PennState

Take Root Home Visitation

Helping Our Youngest Military Family Members and Their Parents Thrive

thrive@psu.edu 1.877.382.9185

CLEARINGHOUSE FOR MILITARY FAMILY READINESS

Acknowledgments

The main authors of this work were: T. Saathoff-Wells, M.T. Czymoniewicz-Klippel, & D.F. Perkins

The authors would like to thank Amy Dombro for her significant contributions to curriculum development, as well as their Clearinghouse colleagues for ongoing support throughout the curriculum development and publication processes.

Recommended citation:

Clearinghouse for Military Family Readiness at Penn State (2019, May). Take Root Home Visitation: Helping our youngest military family members and their parents thrive. University Park: Author.

All correspondence related to this publication should be directed toward: thrive@psu.edu 1.877.382.9185

This material is the result of partnership funded by the Department of Defense between the Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy and the USDA's National Institute of Food and Agriculture through a grant/cooperative agreement with Penn State University.

take root home visitation

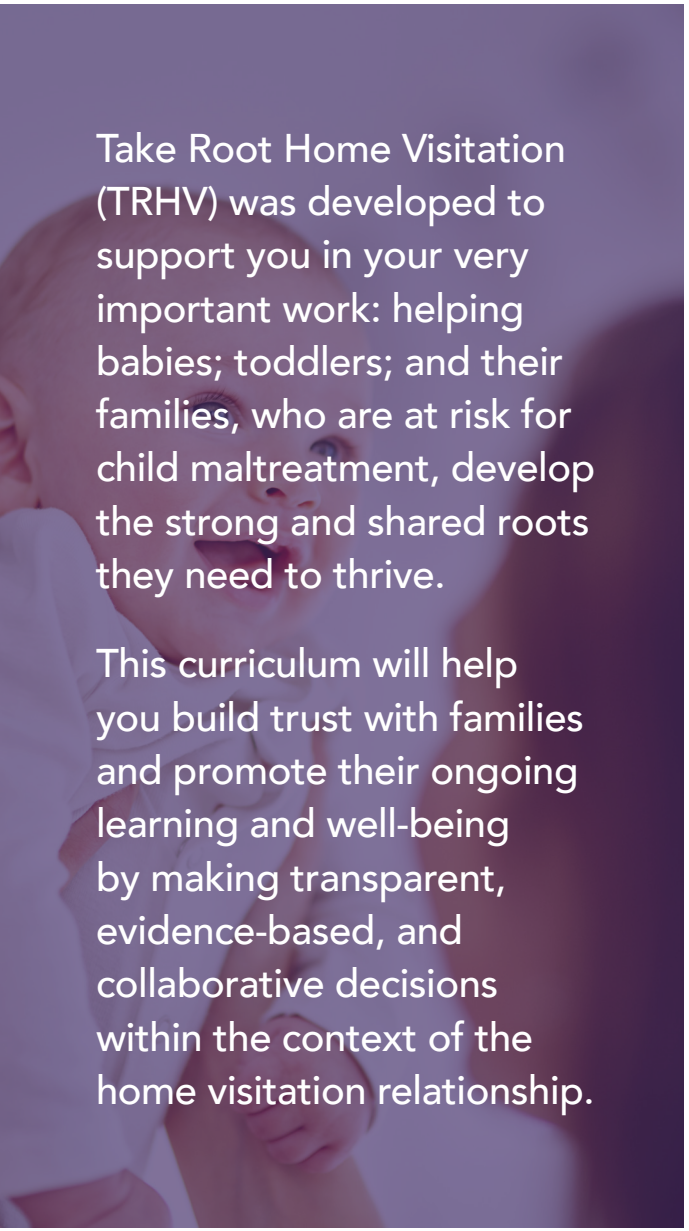
Table of Contents

Thrive Take Root Home Visitation Curriculum

take root home visitation

Welcome to Take Root Home Visitation

Helping Our Youngest Military Family Members and Their Parents Thrive



Take Root Home Visitation (TRHV) was developed to support you in your very important work: helping babies; toddlers; and their families, who are at risk for child maltreatment, develop the strong and shared roots they need to thrive.

This curriculum will help you build trust with families and promote their ongoing learning and well-being by making transparent, evidence-based, and collaborative decisions within the context of the home visitation relationship.

Your Decisions Matter

Every time you plan a visit or walk through the door of a family's home, you make countless decisions about what to say and do—and how to carry out these choices. Some decisions are complex, such as how to engage a family under extreme stress or identify community resources that are appropriate for a family. Some decisions are may be simpler, such as choosing a particular one-on-one activity to introduce during a visit. Some decisions require deliberation and consultation with colleagues, such as the identification of a developmental delay or parental mental health need. Yet, other decisions may come naturally, like how to greet a family member or where to sit in a family's home. However, to make the most effective decisions, you must draw upon your professional expertise and experience, your observations, and your knowledge of yourself and individual families.

With every curriculum decision, you have the opportunity to make parents and their children feel seen, affirmed, and understood. Your decisions to identify and articulate family strengths and then support parents to own and build upon those strengths deepens their trust in you. This strengthens your relationships with families and children, which will ultimately strengthen their relationships with one another, which makes a difference in their lives—today and in the future.

As you read through this guide, you will find the following seven sections:

TRHV supports you as a decision-maker as you assess, plan, implement, and report.

take root home visitation

Part 1 Foundations of Take Root Home Visitation

Introduction

In Part 1, you will learn about how the curriculum is framed within *Everyday and Special Focus Moments* in family life, conscious decision-making, and family strengths and how to foster resilience in families with very young children. TRHV is grounded in the *Protective Factors* and pulls from research and practice in the fields of resilience, neuroscience, attachment, and social cognition to build a curriculum that engages families, builds trust, and supports positive parenting. Best practices from parent education and infant mental health are integrated throughout the content and offer support to new and highly experienced home visitors. You will get your first introduction to the materials for home visits, including how they are grouped and a description of one-on-one activities.

By the end of Part 1, you will be able to:

1. Describe why TRHV is framed in *Everyday* and *Special Focus Moments*.
2. Identify the five *Protective Factors* as part of the foundation of TRHV.
3. Recognize the different materials and tools of the curriculum.

Recognizing Decisions in Everyday Moments

Focusing on decision-making with families provides an opportunity for families to pay attention to specific moments and interactions in the course of their incredibly busy and, at times, overwhelming everyday lives. This focus can make it possible for parents to recognize their effectiveness and strengths as they develop new ideas and strategies to handle daily moments that span crying, feeding, bathing, dressing, dealing with challenging behaviors, getting out the door, and sharing the care—all while trying to maintain their own personal, relational, and work commitments—often without enough sleep, time, or all-hands-on-deck!

Parents recognize some decisions that they make, perhaps because those choices are tied to a specific desire, goal, or part of their own understanding of what parents do. Yet, other decisions are not as visible or recognizable, and they may appear to an outsider to be impulsive, reactive, or on autopilot. TRHV helps parents see and understand the decisions that they make on behalf of their young children and family throughout the *Everyday Moments* of family life. Building greater awareness of these decisions can smooth some of the bumpy transitions into parenthood or the welcoming of another young child into their home.

Focusing on Family Strengths

The parents you serve face many challenges, which may include their young age, being far away from home, the stresses of deployment or homecoming, an injury seen or unseen, and past experiences of maltreatment or family violence. In addition, each is parenting a baby or toddler, which, in the best of circumstances, can be stressful and leave parents feeling vulnerable and in need of support even as they may be fearful of being judged.

At the same time, parents bring strengths to their family and to your work together. These strengths may include having dreams for their child's future success, possessing a sense of humor, having raised younger siblings, considering how they were parented and using the best practices they experienced as children, sharing a love of music, having a special smile for their baby, or making the commitment to be there each time you come into their home. TRHV meets families where they are and offers information and strategies families can use to build upon approaches or plans that work for them. In using TRHV, you can support families by making daily interactions and activities smoother, more engaging, and enjoyable for the child and adult.

Throughout the curriculum, family members will be invited to become more aware of and consider ways to build on their strengths, identify areas to develop (as opposed to weaknesses), and recognize the manageable steps they can use to increase their strengths. Intentionally taking a strengths-based approach within the home visitation relationship and building on the strengths you see from visit to visit are good ways to advance parents towards meaningful and lasting positive change in parenting practices. These are changes parents will own because the changes are built upon the parents' knowledge and skills, which allows parents to feel and be more effective. In turn, parents can enjoy and deepen relationships with their children during *Everyday Moments*, which reinforces the cycle of positive change.

This being said, there will be times when you will need to take more direct action. For example, when you see health or safety hazards, such as bottles of medications being stored on a low, available shelf or observe a parent startle and have an outsized response (e.g., losing it by yelling or other angry, defensive actions and words) at the sudden noise of his toddler dropping blocks on the floor, these types of issues need to be addressed. In addition, observed signs of neglect or abuse need to be documented and reported, even if they may fall outside the boundaries of your direct work with a family.

Part 1 Foundations of Take Root Home Visitation

The TRHV integrated documentation system helps you identify when direct action should be taken. While strengths will vary across families, adopting a strengths-based approach begins with you. Identifying your expectations and being aware of your own feelings and values can help you avoid making assumptions.

- Your expectations. Expecting to see and find parents' strengths is the first step to being strengths-based. Every parent brings strengths to their family and to your work together. In some cases, strengths may take time to see, but knowing strengths are there will help you remain engaged and build upon them.
- Awareness of your own feelings and values will help you avoid making assumptions. Self-awareness allows you to be your own best resource as you apply your observations, knowledge, and skills during a home visit. You need to be aware that you will bring a set of assumptions to every home visit.

  When you acknowledge and understand that, you can then be more open to see, listen, and discover what a parent may be feeling or what a parent's behavior might mean. When you understand the situation, you can decide what to say and how to respond in ways that truly meet parents where they are and be a genuine, respectful decision-making partner with families.

Take a Moment: Your First Interaction with a Family

How do you first approach working with a family? Do you find that your approach is effective? How so?

Would you describe yourself as open to seeing a family's strengths as you begin your work with them? If yes, how does this make your work more effective?

If no, what shifts might you make in your expectations and approach to become more strengths-based?

Creating a Genuine, Respectful Partnership

Every aspect of TRHV is designed to support you in creating a genuine, respectful partnership. This partnership is integral to creating positive and lasting change for families and children. To this end, the TRHV materials intentionally do the following:

1. **Reflect the reality of being a parent to convey the message to parents: "You are seen."** Parenting is a demanding, exhausting, full-time, amazing, loving, heartwarming, and difficult endeavor. No one has all the answers. There are no perfect parents. The purpose of this curriculum is to help parents be their best.
2. **Promote conversations with families.** Each topic creates opportunities for family members to get to know more about their own family strengths and challenges and those of their child. The planning documents support a parent-home visitor collaboration to select topics that address specific areas of interest and need. This is in sharp contrast to the home visitor assuming the stance of expert and telling families what to do.
3. **Integrate *Family Pages*.** These pages invite families to personalize content as a means to empower and give voice to family members at every visit. Design and text elements of these pages make the conversation accessible and welcoming to families of varying levels of literacy and English proficiency.
4. **Offer practical, hands-on, and inexpensive ideas for strategies and activities.** Affordable and easily doable activities for parent-child interactions and play-based learning are based on daily routines and use common household items.

Theory and Practice Foundations of Take Root Home Visitation

Several different fields of research, their theories, and best practices come together as the foundation of TRHV.

In *Figure 1* there is a thick, purple circle encapsulating the different elements that provide the foundation for this curriculum.

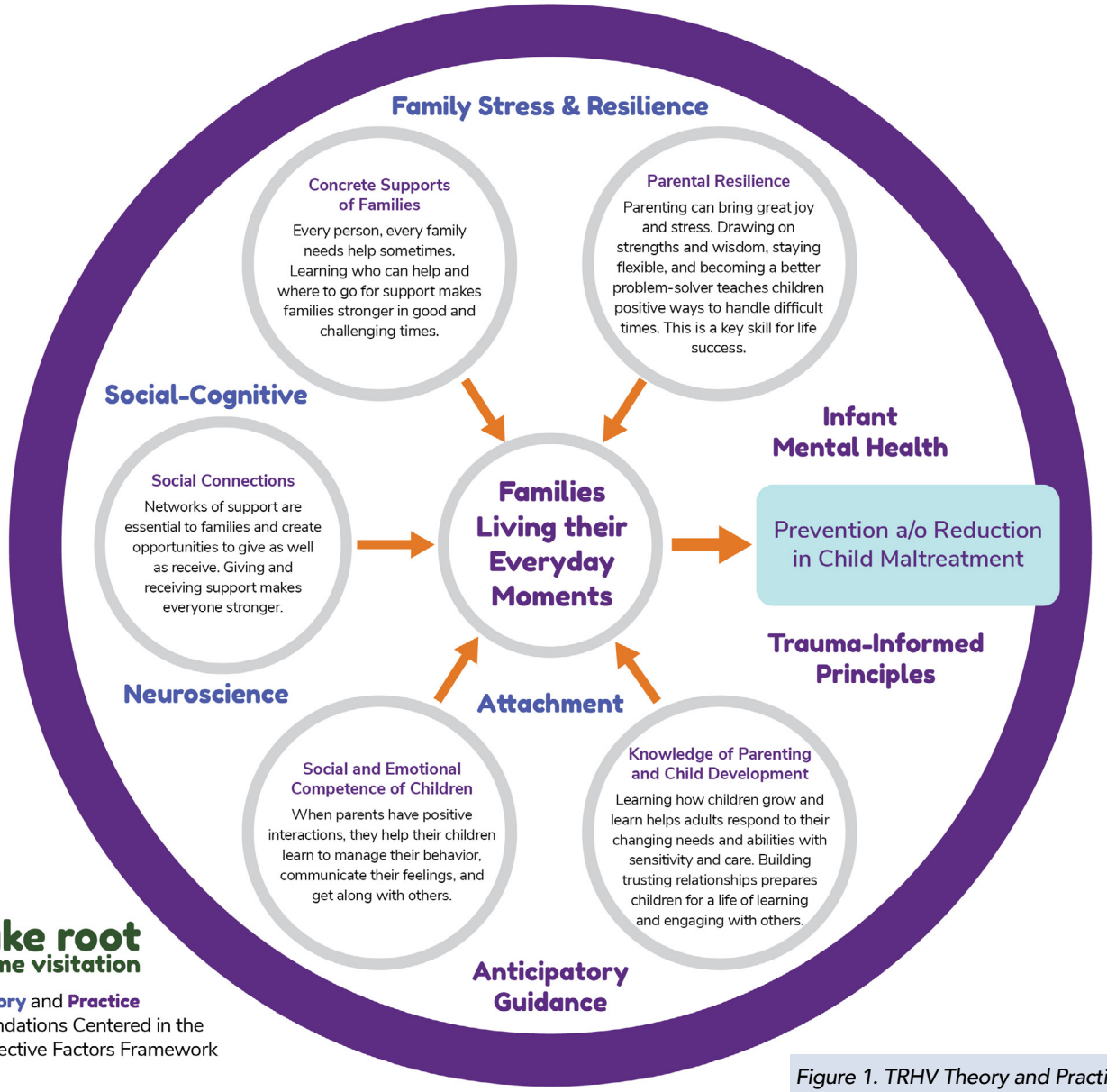


Figure 1. TRHV Theory and Practice Foundations

Figure Key: A Guide to Understanding Figure 1

Protective Factors: Families Centered within the 5 Protective Factors

Families are the focus of our work and, for this reason, are centered within the 5 *Protective Factors*. Arrows from the factors into the family system indicate that these factors influence the daily life and well-being of families.

Five grey circles represent each of the *Protective Factors* in the *Protective Factors Framework* (Center for the Study of Social Policy, 2012). These are written in parent-friendly language for you to use in your home visits. These are also available as a laminated card/fridge magnet that parents can keep:

Social Connections – When you and family, friends, and others in your school, work, and child care communities can count on each other, life is easier and more enjoyable. Giving and receiving support makes everyone stronger.

Concrete Supports of Families – Every person and every family needs help sometimes. Learning who can help you meet your family's needs and where to go for support makes you stronger in good and challenging times.

Parental Resilience – Parenting can bring great joy and stress. When you draw upon your strengths and wisdom, stay flexible, and become an even better problem-solver, you teach your child positive ways to handle difficult times—a key skill for life success.

Knowledge of Parenting and Child Development – Learning how your young child grows and learns will help you respond to his or her changing needs and abilities with sensitivity and care. By building a positive, trusting relationship, you prepare your child for a life of learning and engaging with others.

Social and Emotional Competence of Children – When you have positive interactions, you help your child learn to manage behaviors, communicate feelings, and get along with others.

Theories and Fields of Research

Family resilience, attachment, neuroscience, social cognitive theories, and their respective fields of research guided the topic selection and details of the *Everyday and Special Focus Moments*. These theories and research findings enrich our understanding of what information is important to share with families, while the practice strategies shape the curriculum's beliefs about the most effective ways to share that information. These elements in the graphic are represented by blue text:

1. ***Family Stress and Resilience –*** The study of family resilience has grown significantly in the past two decades. In practical terms, TRHV draws from family resilience literature to integrate ways in which the home visitation relationship can foster family growth, recovery, and repair in the face of a variety of challenges. Families thrive when members are able to build and expand healthy coping and relational capacities.

   When young children have a safe, caring, and responsive caregiving environment, they can gain the necessary life skills of healthy social and emotional regulation through positive and adverse experiences. The *Protective Factors Framework* is a direct outgrowth of linking family resilience theory with research that shows which factors matter in reducing and preventing child maltreatment.

2. ***Attachment –*** As professionals who work with high needs families, you already know how vital a healthy and dynamic attachment relationship is for a young child. Some of the parents you work with may have experiences from their own childhood that challenge their abilities to form healthy connections with their child. TRHV provides opportunities for parents to recognize their young child's verbal and non-verbal cues for safety, care, comfort, and dependability and helps them see their own reactions to their child's needs, behaviors, and emotions.

   Activities include parental practice in responding appropriately and with empathy, incorporating their knowledge of their child's development and abilities, and helping parents see what factors might be driving their own reactions and decisions.

3. ***Neuroscience –*** We learn more about how our brains work every day and how responsive our brains can be to internal conditions (e.g., maturation, getting older) and external conditions (e.g., nutrition, poverty, violence, high- or low-quality care, injury).

   The first 3 years of life are critical for brain development in the areas of the brain that work to identify safety and threats. When young children assess their social world as safe, their brains build neural pathways for engagement and growth. When young children assess their social world as threatening or unpredictable, their brains build neural pathways to minimize threat and optimize safety. These pathways encode experiences across all five senses, and the more certain senses are part of the experience, the stronger the memory—whether positive or adverse. TRHV provides practical activities to help parents build healthy experiences and moments with their child to build pathways that support engagement and growth.

   For example, parents may create a bath routine that shows care, safety, and emotional engagement (e.g., supportive holds, singing about body parts, gentle touch). This may become a routine that reinforces development of positive pathways, and the child learns to count on this as a stable routine filled with good things. Parents may also choose to engage with a 2-year-old's public meltdown

by meeting the child where they are and providing support to help their child through the meltdown. This type of reaction turns a highly emotional and negative experience into an opportunity to provide positive emotional coaching, so the child can start to learn how self-regulate when upset.

Please note, parents' brains are also changing as they gain parenting experiences and engage with the material you share through the home visitation relationship! Everyone can build and foster healthy response pathways in the family system by improving interactions with one another.

4. Social Cognitive – Social Cognitive theory drives many parent education curricula, including TRHV. The premises are that an individual's learning and engagement with content is influenced by several factors, including one's own sense of self-efficacy; ability to self-regulate emotions and behaviors; history of being parented and cared for; and expectations for self, child, and program participation. TRHV is designed to help you create conversations with parents that elicit their own understanding of materials and how information is similar to and different from what they already know and believe. These conversations are opportunities for change and to reinforce current practices and ideas parents may have.

Areas of Professional Practice

For prevention and intervention work, best practices have been identified throughout the Home Visitation and Allied Health fields. The following areas of professional practice provide important touchstones for TRHV service delivery decisions: assessing incoming families, developing strong alliances with families, and selecting and presenting materials with respect for each family's context.

In purple text, three areas of professional practice offer specific ways to build empathic, professional, and therapeutic alliances between early intervention specialists and the families with whom they work:

1. ***Anticipatory Guidance –*** This approach is often used within the pediatric health fields to provide parents and caregivers with targeted knowledge that is useful in understanding their child's needs and abilities at the time of a visit (e.g., well-baby, acute care) and in the near future (e.g., things to look forward to, typical things to expect as baby changes and grows). Anticipatory guidance strategies can introduce topics that can then be revisited as changes occur due to maturation, illness or injury, or if an expected ability or behavior does not seem to be progressing as expected.

   TRHV integrates anticipatory guidance opportunities throughout content whenever possible, so conversations can continue as children grow and their needs change. For example, a home visitor can work with parents before a family visit or vacation where many relatives will be present who are not familiar to their 7- to 14-month-old infant. Parents benefit from understanding common infant reactions of stranger anxiety and separation anxiety and can learn strategies to support their infants who do not want to be held by unfamiliar people or become overwhelmed by enthusiastic greetings and big groups of new people. Providing anticipatory guidance can also help parents find their voices as advocates for their child to be able to say no or offer alternatives to well-meaning relatives in similar situations.

2. ***Infant Mental Health –*** This area of practice focuses on nurturing the healthy development of the infant-family caregiving system. It is a means to promote early mental health in very young children and reduce risks posed by mental and physical health challenges that may be experienced by their parents. As such, attention is given to identifying potential peri- and post-partum mental health needs of women, attachment and bonding, the transition to parenthood, and the early identification of infant developmental and sensory disorders that could adversely impact the development of effective and responsive caregiving. Infant mental health practice always places children within their caregiving context to understand growth and change. TRHV follows this practice by placing infants, toddlers, and their families at the center of our model and by placing the infant-family system at the center of modeling reflective and mindful parenting (see pg. 6).

3. ***Trauma-Informed Care –*** A trauma-informed approach to practice is one that can work across multiple populations whether trauma has occurred or not, whether the trauma is recent or historical, whether it was an acute experience or has chronic characteristics, whether it was singular or multiple moments, and whether a client wants to bring it up with a professional or prefers not to talk about it. Within TRHV, principles of *Trauma-Informed Care* center on creating a professional-client alliance that works from a family strengths perspective (SAMHSA, 2014):
    - Fostering a sense of physical and psychological safety;
    - Modeling transparency in program decisions to build and maintain trust;
    - Encouraging peer support and mutual self-help to build empowerment and resilience;
    - Building a collaborative process to highlight the roles of shared power and decision-making within the family system and the client-home visitor relationship;
    - Cultivating empowerment, voice, and choice by building on what clients have to offer as both parties work toward greater thriving and resilience; and
    - Offering gender- and culture-responsive services, valuing traditional connections, and addressing historical trauma.

In summary, here are some of the ways TRHV assists you in your work that supports families as they grow stronger and more resilient:

1. **Take Root Home Visitation supports you in promoting the *Protective Factors.*** Research indicates that building these five factors reduces the likelihood of child abuse and neglect.

2. **The content of Take Root Home Visitation is based on *Everyday Moments* in the lives of families and their babies and toddlers.** You will be offering practical information, hands-on strategies, and activities parents want and need to make *Everyday Moments* work for themselves and their young child.

3. **Starting with assessing families, Take Root Home Visitation is strengths-based.** Using information from multiple sources, the TRHV curriculum and materials support you and each family in creating a plan tailored to build on strengths and address challenges. It supports parents in setting their own goals for family resilience with your support.

The Context of Everyday Moments and Special Focus Moments

Everyday Moments and *Special Focus Moments* frame the content of this curriculum because these experiences build family systems and set the tone and expectations for how family members relate and interact with one another. *Protective Factor* icons are used to quickly identify that the content addresses one or more specific factors within each *Everyday Moment* topic. Further, the content uses the principles of *Trauma-Informed Care* to foster a collaborative relationship.

Because they happen so often, *Everyday Moments* open a window for you to gain understanding of family life and how you can step in to help families grow to be more resilient.

Patterns and habits develop through every collective experience and individual experience in the family system. *Everyday Moments* group these experiences into three basic categories:

1. **Daily Care and Living Routines**
   Parents develop several daily routines to ensure basic care of their young children, such as establishing sleeping, feeding, bathing/toileting, and dressing routines. Yet, they are not just functional for the health of the infant. These routines form a deep foundation of how to interact with each other, develop expectations, and learn variations in patterns.

