusal to eat, and stated that in her culture when a child did not eat, this was blamed on a "bad" mother. As with all cases involving very young children with very worried parents, this case was prioritized and directly assigned to our infant mental health specialist following discussion at a team meeting. As part of the evaluation phase, an NCAST feeding assessment was conducted and videotaped. The results were of some concern, and indicated real weaknesses in the baby's ability to provide clear cues to her mother as well as in L.'s mother's ability to respond sensitively to her child during the feeding situation. In a subsequent analysis of this dyad's attachment relationship, some questions about the parent's intrusiveness and difficulty with following the baby's lead were raised by the therapist. Furthermore, it became apparent that L. did not often receive comforting or assistance with self-soothing from her mother, although there was some indication that her (oft-absent) father was able to provide this when he was available. Psychometric assessment material from both caregivers, while not placing L. at inordinate risk, did suggest that both parents harbored distorted attributions about the baby's eating behavior. Several sessions were scheduled to allow for the analysis of videotapes, and psychoeducational discussions of developmental issues. This latter

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<sup>1</sup> Please note that the following descriptions are based on amalgams of related cases. They are designed to facilitate an understanding of the types of client presentation seen by our team as well as the assessment and intervention offered rather than to describe any one family's situation faithfully.

component of the intervention proved particularly useful, given some of the culturally based expectations of treatment shared by L.'s parents. Sharing information on infant development naturally led to discussions of realistic attributions and to the generation of alternative, more benign explanations for the baby's eating behavior. Later, greater emphasis was placed by the therapist on the development of parental sensitivity through repeated strength-focused viewing of parent-child interactions—both feeding and play—and discussion of the many ways in which L.'s parents had already begun to respond sensitively to her despite L.'s sometimes ambiguous cues. To follow up with the latter concern, and in consultation with the agency psychologist, a referral was arranged for a full developmental assessment for this infant at a local hospital. A public health nurse also was contacted and asked to provide support and monitoring for this family while they became more confident in their relationship with their daughter. Finally, the parents asked to participate in the *Right from the Start* group program; at the conclusion of the program, they had identified some concerns with their own relationship and asked their therapist to provide a few sessions of family counseling. Their issues were quickly resolved, and the family demitted after an involvement at our center of a total of 7 months.

## *Case 2*

B. was a 4-year-old referred by his mother who was concerned about her son's cruel behavior towards his younger siblings, particularly his 2-year-old sister. There was a worrisome quality to this young, single mother's initial call to the intake department, as the numerous aggressive incidents she described, mostly without the expected degree of worry, could be interpreted as posing quite a risk for the younger children in the family. The intake worker brought this case to the team and recommended that this family be seen for a team assessment at the next available opportunity. The multidisciplinary evaluation was conducted by a social worker and a child therapist, with other team members, including a psychologist, behind the one-way mirror. All involved became increasingly concerned while hearing not only an account of this young child's intentional attempts to harm his sister but also stories relating to the deaths of several family pets, in which he had played a role. During the interview, the young client presented as well above average in many areas of his development; however, it was noted that he appeared to have a speech difficulty. Furthermore, worries were expressed by team members about his mother's relative lack of affect when reporting very disturbing events. This case was rated high risk. It was decided that both assessing clinicians would work with this family, given the very serious nature of our concerns and the likely need to involve a number of other support services. During a subsequent session, psychometric measures would be administered to B.'s mother, and a play assessment was conducted. During administration of the PCIA-II, it became apparent that B. readily used aggressive behavior toward his mother, even in play situations. Some aspects of the dyad's relationship also emerged, in that B.'s mother showed behaviors generally associated with disorganized attachment relationships in several of the play scenarios. For example, she asked for comforting from B. in a scene in which he, as the child, pretends to have fallen and hurt his arm. She further often laughed at times when he pretended to be distressed and taunted him. These maternal behaviors are termed "atypical" in the context of the AMBIANCE and are associated with worrisome outcomes for children. Furthermore, both the viewing of the play on videotape with the therapists and B.'s mother's answers on the Parental Attributions Test revealed distorted, very negative parental attributions, which, alongside answers offered on the Child Abuse Potential inventory, placed this parent within an "at-risk" range. Several sessions were spent reviewing the parent-child interaction on videotape with one of the therapists, highlighting any instance of parent sensitivity found on the latter,

and generating alternative attributions for B.'s problematic behaviors both on the tape and in real life. Over several sessions, B.'s mother began to develop a greater awareness of her own contribution to the relationship with B. With the growing realization that she could influence outcome, she gradually felt empowered. In addition, several behavior consultation sessions were offered by the other therapist, providing B.'s mother with a highly structured framework for responding to B.'s destructive conduct. Both interventions were offered at the family's home. B.'s child-care center also was visited and consulted, but there appeared to be no problems to report in that setting. Finally, several consultations were arranged: the agency's psychiatrist's opinion was sought, a referral was made for a speech and language assessment, and a child-welfare agency was consulted to ascertain that support would be available to this mother should she at any time not feel capable of protecting her younger children from B. At the 6-months' mark in treatment, B.'s mother was enrolled in the Incredible Years group program and still being monitored by her original therapist; she reported marked improvement in B.'s behavior at home, with no aggressive incidents to report for at least 2 months.

