PART 8: KEY CONCEPTS

This glossary describes key concepts relating to mental health in infancy and early childhood. This might be shared locally to help professionals from different backgrounds to engage in discussions and develop a shared understanding.

Adverse childhood experiences

In the mid-1990s, researchers in the USA studied the impact of 10 types of traumatic event or circumstances occurring before the age of 18 on later adult health. These ten forms of adversity were known as Adverse Childhood Experiences (ACEs), and included forms of abuse and neglect, and experience of household disfunction such as having a parent in prison. This "ACE study" was a significant piece of research that found compelling evidence linking poor adult health with negative childhood experiences[90].

A body of research demonstrates a link between ACEs and the development of a variety of later mental health problems and symptoms, encompassing PTSD, OCD, personality disorders, psychotic disorders, mood and anxiety disorders, eating disorders, sleep problems, SUDs, and suicidality[91].

The term Adverse Childhood Experiences often refers to the ten forms of adversity used in the initial ACEs study, although it can be used to refer to other forms of adversity. More recent ACE research includes factors such as historical trauma and social location[92]. A good discussion of the definition of ACEs; the impact of ACEs on outcomes, and how to use ACEs to inform practice, can be found in the Early Intervention Foundation's 2020 report, *Adverse childhood experiences What we know, what we don't know, and what should happen next*.

Attachment

A child's attachment refers to how they behave in the context of a caregiver, the extent to which they seek contact with the caregiver when they are frightened, worried or vulnerable, and whether they find such contact comforting[93]. Attachment is thought to have significant psychobiological and evolutionary functions.

Researchers observe four consistent patterns of attachment in young children, which are known as Secure, Insecure-Avoidant, Insecure-Resistant and Disorganised. These are normally apparent in the second year of life. A child might have different patterns of attachment towards different caregivers. As

toddlers, securely attached children are generally comfortable when with their caregiver, upset upon separation, and happy to explore the world around them using their caregiver as a 'secure base'. At the other end of the spectrum, children with disorganised attachment can show conflicted, disorientated or fearful behaviour towards their caregiver.

A young child's pattern of attachment is largely, if not entirely, the result of the quality of their interactions with their caregiver. Safe, sensitive, responsive care makes it more likely that children will develop a secure attachment. Insecure attachment relationships do not, on their own, indicate cause for concern, but disorganised attachment does suggest that a child has experienced relational trauma. Disorganised attachment in early childhood increases the likelihood of later mental health problems, although these are not inevitable[94].

The Anna Freud Centre's *What is Attachment leaflet* explains attachment for early years workers.

Cumulative risk

The consequences of negative or positive experiences and environments on children's wellbeing and development are cumulative. Research shows that the more different risk factors a child face and the more often the child is exposed to them, the greater the likelihood of poor outcomes later in life.

Evidence that greater numbers of risk factors predicted a greater prevalence of clinical problems was first found in Rutter's (1979) Isle of Wight Study[v] which found that no single risk factor significantly increased risk for mental health problems in young people, but the presence of two risk factors contributed a fourfold increase in the likelihood of mental health problems, and the presence of four risk factors yielded a tenfold increase.

In addition to having a cumulative effect, risk factors also cluster[95] so that if a child has one form of adversity, it may be more likely that they experience others. Children who live in poverty, or who come racially minoritised or immigrant communities, may be particularly likely to experience a number of risk factors.

Infant

The term infant is used differently by different professionals. For example, in paediatrics, infants are babies under one, but in schools infants can be children between the ages of 4 and 7. This report uses the term infancy to refer to the first two years of life, but refers to very young children as babies rather than infants.

[v] Rutter and colleagues initially identified six risk factors significantly correlated with childhood psychiatric disorders: (1) severe marital discord; (2) low social status; (3) large family size; (4) paternal criminality; (5) maternal mental disorder; and (6) foster placement.

Infant mental health

Infant mental health refers to the mental health of babies, most often from pregnancy or birth to age two (although sometimes until age three). The Parent-Infant Foundation (2020) explain that "infant mental health describes the social and emotional wellbeing and development of children in the earliest years of life"[96]. Infant Mental Health has also been defined as "an interdisciplinary professional field of inquiry, practice, and policy that is concerned with alleviating suffering and enhancing the social and emotional competence of young children"[97]. Infant mental health uses a different definition of infant to paediatrics, where infancy is the period until age one[98], or primary education, where infants are children aged between four and seven[99].

In the recent UK government guidance on Family Hubs and Start for Life programmes, infant mental health is defined as *"a baby's social, emotional, and cognitive development and wellbeing."*

Latent vulnerability

Latent vulnerability refers to the way in which a child's developing brain changes in response to early adversity. These changes can be helpful to the child in the short-term, helping them to cope and survive in the face of the adversity. However, they may make the child more vulnerable to developing mental health problems later on[100]. A child who experiences abuse or neglect, for example, may become hypervigilant. This may help them to keep safe in an abusive home, but later on it may mean that they interpret social situations as threatening and react accordingly, which will make social interactions more difficult and can impact on their ability to form enriching relationships[101].

Neurodivergent/neurodiversity

Neurodiversity describes how people experience and interact with the world around them in many different ways; there is no one "right" way of thinking, learning, and behaving, and differences are not viewed as deficits[102]. Children with developmental differences can sometimes be referred to as having special educational needs (SEN)[103], although there are other instances that may mean a child has additional needs.

Neurodiversity refers to the diversity of all people including neurotypical and neurodivergent people.

'Neurotypical' people think, perceive, behave and process information in ways considered standard or typical in the general population.

Neurodivergent people – such as autistic people, and those with neurological or developmental conditions such as ADHD or learning disabilities – are people whose brain functions and behaviours can diverge from those considered typical.