2. **Young Children's Play and Exploration**
   Infants and toddlers are active observers and explorers and are often described as little scientists who are trying to figure out how people, pets, and things in their environment work. TRHV highlights key developmental milestones from 0-36 months and emphasizes the critical social worlds of very young children's

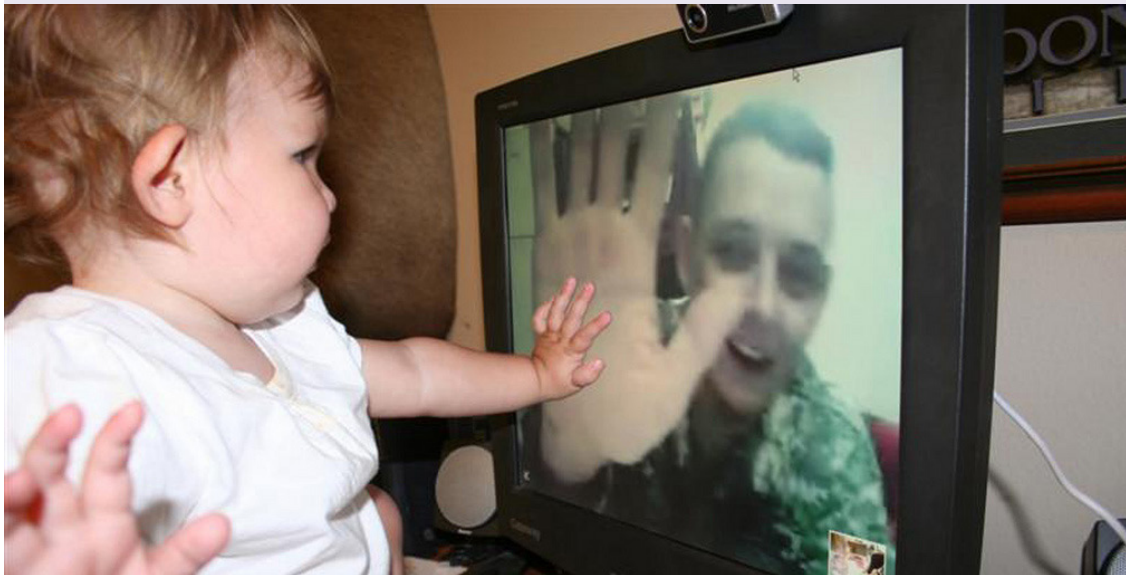
important adults and caregivers and their early friendships. As much as possible, these topics are in the voice of the child, which emphasizes the child's perspective on their own development.

3. **Parenting Life**
   Sometimes parents are surprised to realize that learning a little bit more or adding a new skill to their toolkit helps them meet a parenting challenge. Sometimes these challenges involve recalibrating a balancing act of self-care, sharing care of their infant with others, and learning or unlearning discipline strategies that can vary in their appropriateness and effectiveness with each child. And sometimes, young families are faced with difficult circumstances and significant adversities that can impact their individual and family well-being. Home visitation can provide empathic and concrete support during times of increased stress.

The adults in a young child's life provide a range of everyday experiences whether they are parents, foster parents, grandparents, or guardians. The *Everyday Moments* we focus on happen in all families in unique and common ways, depending upon the individuals involved and their childhood experiences, cultures, hopes, and dreams. Each is an opportunity for you to offer basic parenting information and to identify existing skills and strategies and promote new ones, many of which will be useful across moments.

Our military families face some challenges that are not necessarily common in the non-military population. Thus, TRHV also includes two *Special Focus Moments* that pertain specifically to experiences of military families:

1. **Parental Absence in Military Life:** When parents must be absent for an extended period of time or repeatedly over time due to the nature of their jobs, the absences and reunions can pose challenges for young children's relationships and their parents' intimate and co-parenting rhythms and expectations.
2. **Parenting After Injury:** When a parent is affected by injury, whether visible or invisible, with acute or chronic effects, their parenting abilities and sense of parenting self-efficacy may be affected, and co-parenting strategies may need to be altered. The recovery trajectory of the injured parent has the potential for disruptions in caregiving due to travel for care, changes in daily caregivers and routines, and the sense of stress and (dis)stress that is felt in the family system.



Reflective and Mindful Parenting

Each *Moment*, whether *Everyday* or *Special Focus*, is an opportunity for you to help parents learn to be more mindful and intentional, as opposed to reactive, by modeling and encouraging parents to ask themselves three questions as they decide when and how to interact and how to handle a situation. These three questions, listed below, help parents develop awareness of their own responses and their child's, which can help parents see themselves as decision-makers as opposed to operating on autopilot.

This self check-in can begin to free parents from responses that are habitual and have been learned from their childhoods and that they want to change. Each *Moment* has *Family Pages* that are designed to help reinforce this practice of pausing to think about self, wondering what a child is experiencing, and then deciding how to move forward together:

1. ***What am I feeling and thinking?***

   We begin with the adult because his or her decisions about what he or she says and does shape and color a child's learning about self, others, and the world. Taking a minute's pause is also an unspoken reminder to adults who are under stress—whether from everyday parenting and/or other complicating circumstances and situations—to take a breath, a first step to more mindful responses.

2. ***What is my child feeling and thinking?***

   Children's behavior has meaning and may change over time as a child develops. It is the job of the adults in the child's life to figure out what that meaning is. The only way to do this is to watch and listen from the outside for clues about what is happening on the inside.

3. ***How can we work this out together?***

   Here is where the adult uses the information gathered about self and the child to problem solve and decide what to say and/or do.

Moments are also rich opportunities for you to support children and their most important adults and to promote the strengthening of *Protective Factors*, even within a limited number of visits. If, for example, you visit a family only six or seven times, these *Moments* are still important opportunities to promote meaningful and lasting change because they do the following:

1. Allow you to meet a family where they are. You will gain insight into and be able to address a family's current questions and challenges as you identify the *Protective Factors* to center on and decide together on the *Moment* that will be your shared focus.
2. Provide the opportunity for families and you to learn together about a child. As you invite a parent to share a story or two about how an *Everyday or Special Focus Moment* is going, you will discuss and discover aspects of a child's development, temperament, and preferences.
3. Invite collaborative problem-solving and decision-making about what strategies might work best for a parent and child to make the *Everyday Moment* as smooth and enjoyable as possible. This can help parents feel more effective as they realize there are steps they can learn about, discover, and decide to try, which could make life easier and more fun for everyone.
4. Offer extraordinary learning opportunities for babies and toddlers. They happen often enough to give children a sense of predictability, yet there is enough variation to invite interest and exploration to promote learning about self, others, and the world.
5. Allow families to experience success. This can lead to increased confidence, competence, and more success—in your presence or not.

The chart to the right shows the *Everyday Moments* included in this curriculum and the *Protective Factors* embedded in each.

take root home visitation

Everyday Moments and the Protective Factors

Everyday Moments: Daily Care and Living Routines	
TOPICS	**Protective Factors**
Sleeping	Parental Resilience Knowledge of Parenting and Child Development Social and Emotional Competence of Children
Nutrition and Feeding	
Diapering and Toileting	
Bathing and Dressing	

Everyday Moments: Young Children's Play and Exploration	
TOPICS	**Protective Factors**
Exploring and Learning about the World	Concrete Supports of Families Parental Resilience Knowledge of Parenting and Child Development Social and Emotional Competence of Children
Building Trusting Relationships	
Nurturing Guidance and Discipline	

Everyday Moments: Parenting Life	
TOPICS	**Protective Factors**
Co-Parenting and Sharing Care	Social Connections Concrete Supports of Families Parental Resilience Knowledge of Parenting and Child Development Social and Emotional Competence of Children
Parental Self-Care	
Loss, Grief, and Growth in Young Families	

Special Focus Moments: Military Family Life	
TOPICS	**Protective Factors**
Parental Absence in Military Life	Social Connections Concrete Supports of Families Parental Resilience Knowledge of Parenting and Child Development Social and Emotional Competence of Children
Parenting After Injury	

TRHV Everyday Moments and the Protective Factors Chart.

One-on-One Activities

In addition to the *Moments*, TRHV also provides a set of cards that describe a series of one-on-one activities to share with families. As you plan for a home visit, you will choose a one-on-one activity(s) that offers a family the opportunity to build skills they can use to make the selected *Moments* work for them and their child. For example, during a visit where sleep is discussed, the one-on-one activity may be a soothing activity (e.g., baby massage, reading, singing, telling a story about the child's bedtime routine).

These activities give you the chance to embrace and strengthen the parent-child relationship and support the parents' positive interaction as you do the following:

1. Introduce the activity and offer simple, clear directions and any materials needed. Note: Materials should largely be household objects, recyclable materials, or homemade items.
2. Model as needed.
3. Sit back a short distance.
4. Pay close attention to the interaction—as if shining a light on this parent-child *Moment* to express the message that it matters.
5. Coach parents on how what they say and how this supports their relationship and/or their child's learning.
6. Highlight strengths of the adults and child.
7. Reinforce messages about how children and parents are growing, changing, and learning.
8. Build a family's resilience through the creation of a resource kit that contains a variety of activities that parents and children can do together anytime with affordable, available materials.

One-on-One Activities Incorporated into the TRHV Curriculum

Several parent-child activities are suggested in the accompanying TRHV Activity Card deck. These highlight opportunities for parents and children to connect, wonder, learn, and laugh together.

Face-to-Face

These activities are times to connect, grow trust, learn about each other, and dance your unique "together dance."

Play with Words, Sounds, and Numbers

These activities are a chance to explore ideas, build skills, discover patterns, and support your child to understand pictures and words.

Pretend Together

These activities will inspire imagination and help your child understand their world.

Quiet and Calm Together

These activities will help you both when it is time to slow down and lower stress.

Move Together

These activities help you to be free and silly while you help your child learn about their body.

Touch, Taste, Feel, Hear, See

These activities encourage curiosity and let your child make choices and ask questions.

Lead and Follow; Follow and Lead

These games are times to gently guide and to give your child a chance to practice self-control.

Explore Your Community

These activities help you open the doors to new possibilities for connection and support for you and your child.

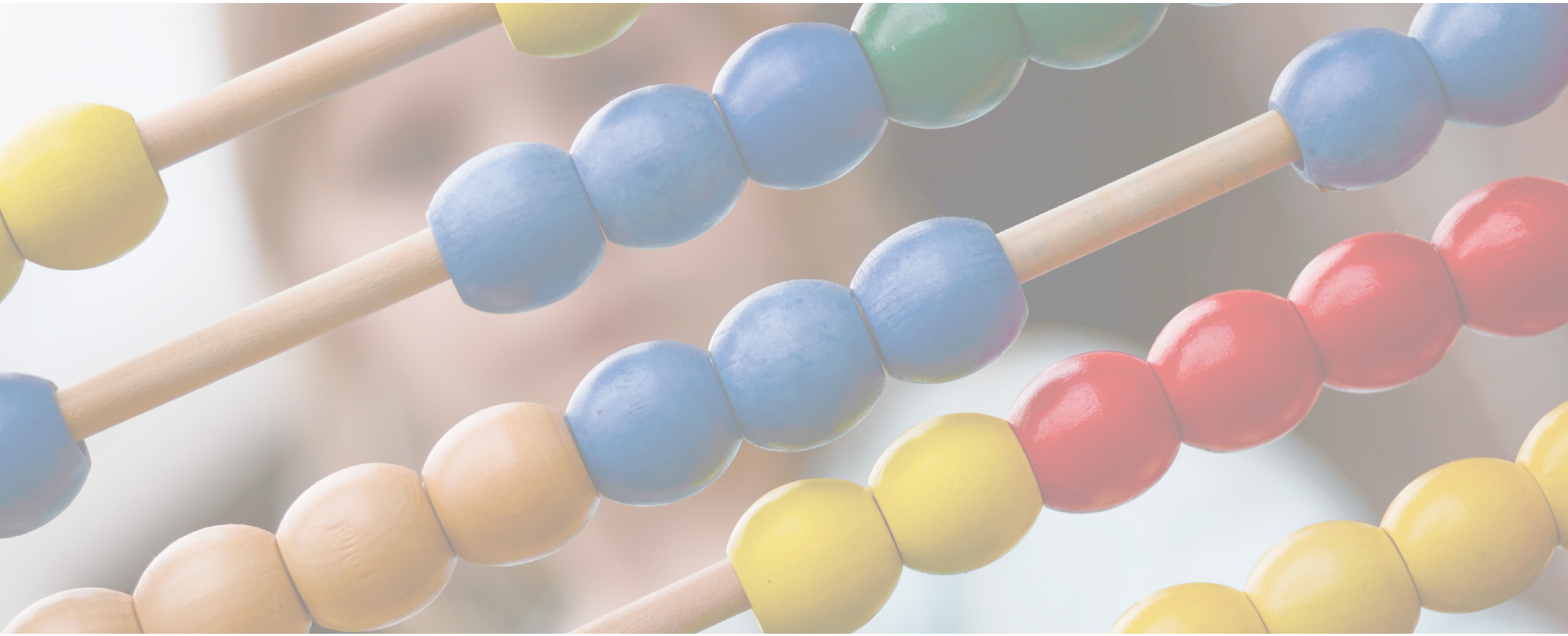
take root home visitation

Part 1 Foundations of Take Root Home Visitation

In Summary

TRHV is a curriculum designed to support home visitors as they meet families where they are, pay attention to the family's historical and current contexts and their perceived strengths and needs, and focus on helping parents support their infants and toddlers by building a healthy family system. The materials are designed to foster strong and trusting alliances with families, and the content focuses on daily parenting and caregiving experiences and insights from a young child's perspective about their own development and life. Careful attention is given to link the content with the five *Protective Factors* so information is clear, and the decisions home visitors and parents make are more visible and intentional.

The next section focuses on the seven guiding principles of *Trauma-Informed Care and Practice* (*TICP*). Practical examples are provided which are likely to affirm aspects of your practice and that of your colleagues.



take root home visitation

Part 2 Using Trauma-Informed Care and Practice to Enhance Collaborations

Safety | Trust & Transparency | Peer Support & Mutual Self-Help | Collaboration & Mutuality | Empowerment, Voice & Choice | Cultural, Historical & Gender Factors

Introduction

The six guiding principles of *Trauma-Informed Care and Practice* (*TICP*) are intentionally woven throughout TRHV. These strength-based concepts are responsive to the impact of trauma by promoting the physical, psychological, and emotional safety of provider organizations, practitioners, and those whom they serve.

By the end of Part 2, you will be able to:

- Identify the six principles of *TICP*.
- Recognize how these principles are or can be used within your organization.
- Recognize how these principles are or can be used within your practice with families.

Babies, toddlers, and their families have a way of evoking strong and deep emotions. Think about times you found yourself in a supermarket checkout line and you observed a proud father cooing back at his infant or were stuck behind a screaming toddler and her mother. If children and families whom you don't know and may never see again can stir up emotions, consider how much the children and families you work with can impact you physically and psychologically.

take root home visitation

Part 2 Using Trauma-Informed Care and Practice to Enhance Collaborations

Professionals who work with families at risk for maltreatment are themselves at risk for compassion fatigue and even burnout. Applying the principles of *TICP* to your own professional care and development can buffer these natural consequences of listening, witnessing people's lives, and wanting the best for the families in your caseload.

The principles of *TICP* can lead to a work environment in which you and your colleagues feel safe to discuss, problem-solve, and support one another in coping with the stressors that are an inherent part of your work. This allows each of you *to be your best self* as decision-makers as you implement TRHV.

When it comes to your work with families, the principles of *TICP* support you as you create opportunities for parents and other family members to rebuild their sense of control and empowerment. This is key to creating the trusting, responsive relationships babies and toddlers need to thrive and to make the best possible parenting decisions across *Moments*.

It should be noted that trauma does not need to occur for family patterns to develop a wobble or become dysfunctional. Sometimes, parents may act a certain way or make comments to a co-parent based on unspoken expectations of roles and relationships, and those actions and possible reactions can contribute to that sense of imbalance. For example, if a mother is trying to be a good mom, insists on being in charge, and always takes the lead in caring for and playing with her child, her spouse may feel left out or incompetent. Their family life may eventually grow out of balance as the mom feels put upon, her spouse feels useless, and their child misses out on experiencing the teamwork of her parents and interactions with both that deepen relationships.

With your support, a mom can realize there may be times when she does have to handle it all, for example, when her spouse is sick or away for field exercises or deployed. She may gain confidence and insight into the importance of experiencing adults working together for her child and taking care of herself, which, in turn, leads her to let go of some of the control and be a more collaborative partner and parent. As a result, the family system is in a more sustainable balance.

On the following pages, you will find definitions of each principle and examples of how these principles can enrich your relationships with colleagues and families you serve. In discussing each principle, we begin with you because your work holds the possibility of helping families see, articulate, discover, claim, and build upon their strengths, which can create ripples of positive change long after your visits.

Part 2 Using Trauma-Informed Care and Practice to Enhance Collaborations

Chances are you have already—intentionally or not—integrated many, if not all, of these principles as they reflect best practices in creating healing relationships.

The principles have been translated into family-friendly language that you may decide to use in conversations with families:

Safety

Family members and home visitors do their best when they feel physically and psychologically safe. Ensuring safety allows home visitors and families to focus on their work together and to interact with the best interests of a young child(ren) in mind.

Working in families' homes means it is possible you could find yourself caught in a potentially dangerous family interaction. Planning ahead with colleagues by identifying and implementing safety policies, procedures, and practices (e.g., making sure someone knows where you are; having a phone contact available; arranging for a phone check-in, articulating the steps to take for your safety and then a family's when things are getting out of control) can give you the security of a safety support network.

Families too can benefit from having safety procedures and practices in place. For example, you may support a family as they develop a safety plan in which parents identify signs that a family member with anger management issues is becoming agitated and have steps in place to take children out of the home if anger escalates.

Part 2 Using Trauma-Informed Care and Practice to Enhance Collaborations

Trust and Transparency

Decisions are discussed and made with openness and honesty to create and sustain trusting relationships. Home visitors and family members, from the youngest to oldest, will be more open to exploring, questioning, and learning when they feel safe and secure in their relationships and interactions.

How family members relate to you (or any service provider) may be impacted by their experience of, or concern about, trauma. You and your colleagues can help each other remember that symptoms, such as fears, heightened watchfulness, and distrust are adaptive and protective behaviors rather than affronts to you and the services you offer. Knowing these reactions are possible will support you and help you feel more positive about your work and be more open to creating trusting relationships with families.

Transparency is another key to *Building Trusting Relationships*, especially given that you wear two hats: one of supporter and the other of mandated reporter. Transparency begins during the consent process as you explain, "I do have a legal and ethical obligation to report if I see or hear something that would put a child or other family member at risk." It continues with transparent, shared decision-making throughout the implementation of TRHV (e.g., developing a family's goals or the most helpful *Moments* to focus upon) and allows parents to see you in your other hat: a thought partner. This is a very different stance than portraying you as an expert telling families what they need to know and do.

Peer Support and Mutual Self-Help

Home visitors and families support each other with information, lessons learned, and/or emotional and hands-on help. This is necessary for building trust, safety, and people's growing confidence about their decisions and taking control of their lives—at work and at home.

When you and colleagues share information and assist each other (e.g., by setting up a system which allows you to record and exchange tips and resources for the *Moments* section of TRHV), you build trust that will form the foundation of your ongoing work together. You also help to buffer your relationship from the bumps that naturally occur in all work settings.

When you and family members share information and assist each other (e.g., by each supplying recyclable materials to make a toy), the same is true.

Part 2 Using Trauma-Informed Care and Practice to Enhance Collaborations

Collaboration and Mutuality

TRHV fosters a home visitor-parent relationship where each person is a decision-making partner, working and learning together for the benefit of the family. Healing happens in relationships and in the meaningful sharing of power and decision-making. This is true whether in an organization, a meeting of home visitors, or in a family's home.

Because TRHV is grounded in a family's *Everyday and Special Focus Moments*, working together as genuine learning and decision-making partners is the only way this curriculum can be implemented effectively. Only when you listen and learn from each other and make decisions together can the information and resources you have to share be individualized to respond to a family's unique blend of circumstances, challenges, and strengths.

Empowerment, Voice, and Choice

Seeing and building upon individuals' strengths and what they have to say and offer paves the path for you to promote new skills as needed. Building on strengths—of home visitors and family members—rather than responding to perceived weaknesses reflects a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma.

When you choose to view colleagues as resourceful and resilient, even in the face of challenging times, you convey your belief and confidence in them to succeed and thrive. This makes it more likely your colleague will be able to problem-solve and to explore and integrate new information or skills.

When you have a similar mindset in your interactions with families, it is as if you reflect back to them their hopes and dreams. They are better able to focus and to see and think about themselves and others in a strengths-based light. (This is true for all of us.) This is key to moving ahead to reach their goals for themselves and their child(ren).

Cultural, Historical, and Gender Factors

Be aware of and move past stereotypes and biases. Interacting respectfully and responsively to individuals means looking beyond cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography). It means recognizing and supporting the healing value of one's cultural connections and addressing trauma that took place in the past.

We all have stereotypes and biases. Being aware of them is a first step to not letting them interfere with seeing others for whom they are. In work environments where this is addressed up front, conversations are more likely to be respectful and lead to helpful insights about working effectively with individual families.

Everyday and Special Focus Moments in a family are steeped with values, family and cultural traditions, and expectations about children's behavior and parenting. Only by putting aside your assumptions and keeping an open mind will you be able to understand what the *Moments* in TRHV mean for a family and use that insight to support parents in making the *Moments* you focus on during your visits work for them and for their child(ren).

Take a Moment: Reflecting on Your Practice

What is an example of a current *TICP* practice(s) of yours in working with colleagues or families that was affirmed in Part 2?

Is there something new you want to experiment with regarding your interactions with colleagues or families? What might that be?

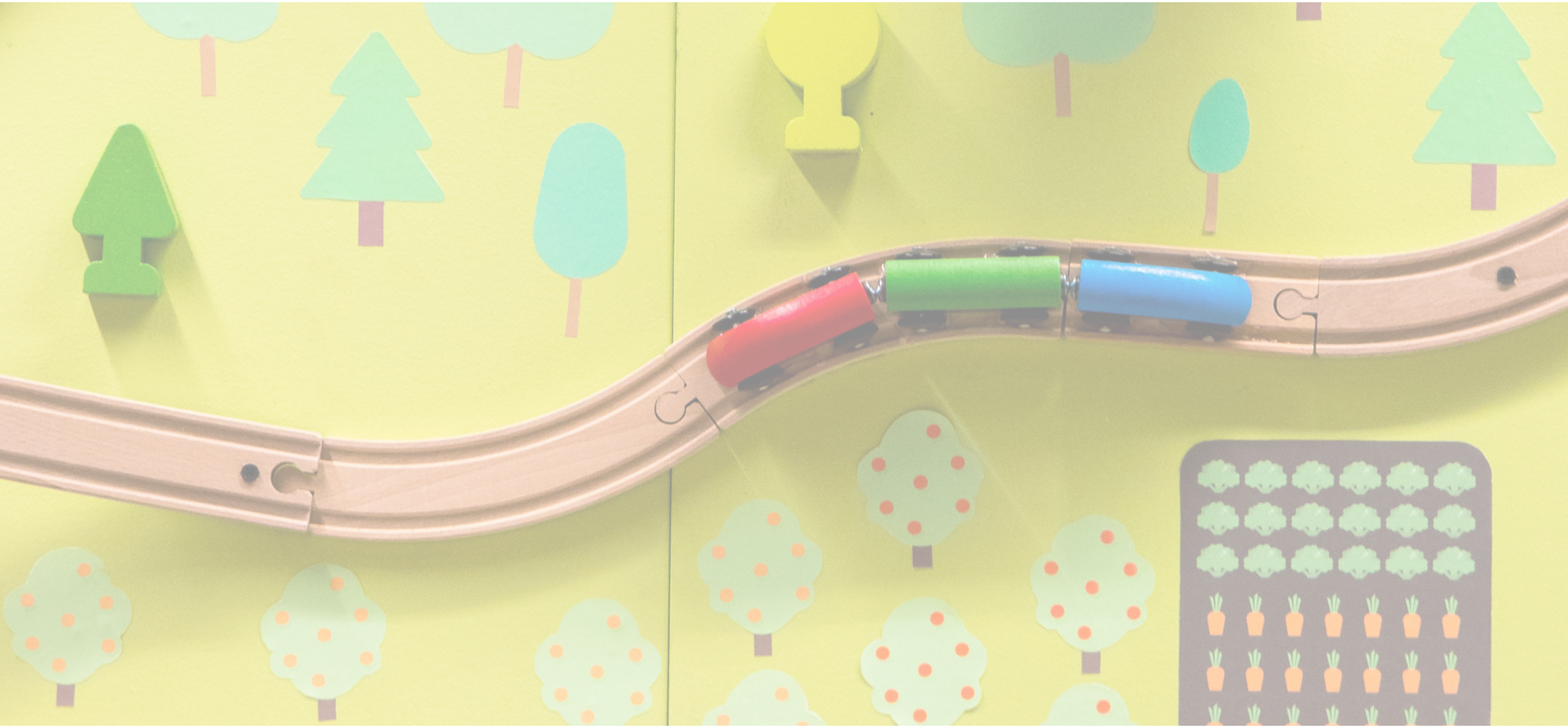
Part 2 Using Trauma-Informed Care and Practice to Enhance Collaborations

In Summary

The principles of *TICP* can be integrated in your work organization and in your work with families. These principles imply an intentional thought process to honor and respect others in daily interactions and hold judgments and assumptions loosely.

TICP is an on-going practice, and *Moments* hold opportunities to recognize one's own actions and progress in implementation.

The next two sections of this guide, Parts 3 and 4, will take you step-by-step through implementing TRHV.



take root home visitation

Part 3 How to Use Take Root Home Visitation

Introduction

There are many ways to plan and implement a home visit. Take Root Home Visitation is a comprehensive curriculum that helps you pull together the pieces of your home visit in a meaningful way. This curriculum includes integrated intake, planning, and reporting documents and recommendations for each step of the visit itself.

By the end of Part 3, you will be able to:

- Identify the many elements of your home visit.
- Understand the resources available to you to assist in your intake, planning, and reporting.

While it may feel like there are many pieces to sort out, this section carefully introduces all the elements to a home visit. Part 4 provides a practical example in the form of a *Case Study Family* to show how all the components come together and offers you an opportunity to flex your home visitor insights into possibilities beyond what is presented.