### **FUTURE DIRECTIONS AND ISSUES: GOING INTO THE SECOND YEAR**

By the end of 2003, the program had served over 350 families with concerns ranging from sleeping disturbances to child sexual abuse. Most were seen within 6 to 8 weeks of first contacting our center. One parenting group had been conducted with the help of interpreters, with most group programs attended by parents from different cultural backgrounds. On being surveyed as part of the agency's standard procedure on discharge, over 90% of clients reported high satisfaction with the program, stating that the issues that had brought them to the center were at least partially resolved.

#### ***Strengths of the Program Model***

- The model is client-centered, strength-based, flexible, and accessible.
- The program is based on empirically validated constructs, assessments, and intervention.
- It integrates several valid orientations, thus offering a comprehensive approach to complex problems.
- It is challenging and stimulating for its clinician members, building expertise, as demonstrated by above-average morale on the implementing team.
- The model allows for a great deal of peer support and consultation, thereby minimizing the risk of burnout and vicarious traumatization of those working with very young children at risk.
- The model will easily be converted to a service that incorporates research and training opportunities, as extensive data is already being collected for clinical purposes, using well-validated and research measures.

#### ***Drawbacks of the Program Model***

- This model is labor intensive, and requires a high degree of expertise and motivation to maintain its integrity on the part of all its practitioners.
- It requires a great deal of organizational activity above and beyond the clinical aspects of the work, and this feature tends to shift use of supervision time to focus on structural

versus process matters; it is hoped that in the next phase of implementation, this shift can be reversed.

- It is relatively costly due to features such as the child-care provision necessary for group programs, translation/interpretation services, and cost of travel in the community and to clients' homes.
- It requires unqualified support from the administrators in the host organization.
- Due to the intensive in-team activity that is at the core of this model, it could be construed as somewhat "inward-looking." Efforts will be made in its second phase to become more "outward-focused," with an emphasis on greater outreach and greater community collaboration

Reflecting on this infant stage of our ICT team, a number of priorities for the future come to mind. First, as the start-up phase for this new program concludes, great care will have to be taken in maintaining the knowledge acquired by this group of professionals during the past year. The relative luxury of "start-up" funds and time allocation allowed us to obtain extensive training in the new approaches that we ultimately chose to adopt to build the framework for our treatment team. Maintenance of the existing knowledge, and keeping up to date with new research findings in the field are required to keep this framework strong. This hopefully will occur through peer and supervisor support and opportunities for team activities and mutual monitoring at monthly meetings as well as recertification for reliability in some instances. Partnerships with research and teaching institutions (e.g., universities) will be intensified to allow for collaborations that will benefit both researchers and clinicians by making bidirectional knowledge transfer more immediate, efficient, and effective.

Second, some focus will have to shift to outreach activities, which should be increased to maximize opportunities for community partnerships and collaboration. Such partnerships and collaborations are increasingly becoming requisites in the competition for funding as well as simply constituting good practice given shrinking service availability. The plan is to arrange for all ICT team members to become involved in meetings with community partners to disseminate information about the team's work and referrals procedures as well as to gather input and conduct informal needs assessments, thus creating a feedback loop for optimal community responsiveness. In the process, information about the program should be distributed widely.

Third, cultural responsiveness will have to be increased, especially for families whose first language is not English. Efforts will be made to ensure that when families from diverse ethnic and cultural groups attend programs (individual and group), interpretation be made more readily available sometimes, if necessary, in more than one language at a time.

Fourth, assessment, in particular risk assessment, of especially our very young clients should become more systematic and comprehensive, and every effort should be made to espouse a multisystemic approach to our most at-risk families. Collaborations with other community systems and organizations, such as child-welfare agencies, public health agencies, and hospitals should initiate this.

Fifth, as an ever increasing number of referred clients have specialized developmental challenges (e.g., Autism Spectrum Disorders), a careful examination of the nature of our referrals should be undertaken. The needs of families with children with Pervasive Developmental Disorders, for example, will have to be considered carefully and possibly separately. To address these identified needs and to ensure expert assessment and treatment of developmentally atypical children, further specialized training may have to be requested for this team.