Parent–infant relationships

Parent–infant relationships are the relationships between babies and their primary caregivers[w], who are typically, but not always their parents. The quality of these relationship has a significant influence on babies' mental health and development.
The UK Government guidance on Family Hubs guidance states that parent-infant relationships "can be interchangeable with" infant mental health this is because many services that are called "Infant Mental Health" or "Parent–Infant Relationships" services do the same sort of clinical work with families.

Parent–infant relationship services

Parent-infant relationship services are services that support the relationship between babies and their primary caregiver, helping caregivers to overcome difficulties and develop capacities to provide babies with the sensitive, responsive care. These services are often known locally by different names such as a PIP, an Infant Mental Health Team, parent-infant mental health service, early CAMHS or an early attachment team.

Specialised parent-infant relationship teams (known as parent-infant teams in short) are services that meet specific criteria set out by the Parent-Infant Foundation. They are multidisciplinary teams, led by specialist mental health professionals with expertise in supporting and strengthening parent-infant relationships. These teams work with any families where there are sufficient concerns about the early relationship (as opposed to focussing only on families who meet specific criteria such as having a moderate or severe perinatal mental health condition or being in the care system). Parent-infant teams generally work at two levels: providing direct therapeutic support to families with the highest levels of need, and also using their expertise to help the local workforce to understand and support parent-infant relationships through offering training, consultation and/or supervision[104].

Perinatal mental health

Perinatal mental health problems are those which occur during pregnancy or after the birth of a child. Typically perinatal mental health refers to the mental health specifically of mothers or parents who give birth to babies (rather than fathers, adoptive mothers or non-birthing mothers in same-sex couples) but the use of the term is not consistent and, in some cases, may refer to the mental health of other new parents. In some cases, perinatal mental health problems refer to problems only in the first year after birth, although in England perinatal mental health services will work with a family until a child is two.

[w] Primary caregivers are the people who spend most time caring for the child.

Relational trauma

Relational trauma is trauma that occurs within a close relationship, typically with a parent or primary caregiver. It arises when there are significant and persistent difficulties in relationships. Relational trauma can describe abuse, neglect or other forms of severe disruption in the relationship. 'Relational poverty' refers to babies and children experiencing interactions where the caregiver does not have the capacity to think about and respond the needs of the child (for example, because they are extremely lonely or isolated or experiencing high levels of stress). Both relational poverty and relational trauma cause acute suffering for the baby, and latent vulnerability, increasing the risk of later poor outcomes. Research has shown that relational poverty in the perinatal period has a stronger impact on development than the presence of adversity. The impact of the quality of relationship with a primary caregiver diminishes as children get older, but it is still a strong predictor of functioning and development[105].

Spiritual wellbeing

Whilst it is not widely used in the UK, some models of mental health capture "spiritual wellbeing and development". Spiritual wellbeing refers to finding meaning and purpose in life, and living in accordance to, values and beliefs. For some people spirituality is about believing in and connecting to a higher being (or beings) and adopting religious beliefs. For others it is about finding a connection to the world around them, or a feeling of inner peace in other ways. Spiritual wellbeing can support mental health through helping people to find meaning, purpose and belonging, and sources of comfort, strength and hope. It can help people to make sense of experiences, and to connect with others. Babies and young children's spiritual development can be supported by helping them to reflect on themselves and the world around them; through discussions of values and ethics; and through helping them to learn about, observe and/or participate in religious practices and rituals. Young children can be encouraged to talk about, express and explore their feelings about family, nature, faith and religion through conversation and/or through play.

Toxic stress

Babies and young children can experience many kinds of stress. Toxic stress refers to "the constant activation of the body's stress response systems due to chronic or traumatic experiences in the absence of caring, stable relationships with adults"[106]. When this form of stress occurs during the earliest years of life, it is distressing for the baby or child, and can have lasting negative impacts on brain architecture and other developing organ systems. The "toxic stress response" describes the physiological and psychological response that can occur when a child experiences strong, frequent, and/or prolonged adversity without adequate adult support. This describes the mechanisms through which adverse experiences impact the developing brain and body, creating latent

vulnerability. The extent to which events lead to toxic stress, and have lasting adverse effects is determined in part by the individual's biological response (mediated by both genetic predispositions and the availability of supportive relationships that help moderate the stress response), and in part by the duration, intensity, timing, and context of the stressful experience[107].

Trauma-informed approaches

There has been a lack of consensus within the health and social care sector on how trauma-informed practice is defined[108]. However, the current working definition published by the Office for Health Improvement and Disparities defines trauma-informed practice by six key principles: safety, trust, choice, collaboration, empowerment, and cultural consideration.

When practitioners, services and policies are trauma-informed, it generally means that they:

- Recognise and understand the different ways that experiences of trauma impact on individuals, groups and communities
- Recognise and understand the signs, symptoms of trauma and how trauma influences individuals' behaviours and needs
- Work with individuals in a way that is sensitive to, and helps to overcome the impact of trauma in their lives and avoids re-traumatisation.

Services working with families in early childhood can recognise and respond to the way in which parents' or primary caregiver's experiences of trauma may impact their wellbeing, engagement with services and relationships with their babies. Understanding trauma also helps professionals to understand why it is so important to address adversity in early life.

Systems can be designed to be trauma-informed, so that all professionals have a good understanding of trauma and are trained and supported to work with individuals and families which is sensitive to the trauma they might have faced and helps them to overcome the impact of trauma in their lives. Trauma-informed systems also consider how to identify those who have experienced multiple childhood traumas, and how to put support in for families that addresses the impacts of trauma and prevents intergenerational transmission of trauma.