The Flow of a Home Visit

TRHV recommends the following steps for each visit. Using the same general steps each time you plan, implement, and report on a home visit helps define a routine and rhythm for you and the families you visit. As the TRHV content helps families discover and reinforce routines that foster resilience and stability, the familiarity of a visit routine also helps establish rapport and engagement between you and the family. When one of you feels strongly that an exception needs to occur, such as a pressing need for using the time differently (e.g., changing the focus of the planned content or an immediate care need of a family member), you and the parent can quickly identify the change in routine and adjust.

These steps are presented as a basic outline to give you a sense of the flow of a visit. Many of them may be very familiar to you; however, you may not have done them exactly like this or in this order.

Basic Visit Outline

- o ***Warm Greetings*** to parent and child.
- o ***Check In with Parent*** How are you? How have things been going since our last visit?

- ***Reflection from Last Visit: What one-on-one activity did you decide to try with your child? Suggested prompts:***
  - o Tell me about what happened.
  - o How did you introduce the activity? How did it feel to you?
  - o How do you think this activity helped your child learn and grow?
  - o What might you do differently next time for you or for your child?
  - o Is there a tip you would share with another parent about this activity?
- ***Discuss Plan for Today's Visit***
- ***Everyday Moments: A Conversation***
  - o Revisit why we chose this *Moment*.
  - o What is working well? What would you like to change?
  - o Discuss information from the module and strategies using *Family Pages* and related resources.
- ***One-on-One Activity: Supporting the Parent-Child Dance***
  - o During the visit: Try out a one-on-one activity related to the *Everyday Moment*.
  - o After the visit: Encourage the parent(s) to continue practicing the one-on-one activity or choose another to try.
- ***Summary of Key Points and Plans for Next Visit***
  - o Go over any new concepts, points of interest, and activities or responses the parent may be trying. Restate what topic(s) are noted for the next visit.
- ***Warm Goodbyes*** to parent and child.

Take a Moment: Flow of a Home Visit

How does this outline compare to your current practices?

How might any of these steps enrich what you already do?

Even if you follow the guidelines we provide in TRHV and draw on your own experiences as a professional, your home visits will not always feel organized or ideal. That is OK. As you work through the next few pages, you will begin to see how the *Basic Visit Outline* gives structure to planning and reporting. In addition, it allows for flexibility to make adjustments as needed once you step into a family's home and meet the parents and child(ren) where they are that day.

Implementing Take Root Home Visitation: A Step-by-Step Process

This section introduces you to the materials and steps used to implement TRHV. The graphic to the right shows the steps that home visitors can use to implement TRHV:

- Gather information,
- Build a collaborative *Family Service Plan*,
- Choose specific topics for visits, and
- Integrate an ongoing assessment that gives parents a voice and choices throughout the process.

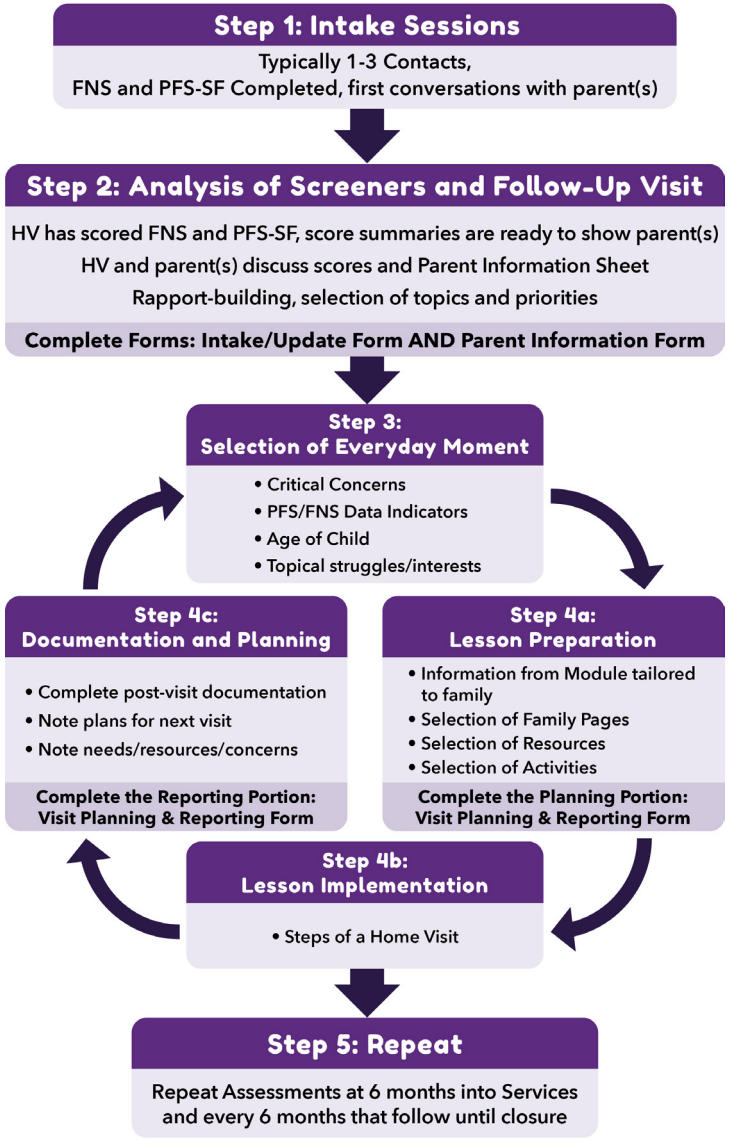
Also highlighted in the graphic are the appropriate time points for using the measures, planning visits, and reporting.

Data-Informed Decisions

Building a *Family Service Plan* starts with gathering information. TRHV uses two screeners and initial family conversations as sources of information. These help you make curricular choices and guide your work together:

1. The *Family Needs Screener* (Screener: *FNS*);
2. The *Protective Factors Survey, Short Form* (15-item *PFS:SF*); and
3. Early conversations with parents about their goals for home visitation and their hopes and dreams for themselves and their child.

These measures are also used to check in with parents at the 6-month point or when closure occurs. This reassessment cycle is explained in Step 5 to the right.



TRHV Step-by-Step Process chart.

Step 1: Intake Sessions (Assessments and Conversations)

TRHV is designed around current practice within the New Parent Support Program across all branches of the Department of Defense. For instance, the *FNS* is part of the intake information used to help you learn about certain critical needs a parent may disclose and then help you assess whether a family is eligible for home visitation services. As part of your current practice, you likely follow up after reviewing the score on the *FNS* and talk with the parent, perhaps asking him or her to complete additional measures or offering other resources.

In TRHV, the *FNS* is one of two measures used to provide intake information. The second measure is the *PFS:SF*. ***If your installation does not yet use the PFS:SF, full training on this measure is available online and via the TRHV-specific training.***

The *PFS:SF* is linked directly to the *Protective Factors Framework* and is also a screening instrument. Whereas the *FNS* identifies several different areas of potential risk or absence of risk, the *PFS:SF* identifies potential areas of protection (resilience) and absence of protection. The two measures complement one another, which will be shown in Part 4 with the *Case Study Family* example.

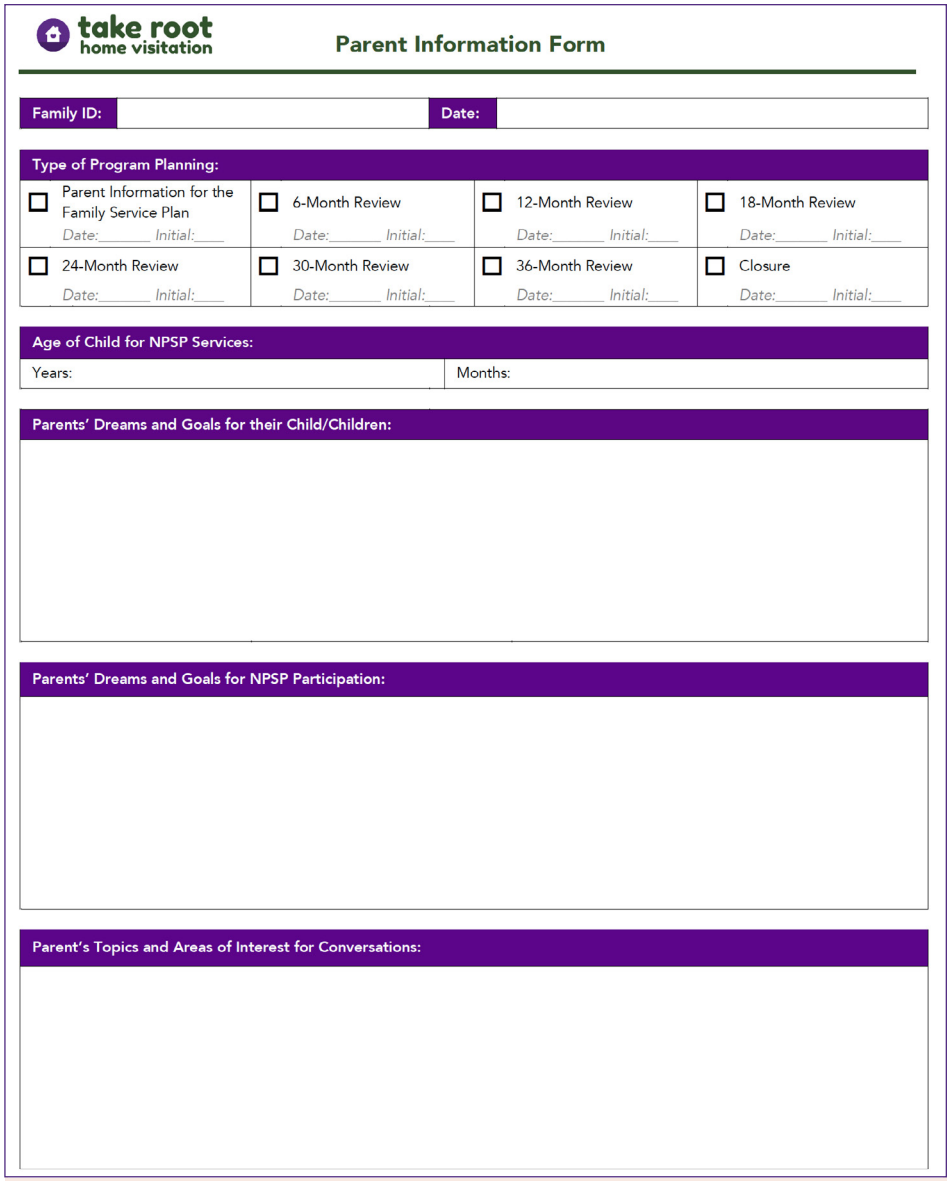
Step 2: Screener Analyses and Follow-Up Visit

Once the *Screener* and the *PFS:SF* are scored, the information provided by these measures can be used to start conversations. Parents can reflect on their answers; home visitors can start modeling strengths-based language to help describe what the scores can indicate.

The third source of information used at intake (and again every 6 months) is the *Parent Information Form*, a short open-ended intake form, shown to the right. It has questions about parents' goals and hopes for themselves and their children and can be completed by the parent alone or with help from a home visitor. This 1-page form helps gather more details about the family background, age of the child who is eligible for services, and if there are any specific topics on which the parent would like to focus.

The questions on the *Parent Information Form* are conversation openers, not prescriptive. The intent is to start the first of many conversations about what a parent may be thinking and feeling while building a connection to someone they can trust. While some of the needs a family has can be beyond the scope of the home visitation program, there may be connections that you can help make or resources that can be shared. If there are needs beyond this secondary prevention program, for example, where intervention is recommended, you and your supervisor may be able to facilitate those warm hand-offs to appropriate programs and professionals.

With these three sources of information, you are ready to draft a Family Service Plan that is informed by data from the two screening measures and by the information shared by the parents. Use the *Intake/Update Form for Family Service Plan* on the next page to combine the information from the FNS, the PFS:SF, and the *Parent Information Form* into a single document.



take root home visitation

Parent Information Form

Family ID: **Date:**

Type of Program Planning:

☐ Parent Information for the Family Service Plan Date:_____ Initial:____	☐ 6-Month Review Date:_____ Initial:____	☐ 12-Month Review Date:_____ Initial:____	☐ 18-Month Review Date:_____ Initial:____
☐ 24-Month Review Date:_____ Initial:____	☐ 30-Month Review Date:_____ Initial:____	☐ 36-Month Review Date:_____ Initial:____	☐ Closure Date:_____ Initial:____

Age of Child for NPSP Services:

Years: Months:

Parents' Dreams and Goals for their Child/Children:

Parents' Dreams and Goals for NPSP Participation:

Parent's Topics and Areas of Interest for Conversations:

TRHV Parent Information Form.

take root home visitation

Part 3 How to Use Take Root Home Visitation

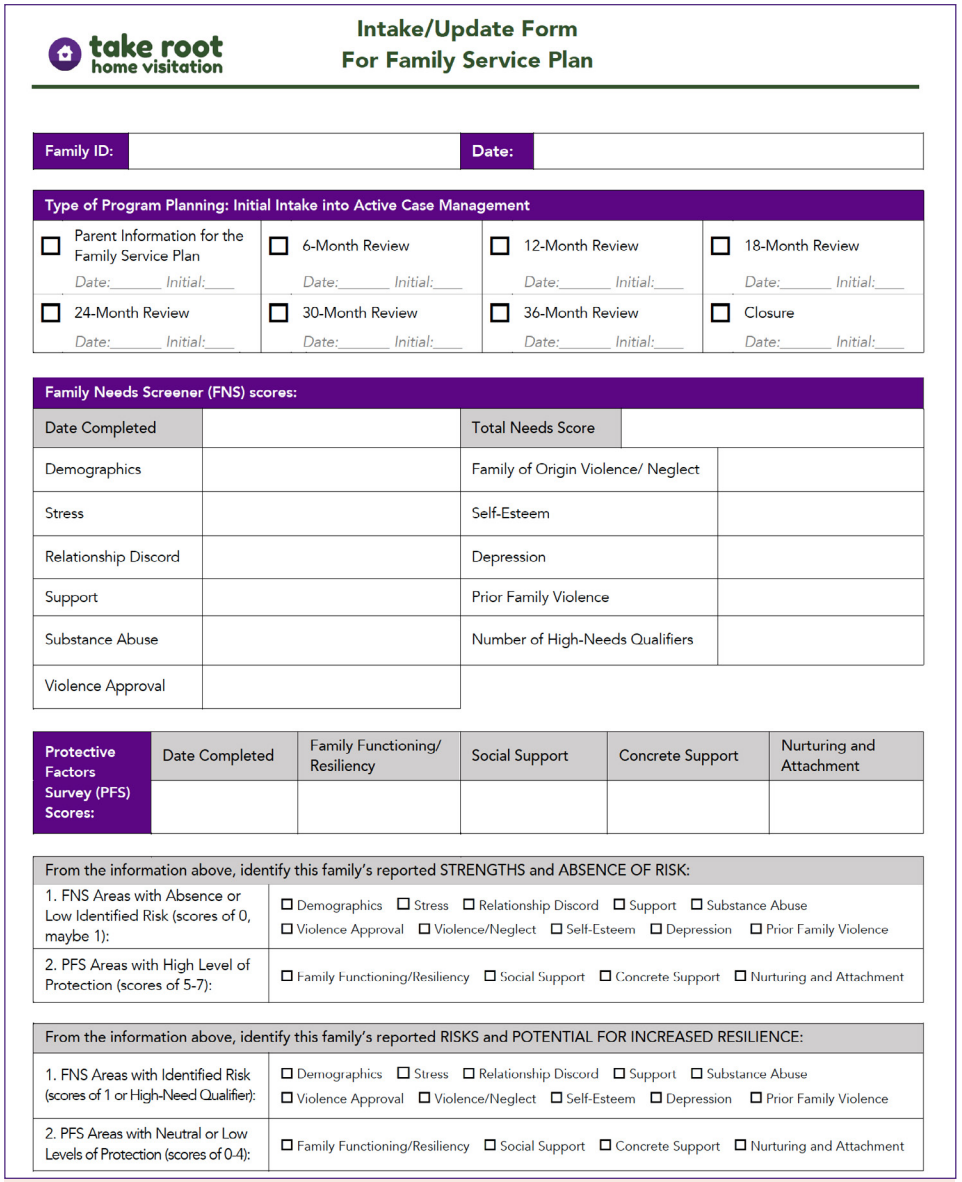
The first page of the *Intake/Update Form* focuses primarily on information from the *FNS* and the *PFS:SF*, as seen on the right.

Notice that it has space to record the family ID, date, and if this is a new intake or a subsequent review and update at the top.

The next section on this page is where you will copy this family's current *FNS* information, including the date it was completed, the scores for each subscale, total number of high-needs qualifiers, and the total needs score.

The third section is where you will record this family's *PFS:SF* scores and the date that measure was completed.

At the bottom of the first page, you are asked to identify this family's reported strengths and risks from the scores on these two measures. This is where you write your first notes, reflecting on what these scores represent to you at this point in your work with the family.



take root home visitation

Intake/Update Form For Family Service Plan

Family ID:		Date:	

Type of Program Planning: Initial Intake into Active Case Management

☐ Parent Information for the Family Service Plan Date:_____ Initial:____	☐ 6-Month Review Date:_____ Initial:____	☐ 12-Month Review Date:_____ Initial:____	☐ 18-Month Review Date:_____ Initial:____
☐ 24-Month Review Date:_____ Initial:____	☐ 30-Month Review Date:_____ Initial:____	☐ 36-Month Review Date:_____ Initial:____	☐ Closure Date:_____ Initial:____

Family Needs Screener (FNS) scores:

Date Completed		Total Needs Score	
Demographics		Family of Origin Violence/ Neglect	
Stress		Self-Esteem	
Relationship Discord		Depression	
Support		Prior Family Violence	
Substance Abuse		Number of High-Needs Qualifiers	
Violence Approval			

Protective Factors Survey (PFS) Scores:	Date Completed	Family Functioning/ Resiliency	Social Support	Concrete Support	Nurturing and Attachment

From the information above, identify this family's reported STRENGTHS and ABSENCE OF RISK:	
1. FNS Areas with Absence or Low Identified Risk (scores of 0, maybe 1):	☐ Demographics ☐ Stress ☐ Relationship Discord ☐ Support ☐ Substance Abuse ☐ Violence Approval ☐ Violence/Neglect ☐ Self-Esteem ☐ Depression ☐ Prior Family Violence
2. PFS Areas with High Level of Protection (scores of 5-7):	☐ Family Functioning/Resiliency ☐ Social Support ☐ Concrete Support ☐ Nurturing and Attachment

From the information above, identify this family's reported RISKS and POTENTIAL FOR INCREASED RESILIENCE:	
1. FNS Areas with Identified Risk (scores of 1 or High-Need Qualifier):	☐ Demographics ☐ Stress ☐ Relationship Discord ☐ Support ☐ Substance Abuse ☐ Violence Approval ☐ Violence/Neglect ☐ Self-Esteem ☐ Depression ☐ Prior Family Violence
2. PFS Areas with Neutral or Low Levels of Protection (scores of 0-4):	☐ Family Functioning/Resiliency ☐ Social Support ☐ Concrete Support ☐ Nurturing and Attachment

TRHV Intake/Update Form for Family Service Plan, Page 1.

The second page of the *Intake/Update Form* focuses on connecting the strengths and risks from page 1 to the five *Protective Factors*.

If this is the beginning of work with this family, you may not have a lot to write. Yet, you may still have early ideas of what could be helpful and what strengths you could start with to engage and build a strong parent-home visitor relationship. Examples are given on the form to help generate your own thoughts about a family.

take root home visitation

Intake/Update Form For Family Service Plan

Link this family's strengths and challenges to the 5 Protective Factors:		
	Strengths *FNS or PFS scores suggest parent(s)*	Challenges *FNS or PFS scores suggest parent(s)*
Social Connections	*(e.g., …has people she can count on for help and to talk to.)*	*(e.g., … currently does not feel she has anyone who supports her or could help if needed.)*
Concrete Supports of Families	*(e.g., …is able to meet the family's basic needs and knows community resources for help.)*	*(e.g., …currently does not feel able to meet the family's basic needs or does not know community resources for help.)*
Parental Resilience	*(e.g., …intimate relationship is supportive and they are able to problem solve in healthy ways where there are conflicts.)*	*(e.g., …intimate relationship currently is not supportive or they are not able to resolve conflicts in healthy ways.)*
Knowledge of Parenting and Child Development	*(e.g., …has knowledge of positive parenting practices or understanding of their young child's needs and abilities.)*	*(e.g., …needs support to gain knowledge of positive parenting practices or understanding of their young child's needs and abilities.)*
Social and Emotional Competence of Children	*(e.g., …has understanding of how his actions as a parent can promote his child's social and emotional skills.)*	*(e.g., …needs support to gain understanding of how his actions as a parent can promote his child's social and emotional skills.)*
Notes:		

TRHV Intake/Update Form for Family Service Plan, Page 2.

Step 3: Selection of Everyday Moment or Special Focus Moment

The TRHV curriculum offers 11 different *Moments* that you can use in your home visit. These *Moments* are grouped topically and are appropriate for children from birth to 3 years old, first-time or experienced parents, and those with or without experience of military family life contexts. The three main groups of *Everyday Moments* were described in depth in Part 2 and are highlighted here:

1. *Daily Care and Living Routines*;
2. *Young Children's Play and Exploration*, fostering parental perspective-taking of children's experiences in their growth and development; and
3. *Parenting Life*, how to build positive parenting and co-parenting skills and practice self-care.

The additional *Special Focus Moments* concentrate on two experiences that have wide-ranging impacts on family and individual health and resilience in our military family population:

1. *Parental Absence in Military Life*; and
2. *Parenting After Injury.*

The current research on these *Special Focus Moments* is not yet reflected in most commonly available parent education curricula. TRHV starts that process.

It is worth highlighting that each *Moments* chapter goes into greater detail than is needed for a single home visit, and a particular chapter may be used across multiple home visits, depending on the needs and priorities of the family. The chapters are purposefully wide-ranging to adequately address important and interesting age-related differences of infants and toddlers and to attend to the knowledge gaps of parents. In addition, there is particular focus on issues of safety and supervision throughout the chapters to better meet needs of parents who may be limited in their current safety knowledge, skills, and abilities.

The TRHV curriculum is based on the idea that home visitors should let the scores on the *FNS*, *PFS:SF*, and the discussion with the parent guide which topics are higher priority. How is this done? The *Intake/Update Form for Family Service Plan* collected information from these three sources.

As you complete and review this form, ask yourself, "What does that information tell me?" Reflect on the information you've learned about a family, and, then, check the list of *Everyday and Special Focus Moments* to see which one(s) best match a family's introductory profile.

Take a Moment: Meeting a New Family

You meet a family who are first-time parents with a 3-month-old daughter who shows signs of colic. The inconsolable crying is wearing on the parents' sense of their ability to care for their child. They find the colic cry pattern very disruptive in their daily lives.

When you review the scores of the *FNS* and *PFS:SF*, you find that this family's social support is very low, and there is a history of family violence in the mother's family of origin. You've also learned through your first conversations that both parents are only children and have very limited experience with infants and toddlers.

These items hang together in a meaningful way as you assess what topics might be most important at the beginning and what topics could be challenging to address early in a home visitor-family dyad. These items can also give insight into a topic that provides a pathway to address multiple concerns between your assessment and the family's stated needs.

Just from the description of the family above, what might you want to focus on first? Second?

How might you find a way to wrap more difficult conversations into a context that is easier to start with and build trust and rapport?

take root home visitation

Everyday Moments and the Protective Factors

Everyday Moments: Daily Care and Living Routines	
TOPICS	**Protective Factors**
Sleeping	Parental Resilience Knowledge of Parenting and Child Development Social and Emotional Competence of Children
Nutrition and Feeding	
Diapering and Toileting	
Bathing and Dressing	

Everyday Moments: Young Children's Play and Exploration	
TOPICS	**Protective Factors**
Exploring and Learning about the World	Concrete Supports of Families Parental Resilience Knowledge of Parenting and Child Development Social and Emotional Competence of Children
Building Trusting Relationships	
Nurturing Guidance and Discipline	

Everyday Moments: Parenting Life	
TOPICS	**Protective Factors**
Co-Parenting and Sharing Care	Social Connections Concrete Supports of Families Parental Resilience Knowledge of Parenting and Child Development Social and Emotional Competence of Children
Parental Self-Care	
Loss, Grief, and Growth in Young Families	

Special Focus Moments: Military Family Life	
TOPICS	**Protective Factors**
Parental Absence in Military Life	Social Connections Concrete Supports of Families Parental Resilience Knowledge of Parenting and Child Development Social and Emotional Competence of Children
Parenting After Injury	

Steps 4a-b: Lesson Preparation and Implementation

The *Visit Planning & Reporting Form* should be used to prepare for each visit. This form helps you complete the process of choosing a topic and the particular pieces of information you want to bring into conversation at the visit. The form also guides you as you collect the appropriate resource materials, including *Family Pages*, to bring to the visit. It provides space to record parents' thoughts and contributions during the visit, making visible the partnership that is growing between you and the families in your caseload.

The *Visit Planning & Reporting Form* models the steps of a home visit we outlined earlier. While it is not mandatory to do these steps in this order, each of the elements serve to create opportunities for conversations, build trust and rapport, and engage with families who come from a spectrum of positive and negative experiences with outside personnel in family and child services.