Finally, a need for comprehensive child-care services became apparent during our first year of providing group services to families with children under 6 years of age. The lack of

funding for this peripheral, yet essential, service was an obstacle to optimal programming. The provision of adequate child care during parenting group programs will have to be addressed at a systemic level if group programs are going to continue to be provided for families in what is supposed to be an ecological model of child treatment.

### HOPES FOR THIS AND SIMILAR PROGRAMS

All infant treatment programs need to harbor hope for effective prevention of later dysfunction. The model discussed here is but one example of an attempt to do just that. Many more such programs are needed in a variety of shapes and forms.

While it has been shown that very early disruptive behavior can result in lifelong patterns of conduct disorder, violence, and delinquency (Lochman & Wells, 1996), we also now know that parenting interventions have consistently been able to improve parenting skills and reduce child conduct problems (Kazdin, 2000). Since conduct disorders in children are one of most costly mental health problems for society, not least because the risk for child abuse is greater for children who exhibit it (Webster-Stratton, 1997, 1998), providing early parenting support and intervention should be of utmost importance. This is especially the case because as was shown in a recent national survey, parents feel that they know the least in areas in which they have the most influence (Invest in Kids, 1999). Since it also has been shown that parenting education can benefit children from all socioeconomic groups (McCain & Mustard, 1999), a very compelling argument could be made for more widely available and accessible parenting programs and very early interventions that have been shown to be effective. We have attempted to do just that in a context of innovation and accessibility, but so much more is needed both in quantitative and qualitative terms. With this program, we hope to move soon to a fully functional scientist–practitioner team model—a true integration of research and practice—that will allow us to explore new ways of understanding the concerns that our families bring to us and to continually evaluate the interventions we offer them to deal with their many challenges.

### REFERENCES

- Abidin, R.R. (1995). *Parenting Stress Index Professional Manual* (3rd ed.). Odessa, FL: Psychological Assessment Resources.
- Abidin, R.R. (1997). Parenting Stress Index: A measure of the parent–child system. In R.J. Wood & C.P. Zalaquett (Eds.), *Evaluating stress: A book of resources* (pp. 277–291). Lanham, MD: Scarecrow Education.
- Alaggia, R. (2001, May). An overview of parenting programs for parents of young children—What works? Report prepared for The Parenting Alliance, Toronto.
- Azar, S.T. (1988). Methodological considerations in treatment outcome research in child maltreatment. In G. Hotaling, D. Finkelhor, J. Kirkpatrick, & M. Straus (Eds.), *Coping with family violence research and policy perspectives* (pp. 288–289). Beverly Hills, CA: Sage.
- Barnard, K.E. (1994). *NCAST Caregiver/Parent–Child Interaction Feeding and Teaching Manuals*. Seattle: NCAST, University of Washington, School of Nursing.
- Barnard, K.E., & Kelly, J.F. (1990). Assessment of parent–child interaction. In J.P. Shonkoff & S.J. Meisels (Eds.), *Handbook of early childhood intervention* (pp. 278–302). New York: Cambridge University Press.
- Benoit, D. (2002). Modified interaction guidance. *IMPrint*, 32, 6–10.