Using the *Visit Planning & Reporting Form*, you are able to quickly identify the *Moment* you want to share with the family. Each *Moment* chapter is your one-stop-shop. In each chapter you will find the following:

- Background content for you, including research, common concerns of parents, and *Boots on the Ground* strategies to share with families;
- *Family Pages*;
- Suggested parent-child activities; and
- Recommended links to national and community resources.

The *Visit Planning & Reporting Form* gives you the opportunity to make sure the parent's voice is heard and acknowledged in the space labeled "What a parent wants to share with or show to me." For example, a parent may have shown you what safe sleep recommendations have been completed since the last visit or disclosed some family history that they are only now comfortable sharing.

take root home visitation **Visit Planning & Reporting Form**

Family ID:		Visit Date Scheduled:		Completed ☐ Yes ☐ No
		Visit Date Completed (If Different):		

Protective Factors Focus During Visit:

	Planned		Addressed	
Social Connections	☐ Yes	☐ No	☐ Yes	☐ No
Concrete Supports	☐ Yes	☐ No	☐ Yes	☐ No
Social and Emotional Competence of Children	☐ Yes	☐ No	☐ Yes	☐ No
Parental Resilience	☐ Yes	☐ No	☐ Yes	☐ No
Knowledge of Parenting and/or Child Development	☐ Yes	☐ No	☐ Yes	☐ No

Everyday Moment Topic and Touching Base (from Last Visit):

Planned (e.g. Safe Sleep/Sleep Routines)	Completed	
a)	☐ Yes	☐ No
b)	☐ Yes	☐ No
c)	☐ Yes	☐ No
Actual, if different:	Completed	
	☐ Yes	☐ No
	☐ Yes	☐ No

Handouts/Resources/Family Pages:

Planned (e.g. Resource/Safety Sheets, Family Pages)	Completed	
a)	☐ Yes	☐ No
b)	☐ Yes	☐ No
c)	☐ Yes	☐ No
Actual, if different:	Completed	
	☐ Yes	☐ No
	☐ Yes	☐ No

Any additional time spent on an item? Please explain.

Parent Shares and/or Shows:	Planned Parent/Child Activity:	Completed ☐ Yes ☐ No
	Actual, if different:	

Additional Notes:

TRHV Visit Planning & Reporting Form, Page 1.

take root home visitation **Visit Planning & Reporting Form**

Amount of Time Spent On:	Planned topic and activities	Back-up topic and activities	Addressing immediate needs (*not crisis)	Additional resource sharing	Crisis management for safety, food, shelter	Assessment or paperwork with parent	Assessment of child
Cannot exceed 100% total across categories							

Reflection on Resilience/Strengths Seen in Parent/Family:

Reflection on Notes of Concerns for Parent/Family:

TRHV Visit Planning & Reporting Form, Page 2.

Step 4c: Post-Visit Documentation and Planning

The *Visit Planning & Reporting Form* also helps you reflect on what actually happened during a visit and start preparing for next steps and the next visit. Developed to work as part of an evaluation of both the TRHV curriculum and a program's implementation of the curriculum, this form is not intended to replace current visit documentation. Consult with your supervisor to see what documentation is still needed for your program.

Post-visit documentation is important for several reasons:

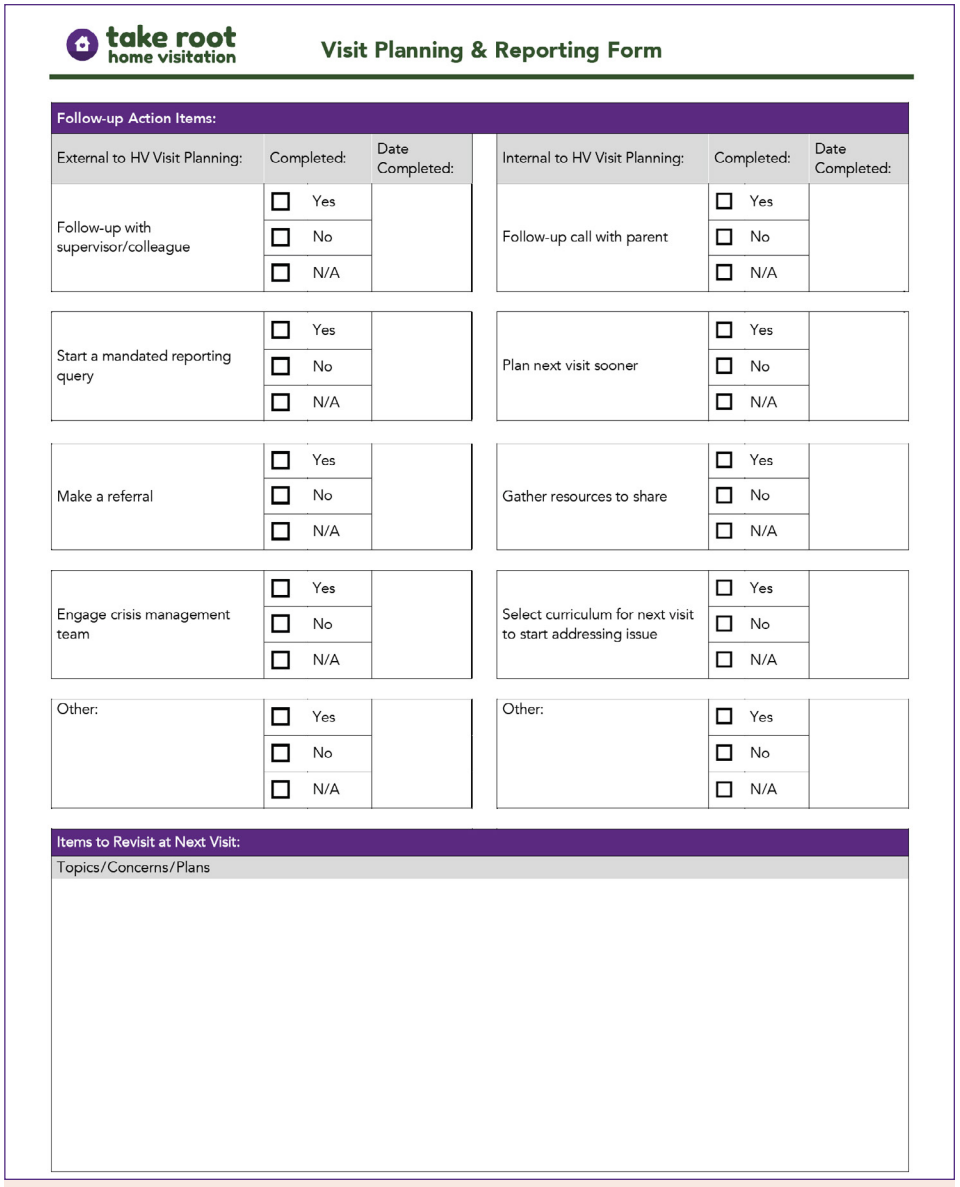
- Track progress and change over time;
- Reflect on elements of resilience and strength seen in the parent/family/child;
- Identify points of concern and improvement;
- Identify potential needs for referrals to other programs and professionals; and
- Document if what is planned for the visit is close to or different from what occurs during the visit.

Post-visit documentation is a good way for you to identify patterns when working with families. This type of documentation can help you and your program assess whether the current approach and interventions are appropriate for the family.

Two short checklists at the end of the *Visit Planning & Reporting Form* help you determine if there are particular action items that need to be completed after a visit:

- The first 4-item checklist identifies items outside the scope of providing prevention support—items that need to be brought to the attention of one's supervisor, other program contacts, or a crisis management contact. These are considered external to most home visitation programs; the majority of home visitation programs are prevention-focused and non-clinical, yet families participating in a home visitation program may also need clinical or other interventional support.

- The second 4-item checklist highlights particular follow-up actions, such as a call, earlier return visit, or a need to find certain resources for the next visit.



take root home visitation

Visit Planning & Reporting Form

Follow-up Action Items:

External to HV Visit Planning:	Completed:	Date Completed:	Internal to HV Visit Planning:	Completed:	Date Completed:
Follow-up with supervisor/colleague	☐ Yes ☐ No ☐ N/A		Follow-up call with parent	☐ Yes ☐ No ☐ N/A	
Start a mandated reporting query	☐ Yes ☐ No ☐ N/A		Plan next visit sooner	☐ Yes ☐ No ☐ N/A	
Make a referral	☐ Yes ☐ No ☐ N/A		Gather resources to share	☐ Yes ☐ No ☐ N/A	
Engage crisis management team	☐ Yes ☐ No ☐ N/A		Select curriculum for next visit to start addressing issue	☐ Yes ☐ No ☐ N/A	
Other:	☐ Yes ☐ No ☐ N/A		Other:	☐ Yes ☐ No ☐ N/A	

Items to Revisit at Next Visit:

Topics/Concerns/Plans

TRHV Visit Planning & Reporting Form, Page 3.

Home Visitation Visit Cycle and Periodic Updates of Information

Once a home visitation plan is established with a family, the *Visit Planning & Reporting Form* is used to prepare for and report on each visit. Every 6 months a parent is in the home visitation program, TRHV strongly recommends that a reassessment be completed.

This means having parents fill out the *FNS* and the *PFS:SF* and reflect on the *Parent Information Form* to determine where they currently are in their goals and dreams for themselves and their child. While it is not standard practice across all Military Services to use the *FNS* as a repeat measure, it is standard practice in at least one Service.

The *PFS:SF* is designed as a pre-post measure. These measures can be used at 6-month intervals or, if a family closes participation, as closure measures.

take root home visitation

Part 3 How to Use Take Root Home Visitation

In Summary

TRHV recommends certain actions for home visitors to engage with parents and build strong home visitor-parent alliances. There are four integrated forms that support the home visitor in making the most of the TRHV curriculum, and they define the planning, preparation, implementation, and reporting cycle: the *Intake/Update Form*, the *Parent Information Form*, and the *Visit Planning & Reporting Form*. Information on each form provides guidance to the home visitor while allowing the curriculum to be tailored to each family receiving services.

In the next section of this manual, a practical example demonstrates how to pull the information gathered through the *FNS*, *PFS*, and *Parent Information Form* into a meaningful assessment-preparation-reporting loop for the first visit with a planned topic. TRHV is designed to give you, the home visitor, an array of strong options for selecting *Moments* that attend to the strengths and needs of each family while creating conversations that build trust, engagement, and knowledge.

take root home visitation

Part 4 Let's Practice!

Introduction

Sean and Marquita Miller are interested in participating in the New Parent Support Program (NPSP) to see what home visitation may have to offer. They have a 1-month-old son, Samuel, who currently has his days and nights mixed up. As is the case for many new parents, sleep is fleeting for Sean and Marquita. As you will learn, they also have some strengths and challenges in their own life experiences.

In this section, you will:

- Apply the steps of a home visit that you learned about in Part 3 to this young, first-time parent family.
- Practice using the TRHV *Intake/Update* and *Visit Planning & Reporting* forms.

Part 4 Let's Practice!

Step 1: Intake Sessions

To record your initial sense of who this family is and to identify Sean and Marquita's hopes for their life together with Samuel, you will use

- the *Family Needs Screener* (*FNS*),
- the *Protective Factors Survey*: *Short Form* (*PFS:SF*), and
- *Parent Information Form*.

Each form is filled out to demonstrate how a beginning case file should be built in order to use TRHV most effectively. Put yourself into the shoes of the Home Visitor (HV) who is making contact with and getting to know Marquita and Sean and baby Samuel:

HV: I received a recently completed *FNS* from my supervisor. This is the first contact with this potential client. Marquita and Sean attended a *Meet and Greet* for new and expecting parents at a Child Development Center on their installation. The NPSP personnel offered the *FNS* to all attendees, and Marquita completed the form at the session.

HV: I make phone contact with Marquita and set up a time to come to their home to follow up. My impression from the call is that there is definite interest. I think I can hear her talking to another adult in the background, possibly her husband Sean, checking that a home visit is OK and that the time we have decided on works.

HV (Post-Visit Reflection): I arrived at the Miller's home, and Marquita and the baby, Samuel, greeted me at the door. The home is small, clean, and Marquita and the baby look well. She had just finished burping him as I arrived. Marquita seems open but hesitant. Sean came home near the end of our visit, and I was able to talk with him too. I gave Marquita information about NPSP services, including the home visitation program, and made sure to invite her to ask questions and learn more about us. I went over her *FNS* with her to see how things might be the same or different from when it was completed. Marquita completed the *PFS:SF* at this visit, and I explained I would come back with it scored at the next visit. I left a copy of the *Parent Information Form* with Marquita and Sean, so they could complete it for the next visit. Here are some additional pieces of information I learned about the Millers at this visit:

Family Background: Sean and Marquita met at Sean's first duty station and have been married almost 2 years. They recently PCS'ed to this duty station. Sean is an E-3 Diesel Mechanic. The Millers have been here for just 2 months and didn't have an opportunity to meet new people before Samuel was born.

Marquita comes from a large, extended Mexican American family who is now located several hours and states away. Marquita's mother was present for the week before and after Samuel was born but had to return home to her job. Marquita is the third of five children. She completed high school and has worked at least part-time since she was 16. She is fluent in English and Spanish.

Sean spoke about being a role model for his younger brothers, taking on the responsibility of the man of the house, and wanting to be a good father. He wondered whether this program could help him with this goal. Marquita shared later that Sean's father was a harsh and violent person to his children and ex-wife.

Post-Visit Actions: Marquita signed the consent for NPSP Home Visitation services, and we talked about the items that were checked as areas of interest. This process helped them write down a few goals and dreams on the *Parent Intake Form* for what they hope to gain from this program and what they want for their family.

A next visit is planned with some beginning information about local resources and the community.

take root home visitation

Part 4 Let's Practice!

Take a Moment: Become Aware of Your First Impressions

Marquita's *FNS* provides your first impression of Marquita and the Miller family. What does her *FNS* tell you as a home visitor?

Hold these impressions gently and see how they may shift as you work through the TRHV process.

take root home visitation

Intake/Update Form For Family Service Plan

Family ID:	Miller, Marquita	Date:	02/28/15

Type of Program Planning: Initial Intake into Active Case Management

☒ Parent Information for the Family Service Plan Date:_____ Initial:___	☐ 6-Month Review Date:_____ Initial:___	☐ 12-Month Review Date:_____ Initial:___	☐ 18-Month Review Date:_____ Initial:___
☐ 24-Month Review Date:_____ Initial:___	☐ 30-Month Review Date:_____ Initial:___	☐ 36-Month Review Date:_____ Initial:___	☐ Closure Date:_____ Initial:___

Family Needs Screener (FNS) scores:

Date Completed	02/20/15	Total Needs Score	16
Demographics	0	Family of Origin Violence/ Neglect	1
Stress	1	Self-Esteem	0
Relationship Discord	1	Depression	0
Support	9	Prior Family Violence	1
Substance Abuse	1	Number of High-Needs Qualifiers	1
Violence Approval	2		

Protective Factors Survey (PFS) Scores:	Date Completed	Family Functioning/ Resiliency	Social Support	Concrete Support	Nurturing and Attachment
	02/28/15	4.2 yellow	3.3 red	3.0 red	5.75 green

From the information above, identify this family's reported STRENGTHS and ABSENCE OF RISK:

1. FNS Areas with Absence or Low Identified Risk (scores of 0, maybe 1):	☒ Demographics ☐ Stress ☐ Relationship Discord ☐ Support ☐ Substance Abuse ☐ Violence Approval ☐ Violence/Neglect ☒ Self-Esteem ☒ Depression ☐ Prior Family Violence
2. PFS Areas with High Level of Protection (scores of 5-7):	☐ Family Functioning/Resiliency ☐ Social Support ☐ Concrete Support ☒ Nurturing and Attachment

From the information above, identify this family's reported RISKS and POTENTIAL FOR INCREASED RESILIENCE:

1. FNS Areas with Identified Risk (scores of 1 or High-Need Qualifier):	☐ Demographics ☐ Stress ☐ Relationship Discord ☐ Support ☒ Substance Abuse ☒ Violence Approval ☒ Violence/Neglect ☐ Self-Esteem ☐ Depression ☒ Prior Family Violence
2. PFS Areas with Neutral or Low Levels of Protection (scores of 0-4):	☒ Family Functioning/Resiliency ☒ Social Support ☒ Concrete Support ☐ Nurturing and Attachment

Example: Marquita's FNS Scoresheet.

take root home visitation

Part 4 Let's Practice!

Try It Out: Use the Intake/Update Form below to start filling in FNS data for the Miller family.

take root home visitation

Intake/Update Form For Family Service Plan

Family ID: **Date:**

Type of Program Planning: Initial Intake into Active Case Management

- ☐ Parent Information for the Family Service Plan — Date: Initial:
- ☐ 6-Month Review — Date: Initial:
- ☐ 12-M — Dat
- ☐ 24-Month Review — Date: Initial:
- ☐ 30-Month Review — Date: Initial:
- ☐ 36-M — Dat

Family Needs Screener (FNS) scores:

Date Completed		Total Need
Demographics		Family of O
Stress		Self-Esteem
Relationship Discord		Depression
Support		Prior Family
Substance Abuse		Number of
Violence Approval		

Family Needs Screener (FNS) scores:

Date Completed		Total Needs Score	
Demographics		Family of Origin Violence/ Neglect	
Stress		Self-Esteem	
Relationship Discord		Depression	
Support		Prior Family Violence	
Substance Abuse		Number of High-Needs Qualifiers	
Violence Approval			

Protective Factors Survey (PFS) Scores:	Date Completed	Family Functioning/ Resiliency	Social Support	Concrete Support	Nurturing and Attachment

From the information above, identify this family's reported STRENGTHS and ABSENCE OF RISK:

1. FNS Areas with Absence or Low Identified Risk (scores of 0, maybe 1):	☐ Demographics ☐ Stress ☐ Relationship Discord ☐ Support ☐ Substance Abuse ☐ Violence Approval ☐ Violence/Neglect ☐ Self-Esteem ☐ Depression ☐ Prior Family Violence
2. PFS Areas with High Level of Protection (scores of 5-7):	☐ Family Functioning/Resiliency ☐ Social Support ☐ Concrete Support ☐ Nurturing and Attachment

From the information above, identify this family's reported RISKS and POTENTIAL FOR INCREASED RESILIENCE:

1. FNS Areas with Identified Risk (scores of 1 or High-Need Qualifier):	☐ Demographics ☐ Stress ☐ Relationship Discord ☐ Support ☐ Substance Abuse ☐ Violence Approval ☐ Violence/Neglect ☐ Self-Esteem ☐ Depression ☐ Prior Family Violence
2. PFS Areas with Neutral or Low Levels of Protection (scores of 0-4):	☐ Family Functioning/Resiliency ☐ Social Support ☐ Concrete Support ☐ Nurturing and Attachment

Step 2: Screener Analyses and Follow-Up Visit

HV Follow-Up Visit Reflection: I returned a week later to the Miller home. Sean was at work. Marquita welcomed me. Baby Samuel stayed sound asleep in a bassinet in the living room. The home is clean, and Marquita looks tired but otherwise appropriate. We eased into conversation about how things are going, and I shared information about the WIC program and how to get to both of the Cumberland County WIC offices. Marquita shared what kind of transportation she has access to and that she has made a few connections with other moms in the Corregidor Courts neighborhood.

I went over the *PFS:SF* with Marquita, shared her scores, and let her reflect on what she feels they represent and how well they reflect her current thoughts. I shared what her answers from the *FNS* and *PFS:SF* are telling me about ways I can support her and her family. Marquita shares the *Parent Information Form* she and Sean completed. Here are some highlights from this visit's conversation:

Marquita is starting to feel lonely and overwhelmed. She is feeling guilty that she isn't contributing to the increased bills for all the supplies and equipment needed by a family with a new baby (e.g., crib, diapers, wipes). It seems that Sean tries to reassure her that caring for their child is contributing so much more to their lives. She is used to working, so this is part of a big set of life changes for the family. The Millers currently have one car, with no plans to purchase another one.

The Millers are thrilled to be parents, but they are nervous. They are also exhausted because Samuel currently "has his days and nights mixed up" and nurses every 2.5 hours. Both Marquita and Sean feel they know a lot about children as they helped with their siblings but are finding it difficult to accomplish daily living tasks like shopping and meal preparation and scheduling and traveling to well-baby visits. Sean used his authorized 10-day Paternity Leave after Marquita's mother returned home 1 week after Samuel was born.

You have your first picture of this family now that all the intake information is complete, and first conversations to get to know each other are underway. Review your notes and, at the same time, be open to see that this first picture may change over time as you move forward to plan specific topics that meet the Miller family where they are and help them grow their capacity for being a healthy and resilient family.

take root home visitation

Part 4 Let's Practice!

Try It Out: Complete Page 1 of the Intake/Update Form for Marquita.

A First, add the summary scores from the *PFS:SF* directly below the *FNS* scores.

B Next, use your "strengths lens" to identify which scores on the *FNS* and *PFS:SF* indicate areas of strength and absence of risk.

C Then, complete the questions that indicate either risk or need for increased support.

take root home visitation

Intake/Update Form For Family Service Plan

Family ID:		Date:	

Type of Program Planning: Initial Intake into Active Case Management

☐ Parent Information for the Family Service Plan Date:____ Initial:____	☐ 6-Month Review Date:____ Initial:____	☐ 12-Month Review Date:____ Initial:____	☐ 18-Month Review Date:____ Initial:____
☐ 24-Month Review Date:____ Initial:____	☐ 30-Month Review Date:____ Initial:____	☐ 36-Month Review Date:____ Initial:____	☐ Closure Date:____ Initial:____

A

Family Needs Screener (FNS) scores:

Date Completed		Total Needs Score	
Demographics		Family of Origin Violence/ Neglect	
Stress		Self-Esteem	
Relationship Discord		Depression	
Support		Prior Family Violence	
Substance Abuse		Number of High-Needs Qualifiers	
Violence Approval			

B

Protective Factors Survey (PFS) Scores:	Date Completed	Family Functioning/ Resiliency	Social Support	Concrete Support	Nurturing and Attachment

C

From the information above, identify this family's reported STRENGTHS and ABSENCE OF RISK:	
1. FNS Areas with Absence or Low Identified Risk (scores of 0, maybe 1):	☐ Demographics ☐ Stress ☐ Relationship Discord ☐ Support ☐ Substance Abuse ☐ Violence Approval ☐ Violence/Neglect ☐ Self-Esteem ☐ Depression ☐ Prior Family Violence
2. PFS Areas with High Level of Protection (scores of 5-7):	☐ Family Functioning/Resiliency ☐ Social Support ☐ Concrete Support ☐ Nurturing and Attachment

From the information above, identify this family's reported RISKS and POTENTIAL FOR INCREASED RESILIENCE:	
1. FNS Areas with Identified Risk (scores of 1 or High-Need Qualifier):	☐ Demographics ☐ Stress ☐ Relationship Discord ☐ Support ☐ Substance Abuse ☐ Violence Approval ☐ Violence/Neglect ☐ Self-Esteem ☐ Depression ☐ Prior Family Violence
2. PFS Areas with Neutral or Low Levels of Protection (scores of 0-4):	☐ Family Functioning/Resiliency ☐ Social Support ☐ Concrete Support ☐ Nurturing and Attachment

take root home visitation

Part 4 Let's Practice!

Try It Out: Complete Page 2 of the Intake/Update Form to link the scores and observations to the five Protective Factors.

Which *Protective Factors* are strengths?

Which *Protective Factors* are challenges?

Are there *Protective Factors* that are not yet clear?
If so, which one(s)?

take root home visitation

Intake/Update Form
For Family Service Plan

Link this family's strengths and challenges to the 5 Protective Factors:

	Strengths *FNS or PFS scores suggest parent(s)*	Challenges *FNS or PFS scores suggest parent(s)*
Social Connections	*(e.g., …has people she can count on for help and to talk to.)*	*(e.g., … currently does not feel she has anyone who supports her or could help if needed.)*
Concrete Supports of Families	*(e.g., …is able to meet the family's basic needs and knows community resources for help.)*	*(e.g., …currently does not feel able to meet the family's basic needs or does not know community resources for help.)*
Parental Resilience	*(e.g., …intimate relationship is supportive and they are able to problem solve in healthy ways where there are conflicts.)*	*(e.g., …intimate relationship currently is not supportive or they are not able to resolve conflicts in healthy ways.)*
Knowledge of Parenting and Child Development	*(e.g., …has knowledge of positive parenting practices or understanding of their young child's needs and abilities.)*	*(e.g., …needs support to gain knowledge of positive parenting practices or understanding of their young child's needs and abilities.)*
Social and Emotional Competence of Children	*(e.g., …has understanding of how his actions as a parent can promote his child's social and emotional skills.)*	*(e.g., …needs support to gain understanding of how his actions as a parent can promote his child's social and emotional skills.)*

Notes:

take root home visitation

Part 4 Let's Practice!

Step 3: Selection of an Everyday Moment or Special Focus Moment

Remember, the Visit *Planning & Reporting Form* should be used for each visit with a family. These forms guide selection of relevant topics and their associated resources for you and the parents and help you report on how well the planned topic worked and other important information from the visit.

It is important to note that there is not a right or wrong in selecting a *Moment*. The decision of what *Moment* to focus on during a home visit is dependent upon your knowledge of a family, the family's expressed needs and interests, and your skills and insights grounded in your experience as a home visitor.

Try It Out: Review the list of Everyday Moment Topics and their associated Protective Factors.

Based on the information you have about the Miller family, which topic(s) are most relevant for the first planned-topic visit?

Which topic would you choose and why?

take root home visitation

Everyday Moments and the Protective Factors

Everyday Moments: Daily Care and Living Routines	
TOPICS	**Protective Factors**
Sleeping	Parental Resilience Knowledge of Parenting and Child Development Social and Emotional Competence of Children
Nutrition and Feeding	
Diapering and Toileting	
Bathing and Dressing	

Everyday Moments: Young Children's Play and Exploration	
TOPICS	**Protective Factors**
Exploring and Learning about the World	Concrete Supports of Families Parental Resilience Knowledge of Parenting and Child Development Social and Emotional Competence of Children
Building Trusting Relationships	
Nurturing Guidance and Discipline	

Everyday Moments: Parenting Life	
TOPICS	**Protective Factors**
Co-Parenting and Sharing Care	Social Connections Concrete Supports of Families Parental Resilience Knowledge of Parenting and Child Development Social and Emotional Competence of Children
Parental Self-Care	
Loss, Grief, and Growth in Young Families	

Special Focus Moments: Military Family Life	
TOPICS	**Protective Factors**
Parental Absence in Military Life	Social Connections Concrete Supports of Families Parental Resilience Knowledge of Parenting and Child Development Social and Emotional Competence of Children
Parenting After Injury	

Part 4 Let's Practice!

Steps 4a and 4b: Lesson Preparation and Implementation

Now, it is time to prepare for a visit using your chosen *Everyday or Special Focus Moment* topic. The next two *Try It Out* activities are designed to help you move from choosing an overall *Moment* topic to identifying the details of specific content you want to share in a single visit.

Each *Moment* has multiple learning opportunities for families. You might spend several visits covering the aspects that are most relevant to the family. Or, you might move to a different *Moment* after one conversation about a topic, depending on the family's interests and needs.

Everyday Moment chapters provide background information to inform your conversations with families, and you can select specific information from within the overall *Moment* to tailor the content to each family. The *Moment* chapters identify additional resources and recommended activities.

In addition, you will find a collection of *Family Pages* to support your conversations. *Family Pages* are designed to be given to the family and build their unique *Family Book* based on your work together.

The *Visit Planning & Reporting Form* is a step-by-step guide for you to use as you make decisions for topic focus and related materials and activities you will share with the family.

Try It Out: Explore your chosen Everyday or Special Focus Moment chapter and its Family Pages. Turn to the Moment chapter you chose and review.

What information is particularly relevant to the Miller family? (Think about this single visit.)

Which *Family Pages* would you select to complement your conversation for this visit?

take root home visitation

Part 4 Let's Practice!

Try It Out: Use a blank Visit Planning & Reporting Form to write out a first draft of a visit with your planned topic.

As you work through each section, consider the following:

A ***Protective Factors Focus During Visit:***

What *Protective Factors* do you want to address at this visit based on the information on the *Parent Information Form*?

B ***Everyday Moment Topic and Touch Base:***

What *Everyday Moment* topic are you choosing for the upcoming visit? <Refer to list of Moment topics on page 38>

What topics/concerns/plans that were discussed in the last visit do you want to touch base about at this visit?

C ***Handouts/Resources/Family Pages:***

Which *Family Pages* and additional resources do you need to assemble for this visit?

D ***Any additional time spent on an item?***

Remember to create opportunities for parents to share what they know and how they care for their child!

What is one or more parent-child activity you can share? Does it support the *Moment* topic?

Using your *Visit Planning & Reporting Form*, review the *Steps of a Home Visit* at the beginning of Part 3. Notice how the *Visit Planning & Reporting Form* supports the different elements of the actual home visit.

take root home visitation — **Visit Planning & Reporting Form**

Family ID:		Visit Date Scheduled:		Completed ☐ Yes ☐ No
		Visit Date Completed (If Different):		

A Protective Factors Focus During Visit:

	Planned		Addressed	
Social Connections	☐ Yes	☐ No	☐ Yes	☐ No
Concrete Supports	☐ Yes	☐ No	☐ Yes	☐ No
Social and Emotional Competence of Children	☐ Yes	☐ No	☐ Yes	☐ No
Parental Resilience	☐ Yes	☐ No	☐ Yes	☐ No
Knowledge of Parenting and/or Child Development	☐ Yes	☐ No	☐ Yes	☐ No

B Everyday Moment Topic and Touching Base (from Last Visit):

Planned (e.g. Safe Sleep/Sleep Routines)	Completed	
a)	☐ Yes	☐ No
b)	☐ Yes	☐ No
c)	☐ Yes	☐ No
Actual, if different:	Completed	
	☐ Yes	☐ No
	☐ Yes	☐ No

C Handouts/Resources/Family Pages:

Planned (e.g. Resource/Safety Sheets, Family Pages)	Completed	
a)	☐ Yes	☐ No
b)	☐ Yes	☐ No
c)	☐ Yes	☐ No
Actual, if different:	Completed	
	☐ Yes	☐ No
	☐ Yes	☐ No

D Any additional time spent on an item? Please explain.

Parent Shares and/or Shows:	Planned Parent/Child Activity:	Completed ☐ Yes ☐ No
	Actual, if different:	

Additional Notes:

Step 4c: Post-Visit Documentation and Planning

Following a home visit, the appropriate fields in the *Visit Planning & Reporting Form* should be reviewed and/or completed. As mentioned in the previous part of the manual, this form enables you reflect on what actually happened in the visit and provides initial direction for next steps with a family.

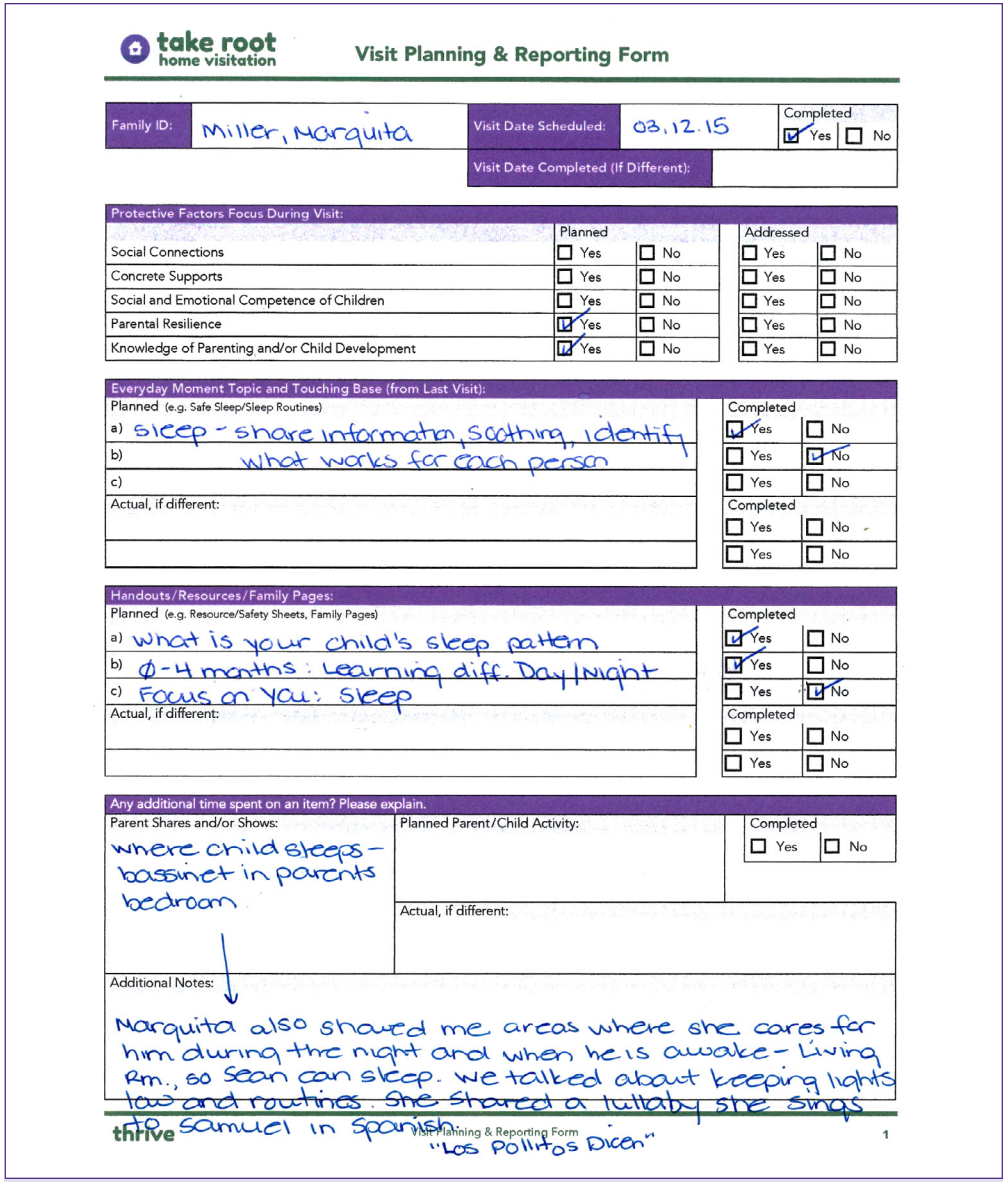
The following example illustrates how this form can be used for a visit, with the Millers, that goes according to plan.

Take a Moment: Sometimes Things Don't Always Go as Anticipated

Have you ever arrived to a visit and had to change what you planned to do? What changed and how did you adapt to the needs of the family at that visit?

What is an example of how you might need to change your plans when you arrive at the Miller family home?

Look at the Visit Planning & Reporting Form. Think about how you can use it to document those changes and make plans for the next visit.



take root home visitation — Visit Planning & Reporting Form

Family ID: Miller, Marquita | Visit Date Scheduled: 03.12.15 | Completed: ☑ Yes ☐ No | Visit Date Completed (If Different):

Protective Factors Focus During Visit:

	Planned		Addressed	
Social Connections	☐ Yes	☐ No	☐ Yes	☐ No
Concrete Supports	☐ Yes	☐ No	☐ Yes	☐ No
Social and Emotional Competence of Children	☐ Yes	☐ No	☐ Yes	☐ No
Parental Resilience	☑ Yes	☐ No	☐ Yes	☐ No
Knowledge of Parenting and/or Child Development	☑ Yes	☐ No	☐ Yes	☐ No

Everyday Moment Topic and Touching Base (from Last Visit):

Planned (e.g. Safe Sleep/Sleep Routines)	Completed	
a) sleep - share information, soothing, identify what works for each person	☑ Yes	☐ No
b)	☐ Yes	☑ No
c)	☐ Yes	☐ No
Actual, if different:	Completed	
	☐ Yes	☐ No
	☐ Yes	☐ No

Handouts/Resources/Family Pages:

Planned (e.g. Resource/Safety Sheets, Family Pages)	Completed	
a) What is your child's sleep pattern	☑ Yes	☐ No
b) Ø-4 months: Learning diff. Day/Night	☑ Yes	☐ No
c) Focus on You: Sleep	☐ Yes	☑ No
Actual, if different:	Completed	
	☐ Yes	☐ No
	☐ Yes	☐ No

Any additional time spent on an item? Please explain.

Parent Shares and/or Shows: where child sleeps – bassinet in parents bedroom

Planned Parent/Child Activity:

Completed: ☐ Yes ☐ No

Actual, if different:

Additional Notes:

Marquita also shared me areas where she cares for him during the night and when he is awake – Living Rm., so Sean can sleep. we talked about keeping lights low and routines. She shared a lullaby she sings to Samuel in Spanish. "Los Pollitos Dicen"

thrive — Visit Planning & Reporting Form — 1

Example: Completed Visit Planning & Reporting Form after a visit with the Millers, Page 1.

take root home visitation — Visit Planning & Reporting Form

Amount of Time Spent On:	Planned topic and activities	Back-up topic and activities	Addressing immediate needs (*not crisis)	Additional resource sharing	Crisis management for safety, food, shelter	Assessment or paperwork with parent	Assessment of child
Cannot exceed 100% total across categories	90	ϕ	5	ϕ	ϕ	ϕ	5

Reflection on Resilience/Strengths Seen in Parent/Family:

- Very connected w/ baby
- Sean not present, but has asked to receive handouts; Marquita thought both Family Pages would interest Sean
- Marquita speaks positively about relationships and parenting

Reflection on Notes of Concerns for Parent/Family:

- 1 car family makes it difficult for her to get out beyond neighborhood
- Not enrolled in WIC – interested by cautious, may be wary of some services
- Social isolation has many pieces - new to area
  - not working
  - transpor.
  - sleeping challenges

Example: Completed Visit Planning & Reporting Form after a visit with the Millers, Page 2.

take root home visitation — Visit Planning & Reporting Form

Follow-up Action Items:

External to HV Visit Planning:	Completed:	Date Completed:	Internal to HV Visit Planning:	Completed:	Date Completed:
Follow-up with supervisor/colleague	☐ Yes ☑ No ☑ N/A		Follow-up call with parent	☐ Yes ☑ No ☐ N/A	
Start a mandated reporting query	☐ Yes ☐ No ☑ N/A		Plan next visit sooner	☐ Yes ☑ No ☐ N/A	
Make a referral	☐ Yes ☑ No ☐ N/A		Gather resources to share: WIC Transportation	☑ Yes ☐ No ☐ N/A	
Engage crisis management team	☐ Yes ☐ No ☑ N/A		Select curriculum for next visit to start addressing issue	☑ Yes ☐ No ☐ N/A	03.15.15
Other:	☐ Yes ☐ No ☐ N/A		Other:	☐ Yes ☐ No ☐ N/A	

Items to Revisit at Next Visit:

Topics/Concerns/Plans

Continue with sleep and bring FP and info. on self-care.

Example: Completed Visit Planning & Reporting Form after a visit with the Millers, Page 3.

take root home visitation

Part 4 Let's Practice!

Steps 3 through 4c: Routinizing

As you begin to implement this curriculum, take time to practice using the different elements of TRHV with your colleagues.

The connections between the forms and curriculum materials will become clearer and more seamless as you integrate your knowledge of the *Protective Factors* and strengths-based practice. In turn, this practice will strengthen your skills in selecting appropriate *Everyday or Special Focus Moments* that meet the goals of your visits with the families you serve.

Step 5: Repeat Assessments

Families may stay active in a home visitation program for just a few months, several months, or leave as a child ages out of the program only to return when a new infant comes into the family.

This variability in program participation can make it difficult to determine if and how a program can create change for families.

- TRHV strongly recommends repeat assessments for the *FNS* and the *PFS:SF* and an update of the *Parent Information Form* every 6 months while continuing participation.
- When a family closes participation, these assessments should be used as part of the closure process whenever possible.

take root home visitation

Part 4 Let's Practice!

In Summary

A primary purpose of TRHV is to provide a strong, research-informed framework for home visitors to develop consistent planning, implementation, and reporting routines. TRHV provides support to guide home visitors' decisions of how best to work with a parent's strengths and address challenges while also providing the ability to help form a strong parent-home visitor alliance.

Because it is you and your decisions that will bring this curriculum to life during a home visit, the final section of this introductory material comes back to where we began: to you. Part 5 focuses on *Taking Care of You*.

take root home visitation

Part 5 Taking Care of You

Introduction

Foundations of Take Root Home Visitation Curriculum began by focusing on you and how what you decide to say and do matters to the families you serve. In closing, it comes full circle back to you. Why? You, as a professional and as a human being, are central to the effectiveness of your work for and with families.

Being an effective home visitor requires you to be aware of how your work impacts you and that you must take care of yourself. It is to be expected that, in caring so deeply about and working with families at risk for trauma, home visitors and other professionals can find themselves feeling vulnerable, helpless, and stressed. Sometimes known as compassion stress, this is a natural reaction of experiencing another person's suffering and wanting to relieve it.

Paying attention to how you are feeling and responding to your own needs will help assure that you can make the best decisions possible for the families you work with and, at the same time, focus on and enjoy life with your own family and friends.

The Center for the Study of Social Policy suggests that a powerful strategy for self-care is integrating the *Protective Factors* discussed earlier into your own life. On the next page, we offer some examples of self-care ideas. We invite you to use these suggestions as starting points in conversations with your spouse, partner, older children, and colleagues to develop additional ideas.

Take a Moment: Your Self-Care Practice

How often do you focus on taking care of yourself?

What do you do for your self-care?

How might you make this an integral part of your professional practice?

take root home visitation

Part 5 Taking Care of You

Social Connections

When you and family, friends, and others in your school, work, and child care communities can count on each other, life is easier and more enjoyable. Giving and receiving support makes everyone stronger.

You give support every day to the families you serve, colleagues, and your family and friends. Here are some ways you can ensure you receive the support you need to take root and thrive at work or at home:

- Make a point of spending time with family and friends playing, relaxing, or just having an interesting conversation.
- Foster supportive relationships with a colleague(s). Whether during one-on-one conversations or team meetings, it is good to know you can count on someone.
- Reach out to colleagues when you experience the inevitable bumps in your work with families of infants and toddlers.

Concrete Supports

Every person and every family need help sometimes. Learning who can help you meet your family's needs and where to go for support makes you stronger in good and challenging times:

- Think about who you can call to help you in different situations: pet sit when you are away, care for your sick child who has to stay home from school and you have to be at work, pick up your child from school when you have to work late, or give you a ride if your car breaks down. It is comforting to know someone is there.
- Make note of community resources that are available for you and your family, friends, and neighbors. Many resources may be the same as those you share with families you serve. Issues around health, housing, food, substance abuse, and violence can arise for all of us. Knowing there is somewhere to turn is a first step in moving forward.
- Prepare ahead for the unexpected. Develop a family emergency kit and contact plan about where to meet and/or how to reach each other in case of a natural or other emergency. Put aside funds to get you through the unwelcome surprise of a car repair, illness, or period of unemployment.

Part 5 Taking Care of You

Personal Resilience

You must nurture yourself to be able to handle difficult times in positive ways. Here are some suggestions on how to do this:

- Make some time for yourself regularly. Do something you enjoy and that replenishes the energy you use focusing on the needs of others. Choose something that makes you happy, makes you feel challenged and engaged, and allows you to take your mind off of others at work and home and just focus on you.

- Be kind to yourself. Have realistic expectations for yourself. No one knows it all. No one is perfect. Just as you do with others, pay attention to your steps forward as you extend your learning and skills.

- Pause and remind yourself of the ripples of positive change you create—at work and at home. Whether you have made someone smile or encouraged someone to take a risk and try something new, what you say and do matters and makes a difference.

Part 5 Taking Care of You

Knowledge of Parenting and Child Development

Learning how young children grow and learn will help you respond to their changing needs and abilities with sensitivity and care. By building a positive, trusting relationship, you prepare children for a life of learning and engaging with others. You do this when you do the following:

- Ask yourself, "What is (child's name) feeling and thinking?" to help you see a situation from a child's perspective. This can be especially helpful when the going gets rough, whether it is your child or the child of a family you serve.
- Remember that parenting is an ongoing, lifelong journey, and no one has all the answers. This idea can help keep things in perspective as a professional and is a valuable point to share with parents.
- Appreciate the wonder that each child is a unique individual. Children have their own ways of being in the world and unique blends of strengths, interests, and needs.

Social and Emotional Competence of Children

When you have positive interactions, you help young children learn to manage their behavior, communicate their feelings, and get along with others in their family and community. You do this when you do the following:

- Model how to disagree, problem-solve, and work together respectfully with another person. This helps children begin to learn that people can get along even when they have different ideas and opinions.
- Acknowledge and respect children's strong and deep feelings, then think together about ways to express these feelings. This shows children that their feelings are legitimate whatever they may be and helps them learn to express their feelings in acceptable, effective ways.
- Give children words for how to handle the unexpected and unwelcome situations, such as a friend's mother offering a snack they do not like or deciding not to join friends in a soccer game because it looks too rough. In doing so, you give children the tools they need to express themselves and, at the same time, remain connected to others.

By taking care of yourself, you can be your best self. While your family members and colleagues will benefit from your self-care, you will gain the most because you will be present to experience, to enjoy, to struggle, to discover, to learn, and to grow in life at home and at work.

take root home visitation

Part 5 Taking Care of You

In Summary

This guide encourages you to consider that you—as a professional and human being—are key to being an effective home visitor. You matter. What you decide to say and do matters. It is you who brings this curriculum, or any home visitation program, to life and encourages families to engage in learning and growing with you as their partner.

Let's briefly recap the content that has been covered in Parts 1-5 of this manual:

Part 1

Foundations of Take Root Home Visitation Curriculum focused on you as a decision-maker. This curriculum centered on considering the extraordinary learning opportunities in the ordinary daily moments of a family's life, seeing families through a strengths-based lens, and helping you work with the parents as partners. It also provided you with the theory and practice foundations of TRHV.

Part 2

How Principles of Trauma-Informed Care Enhance Your Collaboration afforded you the opportunity to explore the seven principles of *TICP* and to examine how they are intentionally woven throughout TRHV to support your effectiveness.

These principles can help create a work environment in which you and colleagues are safe and can be honest and open about coping with the stressors that are an inherent part of your work. *TICP* also creates opportunities for parents and other family members to rebuild the sense of control and empowerment that is key to creating trusting, responsive relationships babies and toddlers need to thrive and to make the best possible parenting decisions during *Everyday and Special Focus Moments*.

Part 3

How to Use Take Root Home Visitation walked you through the steps of a home visit, which included getting to know families through the use of the *Family Needs Screener* and the *Protective Factors Screener* and gathering documentation for planning a visit, including choosing an *Everyday or Special Focus Moment*, and after visit documentation. It also included tips for using the icons as a short cut to identify the content you need.

Part 4

Let's Practice! applied the steps and forms of this curriculum with the Miller family.

Part 5

Taking Care of You circled back directly to you. This chapter explored how you can nurture and fuel yourself in your life at work and at home by integrating the *Protective Factors* into your life and practice.

We now invite you to use TRHV—to make it yours and use it to support the families you work with and yourself.

take root home visitation

Part 6 Everyday and Special Focus Moments

Everyday and Special Focus Moments Contents

Everyday Moments

Special Focus Moments

Everyday Moments and *Special Focus Moments* found in this curriculum fall under four main categories:

- Daily Care and Living Routines
- Young Children's Play and Exploration
- Parenting Life
- Military Family Life

Within each category you will find chapters with specific content information. Chapter-specific *Family Pages* can be found in your *Family Pages Packet* that will help to support your conversations with families.

Part 6 Everyday and Special Focus Moments

Everyday Moments 6.1 Daily Care and Living Routines

Daily care and living routines are fascinating learning opportunities for babies, toddlers, and twos. They are filled with interesting things to see, touch, taste, hear, and do. Children under three are just beginning to shape their first pictures of themselves, other people, and the world around them. They are learning about who they are, their bodies, and their feelings. They are learning how to communicate with others and what to expect from people. They are learning about things around them—their colors, sizes, and shapes and how to use them.

From the perspective of young children, these daily events are predictable, so they can learn what to expect and gain a sense of competence. At the same time, there are enough differences that a child's interest and curiosity are sustained.

This section contains chapters that will support you in conversations with families as you discuss how to assure these routines are carried out in ways that meet children's developmental needs and, at the same time, match a child's personal way of being, preferences, and personality:

6.1.1 Sleep

The topic of sleep is important to every parent. Parents want to make sure their little one is getting the rest he or she needs. In addition, they hope that before long they will be able to get some sleep of their own! This chapter begins with helping a new baby learn the difference between night and day and continues through making bedtime work for 2- and early 3-year-old children who often need a glass of water and one more hug and kiss soon after the lights go out.

6.1.2 Nutrition and Feeding

Everybody eats; everyone needs a healthy diet in order to feel well, develop properly, and have the energy to accomplish tasks and goals. Yet, eating is also about emotions, family culture, traditions, and beliefs. This chapter looks at the nutrition needs of children's safe eating from breast and bottle feeding to restaurant meals with a 2- to 3-year-old dining companion.

6.1.3 Diapering and Toileting

Toilet learning is one of the most discussed and anticipated milestones of early childhood. Yet, using diapers can last for 3 or 4 years. While, of course, there are times adults want and need to hurry through a diaper change, diapering and toilet learning are, in fact, wonderful opportunities to teach children about their bodies and that what their bodies produce is natural and healthy, and to help children develop the body awareness and control they will need to be a successful toilet-user.

6.1.4 Bathing and Dressing

Initially, it seems as if adults are doing all the work when it comes to bathing and dressing. Look carefully and you will see that even the youngest infants who close their eyes when you pull a shirt over their heads are partnering in their first steps to doing these daily tasks independently. Bathing and dressing are chances to deepen your relationship as you work as partners and learn more about each other.

Everyday Moments 6.1 Chapter 1: Sleep

Main Elements

Content Areas

- Teaching About Sleep: *Protective Factors* and *Trauma-Informed Principles*
- The Science: Infant Development, Brain Development, Sleep Patterns, Self-Soothing, Sleep Regression, Sleep Consolidation
- Why it Matters to Families: Different Sleep Patterns, Soothing Strategies, Developing Routines, Reading Your Infant's Body Cues
- Home Visit Activities and *Family Pages*
- Important Safety Supports and Knowledge: Safe Sleep and SIDS (handouts, sleeping space tours or reviews)

Teaching About Sleep: Protective Factors and Trauma-Informed Principles

The topic of sleep is near and dear to every parent's heart. Parents want to make sure their little ones are getting the rest they need. Parents worry and watch over their sleeping child. Parents also often desperately miss the days of being able to set and regulate their *own* sleep and wonder if their new family member is ever going to figure out a sleep pattern that works with the family system.