- Briesmeister, J.M., & Schaefer, C.E. (Eds.). (1998). *Handbook of parent training: Parents as co-therapists for children's behavior problems*. (2nd ed.). New York: Wiley.
- Bugental, D.B. (1998). Parent Attribution Test. Revised manual. Unpublished research measure, University of California, Santa Barbara.
- Bugental, D.B., Blue, J.B., & Cruzcosa, M. (1989). Perceived control over caregiving outcomes: Implications for child abuse. *Developmental Psychology*, 25, 532–539.
- Bugental, D.B., Lin, E.K., Rainey, B., Kotkotovic, A., & O'Hara, N. (2002). A cognitive approach to child abuse prevention. *Journal of Family Psychology*, 16, 243–258.
- Bugental, D.B., & Happaney, K. (2000). Parent–child interaction as a power contest. *Journal of Applied Developmental Psychology*, 21, 267–282.
- Bugental, D.B., Johnston, C., New, M., & Silvester, J. (1998). Measuring parental attributions: Conceptual and methodological issues. *Journal of Family Psychology*, 12, 459–480.
- Gibb, B.E., Butler, A.C., & Beck, J.S. (2003). Childhood abuse, depression, and anxiety in adult psychiatric outpatients. *Depression and Anxiety*, 17, 226–228.
- Guralnick, M.J. (1997). *The effectiveness of early intervention*. Baltimore, MD: Brookes.
- Holigrocki, R.J., Kaminski, P.L., & Frieswyk, S.H. (1999). Introduction to the Parent–Child Interaction Assessment. *Bulletin of the Menninger Clinic*, 63, 413–428.
- Holigrocki, R.J., Kaminski, P.L., & Frieswyk, S.H. (2002). PCIA-II: Parent–Child Interaction Assessment Version II. Unpublished manuscript, University of Indianapolis (Update of PCIA Tech. Report No. 99–1046. Topeka, KS: Child and Family Center, The Menninger Clinic).
- Invest in Kids. (1999). *A national parenting survey*. Toronto.
- Karr-Morse, R., & Wiley, M.S. (1997). *Ghosts from the nursery: Tracing the roots of violence*. New York: Atlantic Monthly Press.
- Kazdin, A.E. (2000). Therapeutic changes in children, parents, and families resulting from treatment of children with conduct problems. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39, 414–420.
- Landy, S. (2002). *Pathways to competence*. Baltimore, MD: Brookes.
- Lochman, J.E., & Wells, K.C. (1996). A social-cognitive intervention with aggressive children: Prevention effects and contextual implementation issues. In R.D. Peters & R.J. McMahon (Eds.), *Preventing childhood disorders, substance abuse and delinquency* (pp. 111–143). Thousand Oaks, CA: Sage.
- Lyons-Ruth, K. (1996). Attachment relationships among children with aggressive behavior problems: The role of disorganized early attachment patterns. *Journal of Consulting and Clinical Psychology*, 64, 64–73.
- Lyons-Ruth, K. (2000). Atypical Maternal Behavior Instrument for Assessment and Classification—AMBIANCE. The AMBIANCE assessment measure for disorganized attachment. Unpublished manuscript, Harvard Medical School, Cambridge Hospital, Cambridge, MA.
- Lyons-Ruth, K., Bronfman, E., & Parsons, E. (1999). Maternal frightened, frightening, or atypical behavior and disorganized infant attachment patterns. In J. Vondra & D. Barnett (Eds.), *Atypical patterns of infant attachment: Theory, research, and current directions*. *Monographs of the Society for Research in Child Development*, 64(3, Serial No. 258).
- Main, M., & Solomon, J. (1990). Security of attachment in infancy, childhood, and adulthood: A move to the level of representation. In I. Bretherton & E. Waters (Eds.), *Growing points in attachment theory and research* (pp. 66–104).
- McCain, M., & Mustard, F. (1999). *Early Years Study*. Ontario Children's Secretariat, Government of Ontario. Toronto: Queen's Printer.
- McDonough, S. (2000). Interaction guidance: An approach for difficult-to-engage families. In C.H.

- Zeanah, Jr. (Ed.), *Handbook of infant mental health* (2nd ed., pp. 485–493). New York: Guilford Press.
- Milner, J.S., Gold, R.G., Ayoub, C., & Jacewitz, H.H. (1984). Predictive validity of the Child Abuse Potential Inventory. *Journal of Consulting and Clinical Psychology*, 52, 879–884.
- Niccols, A. (2001). *Right from the Start: An Attachment-Based Intervention*. Eight week parent training course. McMaster University & Hamilton Health Sciences Centre, Hamilton, Ontario.
- Statistics Canada. (2001). *Census data. Ward Profiles: City of Toronto; Ward 43* (Available from the Author). Retrieved May 5, 2004, from <http://www.toronto.ca/wards2000/pdf/wardprofiles.43.pdf>
- Thomas, H., Camiletti, Y., Cava, M., Feldman, L., Underwood, J., & Wade, K. (1999). The effectiveness of parenting groups with professional involvement in improving parent and child outcomes. *Effective Public Health Practice Project, Public Health Research and Development (PHRED)*. Ontario Ministry of Health.
- Trocme, N., & Wolfe, D. (1998). *Child Maltreatment in Canada—Canadian Incidence Study of Reported Child Abuse and Neglect: Selected Results*. Ottawa: Minister of Public Works and Government Services Canada.
- Van den Boom, D. (1995). Do first-year intervention effects endure? Follow-up during toddlerhood of a sample of Dutch irritable infants. *Child Development*, 66, 1798–1816.
- Webster-Stratton, C. (2000, June). *The Incredible Years Training Series*. *Juvenile Justice Bulletin*. Washington, DC: Department of Justice.
- Webster-Stratton, C. (1997). From parent training to community building. *Families in Society*, 78, 156–171.
- Webster-Stratton, C. (1998). Preventing conduct problems in Head Start children: Strengthening parenting competencies. *Journal of Consulting and Clinical Psychology*, 66, 715–730.
- Webster-Stratton, C., & Hammond, M.A. (1997). Treating children with early-onset conduct problems: A comparison of child and parent training interventions. *Journal of Consulting and Clinical Psychology*, 65, 93–109.

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