Sleep is a common challenge to young and new families. Being able to help a very young child learn to regulate sleep and awake time is critical for all areas of development. It is also important for parents as they must handle disrupted sleep and loss of sleep in their own daily lives while continuing to care for their child, themselves, and meet commitments to their work and community. Working with a family to create or improve sleep patterns and routines is beneficial for everyone.

Identifying and practicing healthy strategies for meeting a child's sleep needs contribute to parental resilience and build trust in the parent-child relationship. Understanding children's current developmental abilities, which will affect sleep and awake patterns, means that parents can use that information to respond with care and sensitivity.

6.1.1 Sleep

Having a parent who can meet an infant or toddler's needs consistently and appropriately fosters positive social and emotional development. With regard to sleep routines, young children who learn to regulate sleep and self-soothe within a supportive caregiving relationship are building a strong foundation for social and emotional skills they will use throughout their lives.

This chapter helps to address the following *Protective Factors*:

- ***Parental Resilience***
- ***Knowledge of Parenting and Child Development***
- ***Social and Emotional Competence of Children***

Teaching about *Sleep* offers opportunities to model the following *Trauma-Informed Principles* in the parent-child relationship:

- ***Safety –*** When families create and use calming routines and behaviors around sleep, young children will begin to understand that life has predictable patterns that they can rely on and caregivers who are consistent.
- ***Trustworthiness and Transparency –*** Parents who learn to use sleep and wake routines consistently are modeling that they are people whom their child can trust for support when needed. By talking to their child about the bedtime routine, parents acknowledge their child's desires, emotions, and physical states.
- ***Peer Support and Mutual Self-Help –*** Providing information about child development, concrete strategies, and lessons learned around child sleep and waking routines can give parents hope and empowerment. It gives drained parents the resources to support their child's development and react with sensitivity. It also gives you the opportunity to gain knowledge about the family's routines and opportunities for empathetic support and reassurance.
- ***Collaboration and Mutuality –*** Routines can become more interactive as the child matures and develops. Singing songs together and doing bedtime/wake time routines, like chants and body motions, involve the child in the activity.
- ***Empowerment, Voice, and Choice –*** Parents can give their young child empowerment, voice, and choices by offering a variety of acceptable options. For example, their child can choose which book to read for bedtime or which song to hear or sing.
- ***Cultural, Historical, and Gender Factors –*** There are many options for including the family's culture into conversations. For example, you can ask parents about important traditions, songs, and stories they may want to pass along to their child or how parents may want to change traditions to better fit their family. Maybe there are strong gender ideas about who does bedtime and waking care.

There may also be some unresolved feelings about these times for parents who have experienced violence or neglect in their childhoods. These feelings or unnamed sensations may be impacting their current parenting. How can you open a door for a supportive conversation if you suspect some lingering trauma?

The Science: Understanding Infant Development and Sleep

Infants and toddlers need sleep. Parents do too! But why? And what does sleep look like for our 0-3 population? How varied are sleep patterns? What is *normal*?

Sleep is considered two of six different states of arousal (*active alert, quiet alert, crying, drowsiness, active sleep* [REM sleep], and *quiet sleep* [non-REM sleep]) for an infant. *Quiet sleep* behaviors are indicated by regular breathing, closed eyes that do not move, and the baby is mostly still. In *active sleep*, the infant's muscles are more tense, there are more spontaneous movements, eyes may be still or move in rapid eye movements (REM), and breathing can be irregular. These two sleep states are present by 32-weeks' gestation and continue throughout a person's lifetime.

These two sleep states are important for this phase of life (0-3 years old) when brain development is speeding along at the fastest rate of the entire lifespan. The *quiet sleep* state is a deep restful state when brain activity is also calm, while the *active sleep* state can be full of brain activity that includes dreaming (including night terrors, a common early childhood experience) and sleepwalking. Quality sleep is one of the three pillars of healthy brain development. The three pillars are sleep, nutrition, and supportive and safe caregiving and physical environments. The infant's brain is working hard to do the following:

- Set up all the basic infrastructure to process, connect, and make sense of sensory input,
- Develop pathways to build and control body movements and functions, and
- Build the basic working models of relationships through interacting with important people in life.

By better understanding infants' sleep needs, families can foster sleeping environments and routines that support healthy brain development. This will give young children a strong foundation for their entire lives. Understanding infants' sleep needs and patterns also helps caregivers become more aware of their own sleep patterns and needs—and maybe realize that each person in their family has different needs and patterns!

People most often think of sleep in terms of rest and rejuvenation, and those are certainly important aspects; however, parents may not realize just how hard their infant's brain is working while sleeping! During sleep, the brain rests and also takes note of what new or potentially important connections were activated during the infant's waking periods. For example, an infant may be learning that the spoon pushed off the high chair tray still exists even though it is out of sight.

6.1.1 Sleep

During sleep, the brain recognizes new connections and prepares to send more energy to strengthen these connections when these experiences are repeated. In order for the brain to experience quality sleep and be able to grow well, infants need to master some sleep skills, and parents and other important caregivers need to examine what they are doing to support a safe and calm sleeping environment.

Sleep Regulation

Getting to sleep and staying asleep; getting to awake and staying awake.

Young infants are trying to master all sorts of big things right after birth. Think about it—they've been attached to a maternal prenatal system that has been their main and backup regulation system for all living and thriving functions for 9 months, if they were full-term. Now, this new person has to sort things out with a support system that is no longer physically attached! Self-regulation of sleep is just one of these tasks.

Infants have to learn their own body's cues to begin to self-soothe and regulate their sleep and awake states. Parents can help their infants develop body awareness and be an active partner in helping shape their infant's experiences of and expectations for sleeping and waking. Sleeping and waking is a multiple-times-a-day activity in the first 12 months of life. The rhythms infants bring into the family system may or may not be similar to the adults and other family members. Being able to notice their patterns without judgment is a good start to supporting sleep and waking patterns that work for the whole family.

Sleep Consolidation

AKA Sleeping through the night! (and more commonly, building a 6-hour block of sleep).

In our faster paced, and often highly scheduled American family life, a solid night's sleep is highly valued. Thus, one of the things many parents desire is a baby who sleeps through the night. Research indicates that this happens for the majority of infants between ages 1 and 4 months; this is when infant sleep patterns become more adult-like. When sleep consolidation does not happen and babies continue to wake through the night, this may create an extra sense of stress for other family members.

Being able to stay asleep is a skill that builds on an infant's biological predispositions. For infants who are already more likely to sleep in longer stretches, learning to sleep through the night is not as much of a learning curve. For infants who typically sleep in shorter periods, it may take into their toddler and preschool years to develop the ability to sleep through the night on a consistent basis. Building supportive sleep and waking routines can help every infant and family system.

Sleep Regression

AKA "She was doing so well and now her sleep pattern is all off — HELP!"

Sleep regression is simply when one's sleep pattern significantly changes, which results in a loss of overall sleep time in a 24-hour period. It typically includes a loss of *consolidated sleep time*. This loss can create stress for the infant's entire family system. Sleep regression is often viewed as a challenge to the young child's developing sleep-regulation skills.

This is typically a short-term issue. Rapid growth and family stress are the two most common experiences associated with sleep regression. Here are three examples:

Rapid Growth, Example 1

It is fairly common for infants, ages 3-4 months, to experience sleep regression. Parents may be feeling that they just figured out their infant's sleep routine, and, then, everything changed! At about this time, infants' brains are undergoing a major reorganization of which sections and pathways control reflex behaviors and voluntary motor control. Brain scans at this age indicate that the brain is especially active, which can make it difficult to reach and stay in a sleeping state.

Rapid Growth, Example 2

It is also quite common for infants between 8-10 months to experience sleep regression. This is a typical time when an infant is developing significant locomotion skills, including crawling, pulling to stand, and early walking. Again, brain scans indicate that the infants are processing many things related to these motor skills — emotions related to their motor abilities (successes and failures), cognitions as they learn about their environment in new ways (e.g., sensory information about textures and safety of different floor surfaces, balance supports), and language (parents talking to their infant about their actions, offering words of caution and encouragement).

The brain is working to combine multiple pieces of information into what *crawling* or *walking* means in a larger sense to the infant. This means the brain is activated across many areas, and it can be difficult to regulate a consolidated sleep pattern.

Family Stress, Example 3

A military family with a young toddler may experience the stressors of deployment. The changes in routines and caregiving may be impacted by the Service member spending blocks of time away for training and preparation and then returning for a few weeks before deploying. The remaining parent is taking on both parenting roles in the daily family life, juggling work obligations, and potentially dealing with extra family and unit functions related to the deployment.

Young children are good barometers of stress in the family system, and one of the ways stress shows up is in disrupted sleep. A 20-month old who has been a consistent sleep-through-the-night baby with 1 short nap may suddenly need a late morning break and a longer afternoon nap again or an earlier bedtime than what was the family norm. When things calm down for the family, the child's sleep patterns will probably even out again.

Why Sleep Matters to Families

Every family member is affected by not getting enough sleep. Tired adults can be grumpy and short on patience and energy. Babies and toddlers often get fussy, more active than usual, and whiny. This is not a good combination.

When an infant's sleep pattern is significantly and consistently different from parents and other family members, it can create a sense of stress—even distress over time. If we can assess the family's expectations about their own and their infant's sleep, it can highlight opportunities for discussion and sharing information. Knowing more about sleep can help tired family members think and decide before reacting.

Why learning to fall asleep and stay asleep matters:

- Babies have to learn how to fall asleep and stay asleep.
- Self-soothing is a life skill that most babies are ready to begin learning between 4-7 months.
- Self-soothing/calming is a skill for school and life success, like learning to read and write. It takes some time and practice. It allows a child (adults, too) to pay attention (focus); to manage feelings; to be able to wait to take a turn on the playground; or to plan for a long-term goal, such saving one's allowance to buy a toy.

Through a Young Child's Eyes		
Sleep		
0-4 months	**4-8 months**	**8-12 months**
I fall asleep anytime, anywhere.	You may think we are getting this nighttime sleep thing down. And then, around 4 months, I start waking up during the night.	At night, I might wake up and call for you. You are my most important person, and I don't want to be apart from you.
I spend a lot of time in deep sleep, which is why it can be hard to wake me up—even to feed me.	Like you, my sleep now goes in and out of light and deep sleep every 1-2 hours. You know how to fall asleep at night and fall back to sleep in the middle of the night. I don't. Yet.	Also, I am learning to move and do things. The world is so exciting it can be hard for me to fall back asleep.
The first 2 months or so, I don't know the difference between night and day. That's why our sleep times might be so different.		I might be your little night owl for months—calling you. It is normal and to be expected because I love you and need you so much.
Chances are I may sleep a few hours at night, then wake up to be fed. Repeat. And take four to six shorter naps during the day.	By the time I'm 6-7 months old, I may be down to two to three naps during the day.	I probably still take two naps a day, 1 to 2 hours each.

Through a Young Child's Eyes		
Sleep		
12-18 months	**18-24 months**	**24-36 months**
As I begin to walk, I want to be on the move. It can be hard for me to fall asleep. You may even see my legs moving when I am asleep.	I want to be with you—just you. At night it can be hard for me to say "goodbye."	Though I know how to fall asleep, I may want to be in charge and fight going to bed.
I may still not want to say "goodbye" to you at night.	I may wake up many times. And, as my brain learns to shift into stages of sleep, I may have nightmares or night terrors (where I may cry, mumble, call out but do not wake up all the way.)	I may still be waking up often. It is because of how my brain shifts me from deep to light sleep so many times at night. Also, I may have nighttime fears—of monsters under my bed or the shadows on my wall.
During this time, I may be ready to shift to one afternoon nap.	By now, I'm probably down to one nap a day.	By now, I may be sleeping in a big bed.

Boots on the Ground: Everyday Moment Conversations with Families

This section highlights content and skill-building strategies that you can chose from as you plan your home visits. For the *Everyday Moment* section of the visit, you will find a list of topics to choose from and explore in conversations with parents who are concerned about their child's sleep or their own. For each, you will find the associated *Protective Factors* and *Trauma-Informed Principles* addressed. *Family Pages* designed to support your conversations are listed next.

In addition, you will find suggestions of related one-on-one activities to choose from for the parent-child interaction portion of your time together.

There are many sleep-related topics to choose from as you plan a visit to a family to tailor the conversation to that family's specific needs and interests. You may find that you discuss one topic now and come back to discuss another in a month or two depending on how things are going.

Using the information from your parent's *Protective Factors*, you can guide your curriculum choices to tailor the home visit discussion and activities. Ideas are presented below with their associated icons to highlight how they correspond to meeting families where they are and building their resilience. These include the following:

Sleep for parents

Parental Resilience may be a visit focus if parents are trying to figure out how to meet their own sleep needs when their infant wakes up several times a night.

Teaching your baby the difference between night and day

Knowledge of Parenting and Child Development can help parents understand that it takes time for infants to learn a family's pattern of activity and rest.

Helping your child learn to fall asleep and fall back asleep after waking

Knowledge of Parenting and Child Development and

Social and Emotional Competence of Children can be supported when parents try and establish routines that help their child regulate his own sleep patterns, even when he wakes for a late-night feeding.

Giving your toddler and 2-year-old a sense of control

Social and Emotional Competence of Children is fostered as parents create opportunities for their child to be an active partner in her sleep routines, such as choosing a book to read together or which songs to listen to when the lights are dimmed.

Safe sleeping

Parental Resilience and

Knowledge of Parenting and Child Development can help parents feel confident in sharing their expectations for what their child's safe sleep practices should be, no matter who is caring for him or where he will sleep.

Family Pages

A series of *Family Pages* on *Sleep* have been created to support your conversations with families while you are visiting and to become a resource parents can refer to between visits. These include the following:

- Sleep from a Child's Point of View
- What is Your Child's Sleep Pattern?
- 0-4 months: Learning the Difference Between Night and Day
- 4-8 months: Learning to Fall Asleep and Fall Back to Sleep
- 8-12 months: Helping Your On-the-Move Baby Slow Down to Sleep
- 12-18 months: Helping Your On-the-Move Toddler Slow Down, so She can Sleep
- 18-24 months: Helping Your On-the-Go Toddler Slow Down to Sleep
- 24-36 months: Making Bedtime Work for Your 2-Year-Old (and You)
- Safe Sleeping
- Focus on You: Looking Back and Moving Ahead with Your Child
- Practical Applications for Families: Figuring It Out Together

Related One-on-One Activities

These are suggested activities to promote healthy sleep patterns for young children. There is a broad selection of one-on-one activities available in the Activity Card deck.

- Telling or reading a story
- Singing a song
- Baby/Toddler massage

Book suggestions:

- *Hush Little Polar Bear* by Jeff Mack
- *Goodnight Moon* by Margaret Wise Brown
- *A Lullaby of Summer Things* by Natalie Ziarnik
- *More More More, Said the Baby* by Vera Williams

Everyday Moments 6.1 Chapter 2: Nutrition and Feeding

Main Elements

Content Areas

- Teaching About Nutrition and Feeding: *Protective Factors* and *Trauma-Informed Principles*
- The Science: Feeding and Self-Feeding Skills, Infant and Toddler Nutrition Needs for Healthy Development, Breast and Formula-Based Nutrition, Introduction of Solid Foods, Food Exploration and Refusal, Early Dental Care, Family Meal Routines and Variations
- Why it Matters to Families: Opportunities to Connect, Developing Individual and Family Meal/Eating Routines, Reading Your Infant's Hunger Cues, Passing Along Family/Cultural Values and Traditions, Picky Eaters
- Home Visit Activities and *Family Pages*
- Important Safety Supports and Knowledge: Allergies and Food Sensitivities, Choking Hazards

Support Connections

- Lactation Consultant
- Pediatrician's Office - Advocating and Communicating if/how Child is Experiencing Feeding/Digestion Distress

Teaching About Nutrition and Feeding: Protective Factors and Trauma-Informed Principles

Infant and toddlers experience significant and dynamic changes in their nutrition needs and their abilities to feed themselves over the first 3 years of life. Parents often experience some level of stress related to feedings and mealtimes, even though (or perhaps because) they occur several times a day. Supporting parents who are navigating experiences of on-demand nursing, formula choices, latch-on challenges, teething, food allergies or sensitivities, food exploration, and meals that seem to go anywhere BUT in their child's mouth and tummy is an important task for home visitors.

Nutrition is an area where referrals are important for a child's well-being. If an infant or young child is struggling with getting enough nutrition for adequate growth and energy, or there are indications that the child may be at risk for *Failure to Thrive*, home visitors are in a position to help families connect to additional providers with specialized knowledge and skills.

Nutrition and Feeding are technical aspects of the more general topic of food. Everybody eats, and everyone needs a healthy diet in order to feel well, develop properly, and have the energy to accomplish tasks and goals. But, food often holds far more meaning than just fuel for our bodies.

6.1.2 Nutrition and Feeding

There are emotional components to food choices: the places and ways families prepare, consume, and share meals and the ways taste and smell senses are integrated into memories of food and social experiences. Most families will likely have food-related memories tied to family traditions. For some families, food may also bring up anxiety or fear, memories of punishments or hard times, or feeling like they were not like other families. When a new mother may voice a concern that she can't tell if her young infant is getting enough nutrition through nursing or a father is worried about his toddler's sudden refusal to eat any food that feels sticky, you may pick up some important family *food values* clues in these conversations. Parents may have received helpful advice from well-meaning relatives and friends, and they are trying to sort out the advice and consider it with regards to their child and their circumstances. Working with a family to identify good sources of nutrition and feeding practice information, as an infant grows into toddlerhood and beyond, is important.

Helping a family bridge what they know and have been told with current recommendations can help reduce confusion and increase healthy nutrition practices for the whole family.

This chapter helps to address the following *Protective Factors*:

- ***Parental Resilience***
- ***Knowledge of Parenting and Child Development***
- ***Social and Emotional Competence of Children***

Teaching about *Nutrition and Feeding* opens doors to learning about a family's history, traditions, and beliefs, and parents may not think about these concepts consciously until faced with a new experience with their young child. *Trauma-Informed Care and Practice* (*TICP*) can help both you and a parent identify and navigate thoughts, feelings, and conflicting advice around food and nutrition and show how developing healthy routines around meals, snacks, and nutritional needs fosters a physically and emotionally healthy family system.

Safety – Very young infants have limited, but direct, communication cues to tell their caregivers that they are hungry: crying, rooting, grunting, and cooing. When parents create consistent and appropriate routines around feeding, young infants learn that their communication skills will be responded to appropriately and that they will get the nourishment they need. In turn, this builds a very early sense of trust that their needs will be met by the people who surround them. Understanding the nutritional needs of infants and toddlers helps parents make nutritionally sound choices regarding the food options and the schedules they develop to meet the nutritional needs of their young children.

Trustworthiness and Transparency – Routines that parents develop as the infant gains self-feeding and communication skills can help everyone get the fuel they need, even if family members need different eating schedules. Families, who have histories of food withholding as a punishment or food insecurity, have opportunities to change harsh patterns to support a sense of security with their children. Talking with young children about food choices and family routines gives the children ways to link their food experiences in positive ways.

Collaboration and Mutuality – Highlight how young children are engaged and want to connect with a parent in the feeding and meal routines from the earliest days. This creates space for building positive routines and conversations around food. For example, active collaboration by the youngest of infants is seen during nursing and feeding times with the rooting reflex and fussing to be repositioned for easier sucking, swallowing, and breathing. Toddlers can show their growing skills for independence by using their own utensils, wiping their own faces, and asking for more food. These steps toward independence show how the parent-child partnership changes over time, and the child assumes a more active role.

Peer Support and Mutual Self-Help – Sharing suggestions and stories of your own experiences of trying to get picky eaters to eat nutritious meals provides a space for parents to discuss frustrations and their own feelings, experiences, and cultures around food. Using this information, you can better tailor suggestions, respond empathically, and foster a positive relationship with families while also giving them useful information to create a more positive experience around food with their child.

Empowerment, Voice, and Choice – As young children develop food preferences and experience family and child care provider meal and snack routines, parents and others can establish ways to give real choices and encourage input in food-related decision-making. For example, parents can offer a new-to-toddler vegetable, like green beans, by putting one on a plate and following the child's decision to try it or not try it or even ask for more without judging the child's reactions.

Cultural, Historical, and Gender Factors – Cultural traditions about food vary widely. Maybe breakfast for young children is boxed cereal and milk with a spoon of peanut butter or maybe a bowl of rice with sautéed greens and a savory fish broth. A family may have traditions that favor feeding all the men in the family before the women eat their meals, or certain foods are not allowed due to religious or cultural traditions or at certain times of the year. Understanding how these different factors influence family systems, food choices, and expectations for behaviors informs how you can best connect important nutrition and feeding information to the culture each family builds and maintains.

The Science: Understanding Infant/Toddler Development and Nutrition

Infant and toddler nutrition needs and developmental abilities to self-feed are good examples of how dynamic the years between birth and 3 years old really are. These changes are not always easily visible to parents and have the potential to become unrecognized challenge points, which can create stress around mealtimes. Parents may have quite a few questions or concerns. What do the changing nutritional needs and feeding abilities of very young children look like? What are some common safety needs? How do very young children and their parents create healthy habits for both eating food and interacting in situations that involve food?

Reflexes → Voluntary Motor Control

Newborns arrive into the world with a few key reflexes that support infants in connecting to their primary caregivers and their mothers, in particular. These feeding and connecting reflexes are adaptive so that an infant can successfully nurse or take a bottle if a caregiver other than a biological mother is responsible for feeding the infant. Fathers, adoptive or fostering parents, medical professionals, and other caregivers can identify, elicit, and respond to these reflexes to help infants get the nutrition they need and promote a feeding routine. This can help build warm and positive interactions between the two individuals, so they can weather challenges when feeding may be difficult or be disrupted, such as during illnesses or changes in schedules.

These early reflexes help organize infants' response to their environment and caregivers. These reflexes form the foundations of voluntary motor skills—actions a young child can learn to control and choose to use. The chart on the next page highlights the important reflexes present at birth that help young infants physically get milk/formula into their systems. In turn, this provides the nutritional fuel needed for all the rapid brain and developmental growth that happens around the clock! As infants gain experiences with their parents and other important people, they are learning about rhythms and routines and developing expectations for how their caregivers respond to their communications, including what actions their parents do to help them understand that a care and feeding routine is starting or ending. Parents incorporate their infant's feeding reflexes into building feeding and mealtime routines and communication patterns that are shared across family members.

Motor Skill Development and Supportive Positioning for Feeding

Reflexes to Voluntary Control from Birth to 6 months

	Rooting	Sucking	Swallowing	Breathing
Infant Reflexes	When a baby's cheek is gently stroked near the mouth, the infant will turn head to the side being stroked.	Putting a nipple-sized object in an infant's mouth will elicit an automatic sucking reflex.	Young infants suck and swallow as a single reflex action until about 6 months. The presence of liquid in the mouth triggers a swallow reflex directly after a sucking reflex.	Breathing remains a semi-reflexive action throughout the lifespan. Very young infants develop a rhythmic burst-pause feeding pattern to begin coordinating breathing with sucking & swallowing. It is common to swallow air during feeding and to confuse a breath with a suck-swallow.
Caregiver Response	Caregivers can stroke the cheek to orient the infant to a bottle or nipple.	Caregivers can and do offer non-nutritive suckers to soothe infants between feeding times.	Caregivers may notice that young infants spit or push liquid and early, soft food options out. This is because the tongue is used to pushing against the nipple to get the milk or formula into their mouths.	Caregivers can use supportive holding positions to help infants coordinate breathing with the burst-pause pattern (head higher than body, turned toward caregiver, outside arm higher than arm against body). Holding the infant upright and over one shoulder part-way through and after a feeding session helps dispel swallowed air that can create tummy distress.

Motor Skill Development and Supportive Positioning for Feeding

Increasing Control Over Reflexes from 6 to 12 months

	Rooting	Sucking	Swallowing	Breathing
Infant Control	The infant is learning to control the strength of response based on hunger and a sense of history of past experiences when this reflex was triggered. Beginning at about 5 months, the rooting reflex may be strong when the infant is hungry, yet not appear if the infant is satisfied or has significant experiences that indicate that no milk is coming after the stroke of the cheek.	This reflex begins to fade at about 6 months as mouthing objects increases*. This means the infant does not automatically suck-swallow, but is starting to explore items and their caregivers' reactions by gumming/ biting, swishing, and spitting. Infants have also started bringing their hands to their mouths, sucking on fingers, fists, thumbs and things they are holding. *teething often starts between 6-8 months, influencing these actions.	Older infants are beginning to control their tongues and thus their automatic swallow reactions. Introduction of soft solid food gives the infant experiences of what happens when the tongue pushes versus pulls food into his mouth.	Infants likely have a consistent routine for feeding and burping established by now. As the infant is more able to get to and hold a sitting position, he is also learning how breathing and feeding change with his body position.
Caregiver Response	Across these reflexes, caregivers can see how the infant is changing over time by gaining experiences within each feeding session and as the infant builds his motor control skills. Infants are developing a sense of pattern and routine with their important people for meals and starting to branch out from needing their parents/ caregivers for every sip and bite.			

Development of Self-Feeding Skills: It's Far More than Motor Skills!

As infants grow into their 6th month and beyond, they start developing several other fine and gross (small and large) motor skills to build their self-feeding skills. These motor skills do not happen separately from other kinds of skills. For example, communication and cognition (thinking, understanding) are woven into learning to feed oneself. Meals are often a social activity, such as shared family meals, which may be a daily occurrence or planned for special holidays, celebrations, and meeting friends.

Very young infants experience social connection from their very earliest days with every feeding session. Sometimes those feeding sessions are quiet, such as those that happen in the evening and nighttime hours, while others may be quite lively with lots of communication with their parent and other family members.

The following charts give examples of how different areas of development and growth contribute to an infant and toddler's growing abilities to be a partner in their own feeding and eventually as part of the family system helping with routines that include preparation and cleanup after meals.

Through a Young Child's Eyes	
Learning to Feed Myself	
0-4 months	**4-6 months**
I have a special cry that tells you, "I am hungry" or "my tummy hurts."	I let you know I am hungry in different ways. I may cry or fuss, reach for you, smack my lips, or get frustrated if I have to wait.
I look in your eyes, coo, and smile when you hold and feed me.	I can control my head better. I can roll over and am beginning to sit with help.
I discover my hands and may reach out to touch your hand, breast, or the bottle.	I am gaining the skills I need to eat solid foods. I can sit in my high chair. My tongue moves food to the back of my mouth, and I know how to swallow it.
I feel better when I'm, burped because this whole sucking, swallowing, and breathing thing is tough to coordinate!	If I am pushing cereal or mashed food out, I may not quite be ready yet, but I'm learning.
	I tell you I am done when I turn away or push away the breast, bottle, or spoon.

Through a Young Child's Eyes

Learning to Feed Myself

6-12 months	12-18 months
I may babble, coo, catch your eye, reach for the breast, or point to my bottle to tell you, "I am hungry."	I may say, "Ba ba," point to or try to reach for a cracker to tell you, "I am hungry."
I can hold my own bottle. I also begin to use my fingers and hands to feed myself. I reach for a graham cracker and dip my finger in the bowl of applesauce and lick it off.	I still enjoy sitting with you and nursing or having my bottle, especially when you talk and sing with me.
	I can drink from a sippy cup.
I may push the bib away to say, "I don't want it." (You can put it on me anyway.)	I like to explore my food and the utensils I'm learning to use. Things may get messy!
I reach for the spoon when you feed me or the washcloth when you wipe my face.	I can hand you the cup or banana when you ask for it.
I may push your hand or the spoon away or shake my head "no" to say, "I am done."	I am getting new finger skills. I try to pick up a crumb and eat it, or I may try to buckle or unbuckle the strap on my high chair.
I may start drooling (a lot!) and mouthing both food and non-food items as my teeth start coming in. You can help me stay safe by watching what I pick up—because I don't yet look at things before putting them in my mouth. And, I may enjoy and be comforted by a teether that you keep chilled in the refrigerator.	I may refuse to eat mashed cauliflower and point to the applesauce that I want instead.
	I may kick the high chair, push my cup onto the floor, or say "down" when I am done.

Through a Young Child's Eyes

Learning to Feed Myself

18-24 months	24-36 months
I may say, "Eat," when I am hungry.	I may walk over to the fridge and try to pull open the door when I am hungry.
I may grab the spoon and try to feed myself. (Having two spoons will make life easier for both of us.)	I may ask for a "sandmich" and refuse apple slices when I am hungry.
I may use my word for bottle when I want my cup.	I may reach for food on your plate or hand you a piece of my peach.
I can use my thumb and forefinger to pick up small pieces of food.	I feel proud to be a real helper when you let me carry the napkins to the table, stir the pancake batter, or tear the lettuce leaves for our salad.
I may get frustrated when things don't go my way, like when the cooked carrots slip off my spoon or fork.	I can walk to the sink and wash my hands with you before we eat.
I pretend to feed my stuffed animals or dolls and to cook. Watch, and you may hear me say and do things you say and do with me.	I can hand you the plate when you ask me to pass the sliced pears to you.
	I may watch to see if someone gets a bigger cookie than I do.
I may say, "No," "Done," pull off my bib, or shake my head to tell you when I am done.	I may tell you, "Get down please," when I am done.
I may get angry when someone teases me with food or pretends to take something off my plate and eat it.	I may show you my sense of how things work by demanding only milk in my blue cup and only juice in my orange cup.

Nutritional Needs Across Infancy and Toddlerhood

There are excellent, evidence-based sources of nutritional information for infants, toddlers, and nursing mothers available in a 2017 report from the Healthy Eating Research group. TRHV encourages you to explore, in particular, the appendices in the 2017 report for family-friendly information about nutritional needs of infants and toddlers and the different hunger and satisfaction cues they express as they learn to connect with their caregivers and engage in meal and snack-time routines.

The following bulleted lists provide a quick summary of nutritional needs and cautions for children from birth to 24 months. By the age of 2 years, most children are able to eat food similar to their older family members, just with caution for smaller bites and portions.

General Nutritional Needs

Birth to 12 Months:

- Breast milk and/or infant formula should be given exclusively for the first 6 months, unless directed by a pediatrician.
- Introduction to cereals and soft solid food can begin between 4.5 and 6 months, with consultation with the infant's healthcare provider. The introduction does not replace breast milk or formula. New foods and textures are more likely to be tolerated if mixed with formula or breast milk.
- Between 6 and 9 months, soft solid foods and cereals are *complementary* to the child's diet. The main source of nutrition is still breast milk or formula.
- At about 6 months, infants can transition from bottles to cups like *sippy* cups.
- By an infant's first birthday (12 months) just over half of daily calories come from solid foods, and the remaining half comes from formula or breast milk.
- Offering a variety of vegetables, cereals, proteins, dairy, and fruits (pureed, no added sugar!) helps infants develop their taste buds and regulate their feelings of hunger and fullness.
- Water can be given as a supplemental drink once an infant starts to eat pureed/soft proteins.
- Supporting food exploration with hands, fingers, and infant-sized utensils helps develop large and small motor skills, cognition, and positive responses to new foods when introduced.

Cautions for Birth to 12 Months

- Even very young infants learn to recognize their bodies' hunger and satisfaction cues. Parents do not need to force feed or withhold food to externally regulate what the child's body is telling her.
- Always mix formula according to the manufacturer's directions. Do not add more or less water than directed as this changes the calorie and nutritional intake by the infant.
- Solid foods introduced before 4.5-6 months often cause gastrointestinal (GI) distress due to the infant's immature digestive abilities.
- Serve cereals and soft foods from a spoon, not a bottle. Serving from a spoon helps the infant learn new skills and reduces early dental problems from unswallowed food sitting in the child's mouth (e.g., falling asleep with a bottle).
- Avoid processed foods that have added sugar and salt. These are not good baby food substitutes, and the added sugar and salt can interfere with the infant learning to like the natural taste of foods.
- Avoid all plant-based milks (e.g., soy, pea, rice, cashew, oat, almond) as these do not provide the needed nutrition and many have added sugar.
- Avoid honey and undercooked eggs (e.g., runny eggs) as each can carry different types of very serious food poisoning.

General Nutritional Needs 12 to 24 Months

- Breastfeeding can continue. If using formula, parents can switch to whole cow's milk or 2%, if recommended by the pediatrician.
- Toddlers this age often eat five to six times a day because their tummies are small. Some of these meals and snacks may be large, and some may be just a bite or two. Toddlers are pretty good at regulating their calorie intake and needs.
- Cow's milk can be introduced after 12 months, and whole milk (and whole milk products, such as yogurt and cheese) is recommended over lower-fat and fat-free options. Look for options with no added sugars (e.g., avoid flavored milks or sweetened yogurt products).
- Offer a wide range of vegetables and fruits. Vegetables that are dark green, red, and orange have vitamins and minerals that are hard to get in other food sources. Fruits that can be eaten with the skin offer fiber, which is good for the GI system, and are naturally sweet. These benefits are more difficult to get in juice form. Offer veggies and fruit at most meals and snack times.
- Children this age benefit from protein. Providing about ½ to 1 ounce at almost every eating opportunity is a good idea. This can come from poultry, fish, meats, and veggie-based options (e.g., lentils, tofu, beans).

  Avoid highly processed options like lunch meats, ham, and pre-packaged and breaded chicken and fish (often found in the frozen or refrigerator aisles). These foods often have higher levels of salt and other additives and preservatives that are linked with sensitivities and allergies.

Cautions for 12 to 24 Months

- Sweetened foods (candy, processed food with sugar added) and beverages (juices, flavored drinks, sodas) are not recommended as they can interfere with healthy food choices and displace good and nutritiously-dense food with simple sugars.
- Choose snacks with good nutritional values, such as apple slices and carrot sticks or whole grain crackers with a nut or seed butter.
- Avoid using food as a reward, punishment, or bribe. Everyone needs food and good, nutritionally-sound options. If a toddler refuses most or all of his lunch, offer the next snack at the regular time without judgment.
- Fad and commercially available diets/programs are not recommended for very young children. These often restrict vital nutrients, which help grow healthy brains and bones. Such programs can also reduce the energy needed to be a healthy, active toddler!
- By the time a child turns 2 years old in the United States, most children are eating food similar to their parents, just in smaller proportions and with less control over their choices and servings.

  When parents and other caregivers make healthy food choices, young children benefit from learning the natural taste of foods and instill early habits to make better choices themselves. The adults' choices influence a child's experiences with a variety of textures and flavors, self-feeding occasions, and food preparation opportunities.

Why Healthy Eating and Nutrition Matters to Families

Eating well is key to good health—today and in the future. Research shows that eating habits are developed at a young age, and eating nutrient-rich foods can lessen the chances of obesity and dental cavities and promote good overall health. In addition to meeting nutritional needs, mealtimes can also provide families the opportunity to deepen relationships and teach children their family's culture and traditions.

Knowing the importance of this *Everyday Moment* can empower parents to step back from the demands and stress of providing for and raising young children and take the time to invite children to participate in meal preparation and shared family meals.

Why Healthy Eating and Nutrition Matters

- It is never too early to teach children about healthy eating. As their children's most important adults, family members are setting examples and modeling behaviors, including food choice and mealtime traditions that children will make their own.
- Healthy eating is an important step towards enjoying a healthy and productive life.
- Food is an element of cultural identity that helps children learn about who they are and, over time, be able to share their culture with others who may come from similar or very different backgrounds.

For some families, mealtimes and food choices may be challenging. Here are some concerns or challenges parents may have (or that you may notice, but they think are typical) and some strategies to use to find better responses and patterns:

Sharing the Care – Sometimes it can be overwhelming to figure out feeding routines with very young infants. Early patterns of one parent doing most of the feeding may become habits that are hard to break or could cause resentment for the partner who is not involved. If a family has more than one caregiver in the system, such as a spousal partner or other relative living in close quarters, there are some ways to create feeding opportunities to share the work whether breast or formula feeding.

A breast-feeding mother may hand the infant over to her partner and supporter for burping; a partner may bring the baby to the mother for night-feedings; the mother may pump and store extra breast milk so that other caregivers can provide feeding to the infant.

Sometimes, there is concern that a partner or relative may be doing something not quite right. Being able to frame those concerns in ways that support instead of frustrate the partner can mean all the difference in developing a sense of truly shared care during feeding.

Food Refusal – This has been touched upon in some of the earlier points about children's ability to recognize their hunger and satisfaction signals and, in turn, regulate their food intake. But, it is worth a bit more discussion when a parent is worried that her toddler only wants chicken nuggets and ranch dressing for every meal. Many children go through phases where a food that they liked is suddenly off the list of acceptable options. Their taste buds are changing throughout the early years. That food may come back onto the list in 6 months. Additionally, toddlers are exploring routines and models of *how things work*. You know that divided plate that keeps food from touching? A toddler may refuse to eat a food that is put in the *wrong* place, even if it is a favorite. Depending on the individual toddler, it might be a quiet refusal or a very loud refusal.

Parents may want to think ahead of time if there is an alternative choice that can be offered that meets the needs of the meal/snack and is available (e.g., a cheese stick instead of the chicken bites).

If the child seems to be refusing, the parent might look for other cues—is the child not hungry or does she not like the food? Maybe the toddler is overly tired and sitting and eating just takes too much control at the moment.

What are some responses that honor the child's communications? If the refusal is putting stress on a family schedule, what are some options that can ensure that the child can eat when ready without creating a separate meal or going to extraordinary lengths? Finite choices (e.g., cheese sticks or chicken) and back-up options that are already identified (e.g., sunflower seed butter and crackers, cereal with milk) are good strategies to put into place. It may be comforting to know that it can take up to 15 offers of a new food for a very young child to decide whether he or she likes it or not! So, it is OK to try again on another day or meal after a child has communicated a "No."

Food Insecurity – Food insecurity occurs when a person or family has reduced access to food, usually due to economic limits. The United States Department of Agriculture (USDA) describes two levels of food insecurity:

- *Low food insecurity (less severe level)* – a household reports reduced variety, quality, or desirability of food available to the household but no reports of hunger.
- *High food insecurity (more severe level)* – when there are reports of disrupted eating patterns, food accessibility, and intake in addition to reduced variety, quality, or desirability of food.

In 2016, food insecurity across the U.S. population was estimated to be highest in single, mother-headed households with children (20%) followed by married parents with children (16%) Why does this matter to families? Experiences with food insecurity, whether short-term or chronic, impact behaviors and expectations within family systems, including the parent-child relationship. Recent research, focused on adverse childhood experiences (ACEs), indicates that ACEs can have a

generational impact on families regarding food insecurity. Mothers who indicate they experienced four or more ACEs and who have also reported depression are also more likely to report both current household and child food insecurity.

Recognizing the potential effects of food insecurity experiences can help a home visitor work more effectively with families from connecting parents to the WIC program to helping parents think about their own experiences and how those might influence their thoughts and responses when they see a young child playing with food instead of eating. Using food as a reward, punishment, or bribe may come from some of these experiences, as may other behaviors that are serving to control the food environment of the home, but using food in these ways may have other unexpected consequences. For example, a parent may buy several sandwiches at a fast food place that is running a special and then refrigerate them for several meals and cut them into bites. Parents may dilute a bottle of formula or reuse an open jar of baby food from which they have already fed their infant. While these examples may show frugality, each introduces food safety challenges or reduced nutrition to the child. Home visitors may be able to work with a family to reset their food patterns and behaviors to a healthier level—from food choices to greater security.

Failure to Thrive (FTT) – *Failure to Thrive* refers to a set of conditions that lead to a clinical diagnosis of malnutrition by a healthcare provider during a well-baby or other medical visit. Infants who do not meet the 5th percentile of height and weight standards for their age, or who have negative growth changes across two major growth percentiles, would be assessed further. The next step in assessment is to determine the underlying causes of poor growth so that appropriate interventions can be identified:

- Medical causes: Under-nutrition; infection; digestive system or metabolic problems; physical issues, such as a cleft palate; or food intolerances.
- Psychosocial causes: Parent/caregiver mental health or physical health challenges, including substance use; family stress, such as economic issues; or lack of knowledge about healthy feeding or understanding the infant's needs.

While it is not within the scope of practice for most home visitation programs, it is helpful for home visitors to have a basic understanding of the characteristics of *FTT* so that referrals and recommendations to other service providers can be coordinated. If food insecurity is part of the family context, home visitors can be resource bridges for families to connect to community resources, such as WIC and food pantries.

Boots on the Ground: Everyday Moment Conversations with Families

This section highlights content and skill building strategies you can use as you plan your home visits. For the *Everyday Moment* section of the visit, you will find a list of topics to choose from and to explore in conversations with parents who have questions or concerns about their child's eating habits—or their own practices.

For each topic, the associated *Protective Factors* and *Trauma-Informed Principles* are addressed. *Family Pages* designed to support your conversations are listed next.

In addition, you will find suggestions of related one-on-one activities to choose from for the parent-child interaction portion of the visit.

There are many feeding and nutrition related topics to choose from as you plan a visit to a family, and you should tailor the conversation to that family's specific needs and interests. You may find that you discuss one topic now and come back to discuss another in a month or two depending on certain circumstances.

Using the information you have about a family's *Protective Factors*, you can guide your curriculum choices to tailor the home visit discussion and activities. Ideas are presented below with their associated icons to highlight how they correspond to meeting a family's needs and building each family member's resilience. These include the following:

Nutrition guidelines for infants, toddlers, and 2-year-olds

Knowledge of Parenting and Child Development can be promoted through discussions about a young child's nutritional needs and how to offer healthy choices when a child is a picky eater.

Developing routines for family meals with toddlers

Social and Emotional Competence of Children is encouraged when young children learn to contribute to meal routines, such as placing napkins by each plate and holding hands or becoming still while a moment of grace or silence is observed.

Food exploration and refusal

Knowledge of Parenting and Child Development can guide parents' reactions in appropriate and responsive ways when their child smears food across the high chair top or spits out a bite of a vegetable.

Eating out with infants, toddlers, and twos

Parental Resilience and

Knowledge of Parenting and Child Development and

Social and Emotional Competence of Children are strengthened when parents are able to plan ahead when eating at a restaurant by planning for their child 's needs while out (e.g., food, quiet activities, emotional support), knowing how their child responds to unfamiliar environments, and thinking proactively about how to handle difficult situations like a toddler meltdown.

Understanding food allergies and sensitivities

Parental Resilience and

Knowledge of Parenting and Child Development are fostered when parents are able to recognize their child's adverse reactions to a food, seek timely medical help, and ask questions of their child's healthcare providers.

Safe food and feeding practices

Knowledge of Parenting and Child Development is gained when parents know how to store and prepare infant food safely, such as milk storage and heating, and how to support their young child in safe feeding practices, like not putting an infant to bed with a bottle and making sure foods are in small pieces.

Family Pages

A series of *Family Pages* on *Nutrition and Feeding* have been created to support your conversations with families while you are visiting and to become a resource for a parent to refer to between visits. These include the following:

- Learning to Feed Myself from a Child's Point of View
- Understanding Your Baby's Needs
- Eating Right for Toddlers and Twos
- Meals are About More than Eating Right
- Safe Eating
- Prenatal Health: Your Nutrition
- Focus on You: Looking Back and Moving Ahead with Your Child
- Practical Applications for Families: Figuring It Out Together

Related One-on-One Activities

These are suggested activities to promote healthy eating and family routines around meals. A broad selection of one-on-one activities are available in the Activity Card deck.

- Notice and Wonder: How does your child participate in feeding himself?
- "Cooking" and "Eating" with your Toddler or Two: Pretend playing a scenario of cooking or eating a meal together.
- Matching lids and containers, utensils: If you have a container storage space, ensure it is in a toddler-friendly place where a child can explore matching lids to containers; can identify and match other kitchen items, like spoons and forks; or can learn to set parts of a table.

Book suggestions:

- *The Very Hungry Caterpillar* by Eric Carle
- *Bee-bim Bop!* by Linda Sue Park

Additional Resources

Community and health connections may include:

- WIC
- Lactation Consultants
- Pediatrician's Office, other Healthcare Providers
- Community/County Health Department

Everyday Moments 6.1 Chapter 3: Diapering and Toileting

Main Elements

Content Areas

- Teaching About Diapering and Toileting: *Protective Factors* and *Trauma-Informed Principles*
- The Science: Body Awareness and Control, Understanding Routines and Time, Stress and Regression
- Why it Matters to Families: Opportunities to Connect, Developing Routines and Normalizing Body Functions, Reading Your Child's Toilet Cues, Working with Child Care, Cultural and Family Influences on Expectations
- Home Visit Activities and *Family Pages*
- Important Safety Supports and Knowledge: Physical Safety—Changing Tables, Toilet Locks, Diaper Rash, Dehydration, and Constipation

Support Connections

- Pediatrician's Office

Teaching About Diapering and Toileting: Protective Factors and Trauma-Informed Principles

Toilet learning is one of the most discussed and anticipated milestones of early childhood. Parents may experience pressure to get their young child to meet expectations from a variety of sources—extended family members, child care professionals, and other parents in their social networks. Parents may have expectations of when young children will consistently be successful in *staying dry* and managing their toileting needs throughout the day and overnight. Parents may also face economic pressures for their children to meet this milestone. Diapers are expensive, whether disposable or cloth systems are used. Helping parents support their young children in achieving the body control and communication skills needed for successful, consistent toilet use is multidimensional.

Helping parents address the sources of pressure they experience is vital in helping them help their child learn these skills without shame and punishment. When shame and punishment are used to try to force a child's bodily control, those can create long-term challenges to a child's sense of competency and self-esteem. TRHV purposefully uses the phrase "toilet learning," rather than the more adult-focused phrase of "toilet training," to help keep the focus on supporting the child's growing abilities and skills.

6.1.3 Diapering and Toileting

Accidents are going to happen. Bodies do not always do what we think they should in the manner they should. Normalizing regular body functions and recognizing both the abilities and limitations of a young child's body awareness and control are key to building parents' healthy expectations for toilet learning. This awareness and understanding, in turn, can help parents address the range of comments and advice they may receive from well-meaning individuals. In addition, parents will be more confident and competent in working with healthcare providers if their young child experiences challenges that are not typical or that indicate a potentially serious issue related to toileting. These may include diaper rash, significant changes in stool consistency (e.g., diarrhea or constipation), or unexplained pain.

This chapter helps to address the following *Protective Factors*:

- ***Parental Resilience***
- ***Knowledge of Parenting and Child Development***
- ***Social and Emotional Competence of Children***

Diapering and Toileting is a topic that may open home visitor-family conversations about control and expectations in a variety of ways including the following:

- Parent control and desires for toilet learning,
- Insight into what parents think are important for developing their child's abilities,
- Stories parents have heard from family and friends about how children were *early* or *late* for this milestone and the associated emotions of pride or shame,
- Parents' feelings about experiencing diaper blowouts or a toddler's loud announcement in every restaurant that they need to use the potty, and
- Feeling embarrassed by an early childhood care professional when the parent is given a bag of wet or soiled clothes and announces the child went through three sets of clothes that day.

The principles of *Trauma-Informed Care and Practice* (*TICP*) can help you create conversations and strategies to support families and their infants and toddlers. These principles highlight ways that families can create safe, loving, and empowering connections to support young children's progression toward successful toileting in their first 3 years.

Safety – Both physical and psychological safety are important for an infant and toddler's experiences with diapering and toileting. Babies typically have diaper changes 8-12 times a day, and the diaper routines that are established by their caregivers create early expectations for how they will be treated, talked to, and touched as they are cared for. Physically, very young children who stay in wet or soiled diapers for extended periods of time are more at risk of diaper rash and infections. These can lead to having pain and negative emotions associated with that part of their body. Medical interventions to address these condition(s) may also be stressful and painful. Making sure that a changing space is secure for an increasingly mobile infant is another element of physical safety.

Psychologically, diaper changing times are opportunities for parents to connect with their infants—talking about their body and the actions the parent is taking to clean and support them. Parents can begin communicating about how their child's body works, normalizing daily functions, and showing care. When accidents occur, a parent's response can lead a child toward increased or decreased feelings of competence.

Trustworthiness and Transparency – Early infusion of care and connection into diapering routines supports a growing sense of trust between infants and their caregivers. This forms a foundation for emotional and physical support as the child grows into toddlerhood and starts taking steps to gain greater body awareness (e.g., recognizing sensations that one needs to pee or potty) and body control (e.g., the ability to hold one's bladder until at a toilet and clothing is out of the way). Young children who can trust their parents and caregivers when accidents occur are less likely to experience shame or punishment as a result. This, in turn, can lessen the likelihood of a young child developing fears about toileting.

Peer Support and Mutual Self-Help – Home visitors can model supportive, non-judgmental responses when a young child has a toileting need, including accidents and toilet-learning milestones. Sometimes, parents do not have supportive words or responses from their own experiences or watching others; maybe they only know what they *don't* want to do or say.

By modeling developmentally-appropriate strategies and language, home visitors can offer positive alternatives to replace or prevent parents from using punishment and shame-based responses. These can include setting realistic goals, making charts, and using positive reinforcement. Sharing information about their child's development supports parents by fostering patience and realistic expectations. It also helps parents address social pressures that they may feel in their day-to-day lives related to their child's toileting.

Collaboration and Mutuality – Parents can help even the youngest infants become engaged partners in diapering and later toilet learning. Sometimes, parents can benefit from narrating their and their infant's actions so that movements and abilities become more visible to each person in the partnership. For example, you can model language that connects to the infant's actions, such as "You pushed up your bottom to help me move the diaper—thank you!" Parents can meet their toddler during play and change the pull-up without interrupting the child's exploration, narrating "Now lift your right leg" while touching it to cue which leg to lift.

Empowerment, Voice, and Choice – Young children are developing their internal motivations for toileting (e.g., I like to stay dry, I don't want to wear a diaper/pull-up) as their families and caregivers provide external motivation and support (e.g., buying a child-sized toilet, reading books, providing rewards for peeing and/or pooping in a toilet).

There are several strategies to support a young child's empowerment and choice. For example, parents can help children learn how types of clothing affect how easy or difficult it will be for them to manage their own toilet needs. Parents and other caregivers can establish a standard routine that everyone uses the toilet before an event or travel or limits drinks before bedtime. Some children may be more or less inclined to use *strange* or public toilets. Can you think of other strategies that are supportive and safe?

Cultural, Historical, and Gender Factors – As mentioned at the beginning of this topic, parents bring their own experiences and expectations with diapering and toileting and often receive comments and advice from extended family and friends. Families you serve may have diverse cultural backgrounds with different methods for caring for young children's toileting needs and strategies for bladder and bowel control that have worked well in their cultural context. Taking time to learn about the family's cultural and historical background helps you understand their concerns, motivations, and expectations around toilet learning.

The Science: Understanding Progression of Infant/Toddler Toilet Learning

Development of Body Awareness, Communication, and Control

There are several individual cognitive, communicative, and motor skills that must develop in order to successfully reach toilet learning milestones. Remember, there are many smaller milestones to notice and celebrate with a young child. It is also very important to note that complete control over toileting typically does not occur before age 3 years. It is common for young children to gain the abilities to control their bladders and bowels during the daytime, yet they may still need support for nap-time in preschool and nighttime during the elementary years. In addition, it can be difficult to make a choice to stop playing or doing something interesting and engaging just to go to the bathroom. It is common for children into early elementary years to make an error in judging how long they can wait when there are options for doing other things. Even adults can make a mistake in how long an errand, a meeting, or a trip home will take and then need to do the "I gotta GO!" dance to the nearest restroom!

Body Awareness

Body awareness is the cognitive and sensory development of young infants learning about themselves. Infants are learning about things they experience internally, such as recognizing physical states of hunger and fullness; being tired; and tummy rumbles, burps, and toots and emotional states, like contentedness, fear, and happiness. Infants are also learning about their physical presence in their world—where their body is in relation to other aspects of their environment, including their important people, places where they are put (e.g., carriers, the floor during tummy time, sleep spaces) or move to on their own (e.g., pushing up into a corner of a crib, rolling across the floor to a toy).

6.1.3 Diapering and Toileting

Body awareness is a necessary first step in being able to eventually control and guide one's own actions, including holding and releasing one's bladder and bowels.

The feelings of being wet and of having a bowel movement are some of the most direct and recurring sensations a young infant can experience. There is significant cultural variation in infants' development of this awareness. The type of diapering products used can influence how easy or difficult it is for an infant and toddler to feel that wetness or messy diaper. In cultures that use cloth diapers or simply cloth coverings or let their infant be bare-bottomed, infants develop body awareness for bladder and bowel control in the first year. These cultures also tend to have adults (e.g., mothers, extended family members, older siblings) carry infants in slings and wraps, so, when an infant pees or poops, there is a person right there who knows immediately and who can help the infant make connections to anticipate their body functions. In many of these early awareness communities, mothers and extended caregiving kin will use cues, such as a certain whistle or phrase and then hold the infant over an appropriate space to toilet and repeat this on a regular routine. Toddlers in these communities tend to reach daytime toileting milestones as early as 12-14 months, which is much earlier than in the United States.

In the United States, disposable diapers are the most common choice of parents, and many parents need to use paid or familial child care during part of the week in order to meet other family and work responsibilities. In addition, parents are not as likely to do extended baby-wearing. Instead, they use cribs, play spaces, bouncy seats, strollers, and car seats throughout the day. These different contexts impact how close an adult is to an infant and how quickly one can respond when a diaper change is needed. Disposable diapers are also highly absorbent and wick away moisture from a baby's skin, which can be positive in

terms of helping reduce risk of diaper rash. However, these product characteristics also mean that it can be more difficult for infants and toddlers to become aware of their body's functions.

Did you know that when disposable training pants (e.g., Pull-Ups) first came out in 1989 and through the mid-1990s, they advertised that cartoon characters on the front of the pull-up would disappear when the child was wet, and that was how a toddler could *learn* a change was needed? This meant that toddlers could not feel when they were wet, and the marketing directed parents to teach their young children to look at the cartoon character to know if they had wet themselves. It probably seems silly to look for disappearing cartoon characters instead of learning about one's body sensations to know if one is wet.

But, sometimes products have more direct benefits for a parent or caregiver than for the child. High absorbency and disappearing characters work for caregivers who cannot quickly change out a wet pull-up or who need to care for multiple children and respond swiftly if a child needs a change. It can be helpful to talk with parents about diapering choices they make and how each choice can have both expected and unexpected benefits and drawbacks in helping a young child work toward toileting milestones.

There is a lot of sensory information coming in through sight, hearing, touch, smell, and taste. Each of these experiences help infants understand just a bit more about themselves and their world. Learning about one's body functions and sensations prepares a young infant to anticipate changes in feelings and sensations due to changes in the caregiving or physical environment. Think of a father who crinkles up his nose and face while changing a messy diaper, drawing his infant into the running conversation about what the infant's body accomplished with a "Shew! That's a lot today. Look at you, digesting all that food. Let's get you cleaned up and feeling comfortable." That dad is helping his infant learn about body functions, engaging with the child in a positive way, and encouraging responses from his infant with the way he is speaking. Dad is helping his infant form a mental script of sensations and expectations that are not yet words. If words were to describe what the infant hears and learns, they may be:"When my diaper is uncomfortable, my dad talks to me about what my body did and what he is doing to help me, while wiping my bottom and changing my diaper and clothing."

Communication

In the first few months of infancy, a child will communicate about wet and soiled diapers through a range of distressed expressions, body movements, and cries. Parents can support these early communications by using words that reflect and respond to the infant's emotions and needs and using touch that conveys care and respect for the infant's body and emotional state.

As infants gain motor control, they can begin coordinating their actions with the routines that are developing during diaper changes. This, too, is a form of communication and contributes to an ordered pattern infants are learning to anticipate. As the relationship deepens, both infants and parents may introduce silly and teasing moments. A parent may blow raspberries on a child's tummy, kiss and count toes and fingers, or use a clean diaper to play a bit of peekaboo. Infants and toddlers may lift a foot in the air for a kiss or tickle or roll over in a new game of "watch me flip!"—for which a parent needs to have both quick reflexes and make safety adjustments!

6.1.3 Diapering and Toileting

As a child grows into toddlerhood, words are added to communicate a body function or need. A 14-month-old may go to the changing table and point to the wipes and then to his or her messy diaper. Unique personality and temperament characteristics develop that let parents understand how their toddler feels about and reacts to potty needs.

Some toddlers may really not like the feeling of a wet or messy diaper and demand immediate changes or decide they want to potty like a big girl or boy, while other toddlers may not care deeply about a messy diaper and want to continue with their current activity. Others simply need more time for their body control to mature, and it can be stressful to feel pressure to perform for parents, preschools, and others.

Children may communicate their level of comfort with toileting in new or different places, such as restaurants and churches. Older toddlers are often curious about bathrooms in different places,and they may want to explore them. It is common to have a toddler who is shy or cautious about unfamiliar bathrooms and who does NOT want to use it.

Tuning in to the verbal and non-verbal communications infants and toddlers share is important for parents as they build a partnership with their young child to work together and take care of their child's toileting needs. These needs may happen on a typical schedule, like after nap; an inconvenient time and place, like the checkout line of the grocery store; or when the child is ill or reacts badly to a food, losing body control. Being able to engage with the goal of supporting the infant or toddler through the moments of struggle make a big difference in helping children move forward with confidence and success on their milestone timelines.

Body Awareness → Body Control

Body control for toileting uses a wide-ranging set of fine and large motor skills, which continue to develop through and past the infant and toddler years. If body awareness is learning what your body does and recognizing certain cues and urges for peeing and pooping, then body control is the brain's growing ability to decide what actions need to be taken and what muscles need to engage and disengage to get the job done in a timely manner and in an appropriate spot!

There are internal body control aspects, such as learning to hold one's bladder or bowels when there is an urge to go to the restroom. These develop from the growing awareness toddlers have about their own body's functions. These skills typically develop over several months and years. As mentioned earlier, daytime milestones for staying dry and using a toilet often occur before a child is able to stay dry and not have a bowel movement at night. In the United States, there are typically higher levels of monitoring on a regular basis and routines in the home and in child care for going to the restroom at particular intervals. Nighttime wetting may occur through the early elementary years, depending on how deeply a child sleeps and how effective the brain and nervous system are at rousing them to go to the bathroom. Parents may try to help with nighttime needs by making sure that late night drink requests do not become a habit, scheduling bathroom visits just before bedtime, and taking their young child to the bathroom again just before they go to bed.

There are other aspects of body control that impact a young child's ability to take care of the overall toileting process. Mobility is one aspect—can toddlers get themselves from where they first feel the need to use the toilet to their potty seat or climb up onto a big toilet if that is all that is available? Fine motors skills to undo pieces of clothing is another aspect of body control.

Many parents start looking for elastic waist pants instead of button/zipper/overall options as toilet learning progresses. Fine motor skills are also necessary as toddlers learn to clean themselves after using the toilet. Support is typically needed for some time once young children start adding this step to their toileting.

Using the toilet requires coordination of fine and large motor skills as one must reach a light switch, open a toilet seat, pull down clothing, reach and get toilet tissue or wipes, put clothes back into place, and wash and dry hands. These are steps of navigating a bathroom space and going through the entire toileting sequence of actions. Toddlers who are not yet mobile or who cannot navigate the bathroom environment safely, must rely on a caregiver to respond to their communications to help get them situated for toileting.

Through a Young Child's Eyes

Diapering and Signs of Readiness for Toilet Learning

0-4 months	4-6 months	6-12 months
I am learning the sounds and feels of milk moving from my tummy and out from my body.	The gentle, respectful, safe way that you handle my body tells me that you love me and teaches me about respect. You also help me begin to learn I can count on you to keep me safe and comfortable.	I look at you and hold out my arms to be picked up when you say, "Time to get changed."
Sometimes my body makes funny noises and you can help me by holding and burping me and by rubbing my tummy.		
I may be a baby who does not like feeling wet or soiled at all! I cry as soon as I notice it. I may be a baby who does not seem to get upset with a full diaper. You will get to know me and my reactions to wet and messy diapers and then be able to help me.	I want to be a partner. I begin to lift my bottom when you slide my clean diaper under me.	I might cry or kick in frustration when you interrupt my play to pick me up and change my diaper.
	I learn new words you use to describe what is happening and that talking with you is fun when you tell me about what we are doing together.	I am learning parts of my body. I point to my nose, tummy and belly button when you name them.
One day I will be using the potty. Can you believe it? I will need your support all the way.	I start to babble and talk back to you, letting you know I'm paying attention, and I want to stay engaged.	I may protest, squirm, and try to roll over when you lay me on my back to change me.

Through a Young Child's Eyes

Diapering and Signs of Readiness for Toilet Learning

12-18 months	18-24 months	24-36 months
I can carry my clean diaper to you and, if I'm close to that box of wipes, I may pull out a few to help you!	I am learning the names of more parts of my body and repeat the new names you tell me.	I act out using the potty—with my doll or myself. You can support me and also help me learn about setting my own privacy about my body.
I may want to continue playing when a diaper change is needed. I can stand and play and still help you change me. It will take some practice and coordination, but we can do it together.	I can go to the sink and wash my hands (with a little help) after you change me.	I begin knowing when I have to *go* or when I have gone to the bathroom. I may pull on my pants. Tell you, "I am wet." I might hide when I'm having a bowel movement.
	I stick out my legs one-by-one as you pull on my pants.	I love to practice flushing the potty. Again and again. Unless the noise frightens me, in which case, I may ask you to flush.
		I can hold my urine longer and can signal to you when I need to *pee-pee*.
I am very busy. I can be in the bathroom in a flash, so be sure toilet locks and cabinets are secured.	I may start noticing differences and similarities between my body and others—particularly if I have siblings or go to a day care with others my age.	I'm curious. I may follow you into the bathroom and imitate you by sitting on my potty seat and *reading* just like you are doing as you sit on the toilet.
		I may be able to stay dry during the day but learning to stay dry at night can take much longer. Sometimes even children in elementary school have nighttime accidents.

Challenges to Toileting Control

There are some situations in a young child's life that may interfere with reaching or maintaining toileting milestones. Stress and illness are known to impact a young child's abilities—and not just with toileting, although that often feels very stressful to parents who thought they had just finished with daily diapers. Regression is the term that healthcare providers and early care personnel may use to describe these experiences. It means that a child who has reached a certain milestone or ability and seems to have been stable at being able to maintain that skill starts *going backwards*. One of the ways young children show they are stressed is through this regression. New skills and abilities are not always the most comfortable ones. Children tend to go back toward a level of ability that is easier to maintain. New toileting skills can be particularly tough to sustain when a new baby comes into the family or when parents and caregivers are not able to be as consistent and supportive as they were before a family stress situation occurred.

Illness can also adversely impact toileting control. Sometimes bodies do things that are painful, explosive, constipating, and bewildering. Having a plan for accidents and frequent changes will go a long way to reducing some of the stress of illness. Being able to communicate with toddlers about what their bodies are doing can help relieve fears and potential disappointment in failing to control themselves. Knowing what is and what is not normal is key for parents as they must make timely decisions to seek medical care. If a fever or unusual low energy is noticed and if there is a change in stool quality to very loose or constipated, healthcare providers will want to know information about water and liquid intake and food intake to help assess what needs to happen next.

Why Healthy Diapering and Toileting Matters to Families

For most parents, the day a child starts using the toilet is cause for celebration. Toilet learning is an opportunity for children to master new skills and gain positive, healthy sense of their body. It is natural that parents grow tired of changing diapers and are eager to put pressure on their child to use the toilet. Parents may also experience pressure from their families, child care settings that make using the toilet a prerequisite for admission or moving up to the next class, and other parents. Waiting until a child shows signs of being ready, such as items in the chart on the last page and working in a respectful, supportive way with a child as a partner can help parents make the process less stressful and more positive for all.

Boots on the Ground: Everyday Moment Conversations with Families

Parents' experiences with and expectations of diapering and toileting

Parental Resilience can be supported when parents are sorting through all the advice they may receive from family and friends about toilet learning and are trying to figure out what works for their child and family.

Partnering with and making diapering work for infants and toddlers

Knowledge of Parenting and Child Development and

Social and Emotional Competence of Children can be fostered when parents see their infant or toddler as an active partner in diaper routines, maybe by lifting her bottom and holding a clean wipe.

Making toilet learning work for parents, twos, and threes

Parental Resilience and

Knowledge of Parenting and Child Development and

Social and Emotional Competence of Children are nurtured as parents work with and appreciate their young child's growing body awareness and control, and can support and advocate for their child's toileting needs with family, friends, and child care providers.

Safe diapering and toileting practices

Knowledge of Parenting and Child Development can encourage parents to be proactive in creating and maintaining safe toileting routines and environments as their child grows and becomes more mobile from infancy to toddlerhood.

Family Pages

A series of *Family Pages* on *Diapering and Toileting* have been created to support your conversations with families while you are visiting and to become a resource for parent to refer to between visits. These include the following:

- Diapering and Toileting from a Child's Point of View
- Making Diapering Work for Your Baby and You
- Making Toilet Learning Work for You and Your Child
- Safe Diapering and Toileting
- Focus on You: Looking Back and Moving Ahead with Your Child
- Practical Applications for Families: Figuring It Out Together

Related One-on-One Activities

These are suggested activities to promote healthy and family routines around diapering and toileting. A broad selection of one-on-one activities are available in the Activity Card deck.

- Notice and Wonder: How does your child participate in diaper/pull-up changes or in managing his need to visit a toilet? Is your toddler wearing clothes he can pull on and off by himself?
- Talking and reading about bodies with your Toddler or Two: Develop routines that help address daily toileting needs with care and connection—make up a silly "Everybody potties before we get in the car" song, find books to read together about toilet learning, play a "name that body part" game.
- Pretend play about using the toilet with a doll or stuffed animal.

Book suggestions:

- *Please, Baby Please* by Spike Lee & Tonya Lewis Lee
- *Once Upon a Potty* by Alona Frankel

Additional Resources

Community and health connections may include:

- Pediatrician's Office, other Healthcare Providers
- Community/County Health Department

Everyday Moments 6.1 Chapter 4: Bathing and Dressing

Main Elements

Content Areas

- Teaching About Bathing and Dressing: *Protective Factors* and *Trauma-Informed Principles*
- The Science: Thermoregulation, Routines for Hygiene and Typical Skin Conditions in Infancy, Body Awareness and Curiosity, Exploring Personal Styles
- Why it Matters to Families: Developing Routines and Understanding Body Curiosity, Helping Your Child Discover Their Personal Styles and Expressions, Working with Child Care, Cultural and Family Influences on Expectations
- Home Visit Activities and *Family Pages*
- Important Safety Supports and Knowledge: Safety During Bathing, Clothing, Developing a Sense of Personal Safety and Autonomy Through Respect of One's Body

Support Connections

- Pediatrician's Office
- Child Care Personnel

Teaching About Bathing and Dressing: Protective Factors and Trauma-Informed Principles

Bathing and Dressing are unique, yet related topics that parents may have questions or concerns about throughout their child's first 3 years. First-time and expectant parents may have questions or concerns about safe bathing practices, what to do if their baby cries when bathed or poops in the bath water, what is cradle cap, or is a rash something that needs medical attention. New parents also often wonder and worry about how to keep their baby comfortably dressed in cooler and warmer environments. Parents might need time to figure out which clothing is easy or difficult to adjust for diaper changes or how many layers (in winter) can be used such that the baby still fits into the car seat safely. Parents also learn what textures and clothing their infants like by the way children communicate their comfort or discomfort; this is part of developing an early sense of personal style.

As they become parents of a toddler, parents' questions and concerns change to topics about continued supervision during bath time, shared baths with siblings or buddies, body curiosity, and the developmental struggles of self-dressing. For instance, why does putting on shoes seem to always trigger a melt-down, and what should they do if their 3-year-old insists on wearing his full-body superhero costume to school every day and it's summer?!

6.1.4 Bathing and Dressing

This chapter focuses on safe and recommended care for bathing and dressing and working with parents who are beginning to understand their children's curiosity about their bodies and themselves as unique persons. Some parents may not have much confidence in talking with their young child about bodies, particularly when young children discover or notice a body part that is considered private by adults. Infants and toddlers are naturally curious about their bodies and how other bodies look and work as they learn more about their world. Working with parents to find healthy and developmentally-appropriate ways of communicating about bodies provides a foundation for helping young children build a sense of who they are and how they want to present themselves to the world.

This chapter helps to address the following *Protective Factors*:

- ***Parental Resilience***
- ***Knowledge of Parenting and Child Development***
- ***Social and Emotional Competence of Children***

Bathing and dressing routines can have strong safety and cultural elements. Both are daily-living tasks that parents will do with their child over and over again. These tasks create opportunities to build skills for a new parent and a young child and to introduce early expectations and norms for self-care, dress, expression, and gender and social norms. The principles of *Trauma-Informed Care and Practice* (*TICP*) can help you create conversations and strategies to support parents and their infants and toddlers and highlight ways that parents can create safe, loving, and empowering connections to support young children's first practices of taking care of personal hygiene and beginning to learn how they express themselves.

Safety – New parents often express feelings of anxiety around infant and toddler bathing processes. Even the youngest infants are wiggly, and all people are slippery when wet and soapy! There are several practical strategies in the *Family Pages* to help minimize risks and build parents' confidence in safely and successfully bathing their infant. When parents are able to create a safe and comfortable bathing experience early, infants and toddlers can begin to anticipate this routine positively.

Bath time may become a routine that parents and children look forward to! For parents, bathing times are wonderful opportunities to make sure that their infant's skin and overall body are healthy. If a change is noticed, like a rash, swelling, or sensitivity, parents are able to take action to see if the change is something to monitor or find medical care to address.

Safety in dressing certainly focuses on clothing and clothing embellishments that could be a choking or strangulation risk. But, safety can also be modeled by parents talking with their 3-year-old about why a coat and hat is needed on a wintry day or by a parent taking a moment to consider that a 2-year-old boy wanting to wear his older sister's new dance leotard is probably about exploring different ideas about people, not, in fact, a strong indicator of gender identity.

Trustworthiness and Transparency – Infants can experience bath times filled with trust by parents who hold them securely, sponge them gently, and offer reassurances and comfort if something feels stressful, such as water rolling onto their face or if a slip happens that startles baby and parent. As infants grow into toddlerhood and beyond, the theme of "I can trust my parent when I'm bathing" can remain stable as their own skills grow, and they can sit in a tub with supervision but not need extra help.

Peer Support and Mutual Self-Help – Some parents may feel uncomfortable or unsure about how to approach conversations with their child about body curiosity. Providing culturally-sensitive suggestions for how to handle these conversations in an age-appropriate way is a great way to offer support to a parent. It is also an opportunity to normalize this potentially awkward experience for the parents because most children have questions about their bodies!

Collaboration and Mutuality – Bath times are a good opportunity for parents to develop a partnership-style interaction with their little one. As with other daily-living routines, bathing, even though it may not be a full bath every day, offers experiences of narrating to the infant what is happening and naming body parts and items used to help bathe (e.g., washcloths, sponges, towels, soap, lotion/oil).

As infants grow, their gains in body awareness and control help them become an active collaborator in bathing. Bath water can be a good sensory experience with splashing and bubbles. Having a partner who engages with them while ensuring safety builds the child's sense of their world as a safe place.

Young children can also actively help select their clothing. While dressing has the potential to become a battle of the wills, there are ways to engage with young children to help them identify their desires while also learning about times when some clothing is not negotiable (e.g. pants must be worn in public places!) or special routines for pieces of clothing, like taking off shoes inside the house and putting on slippers.

Young children may develop a strong attachment to a particular piece of clothing and want to wear it every day. Parents can work with their young child to develop a mutually agreed upon wash-and-wear plan that can lessen the drama and model a routine of care for self and clothing to their child.

6.1.4 Bathing and Dressing

Empowerment, Voice, and Choice – Parents can develop messages that empower their young children across bathing and dressing routines. Describing what their toddler is doing to help wash as part of a bath narrative and noticing how their 2 ½-year-old can zip, button, or snap a piece of clothing are ways to build on their child's growing capabilities. Giving a young child realistic choices about bath options (e.g., quick rinse down or tub of bubbles tonight?) and clothing choices (e.g., You need a shirt for tomorrow. Let's look at your shirts and pick one together) encourages participation in self-care and expression at levels where young children can notice their own skills, make a choice, and experience the follow through of that choice.

Cultural, Historical, and Gender Factors – Parents' cultural background and gender expectations may become apparent in conversations about advice they've received for proper bathing and hygiene, particularly for newborns and very young infants. Cultural influences and gender expectations may also be visible in the clothing they choose for their young infant.

Some cultures have very specific clothing associated with the child's gender and/or age. In the United States general culture, colors and types of clothes often are used to signal a child's gender, such as pinks and dresses/frilly tops/hair bows for little girls and blues and jeans/button down shirts/t-shirts with action figures for little boys. Clothing for very young children in Mediterranean-origin families often include a *nazar*, a small glass bead that is blue with a white or yellow center that has a black dot in the very middle. It is a physical sign of protection from *the evil eye* or ill wishes from others.

Young children can and do develop their unique way of expressing their clothing preferences and explore different styles and ideas through dressing that does not necessarily match or relate to the child's gender or culture. Parents can benefit from exploring their own expectations and family traditions of bathing and dressing and having a skilled home visitor as a partner to think about ideas and strategies if a particular event feels troubling.

The Science: Understanding Bathing, Dressing, and Milestones in Infancy and Toddlerhood

Bathing and dressing are part of a young child's care routine, and parents can guide a child's sense of how things work in the family system. While bathing is not strictly a daily routine, personal hygiene practices are started early, and many families establish a 3-times-a-week schedule for regular bathing. Families also develop bathing variations for quick rinses, hair washing, and sometimes seasonal schedules for bathing. For example, more bathing in the summer or when certain activities occur, like vigorous play, and less in winter when skin may be more sensitive or it is more difficult to keep warm afterward. Infants in the United States typically are clothed and/or covered before and after a bath, so bath time also becomes a time of curiosity as the child grows.

This curiosity shows up in body exploration, such as when a child asks names of different body parts or wiggles a foot when a parent asks, "Where's baby's foot?! There it is!" Young children have not yet developed a sense that certain parts of bodies are private. However, if they spend time with others in bathing and private settings, they will soon learn about body differences and similarities, and they will show interest and ask questions. Parents can start, when their child is very young, to create their language for talking about bodies and body parts, privacy, and sharing family norms for public and private conversations.

Dressing is often a logical next action after bathing whether one is starting the day or ending it. In these early infant and toddler years, dressing and undressing happens multiple times a day—through diaper changes, spit-up, illnesses, and adding or removing layers when moving inside and outside, and these are just the ones that may be parent initiated! Once toddlers start practicing their (un)dressing skills, matching socks and shoes may be hard to find.

Young children also find their voice in showing dressing preferences, which can present some challenges for their parents and other caregivers. For example, a 3-year-old may have a very strong style preference that includes wearing three dresses (at the same time!), which makes her feel strong and beautiful, and a pair of rain boots.

If this child's parents feel that the three dresses are a hassle or go against their own expectations of what we wear and how we wear it, the moment is set for a tussle of the wills. Alternatively, parents may just let the child's choices play out and caution the child regarding what she might experience while wearing three dresses and rain boots. Maybe it is hot with all those layers and boots, or clothes fit very tightly as more layers are added, or clothes just don't fit at all. This could be a moment of struggle and frustration, or it could be a moment where a child is supported in her choices and learns more about herself and how her decisions can play out.

Work with parents to identify ways their young child is exploring different social roles and making connections to how clothing can make her feel and imagine herself in different roles. These discussions can help address anxieties or fears that parents may be feeling if their child is doing something that does not fit cultural or family expectations or is simply baffling (e.g., "Why does my toddler want to wear footie pajamas underneath shorts and t-shirt to day care?").

Thermoregulation and Bathing and Dressing

A young infant's body and brain are working to master several self-regulation tasks soon after birth, including temperature regulation and healthy production of skin oils. As with any new skill, these tasks can take a while for a newborn's brain to master. Young infants are not able to regulate their body temperature quickly in response to external temperature changes. They simply do not have a lot of range in what temperatures they can tolerate comfortably without a caregiver providing support through adding or subtracting clothing or coverings, adjusting the air temperature, or making sure the infant is dry and protected from wet conditions. Younger infants also lack the motor skills to take action for themselves to cool down or warm up, like an older child or adult might do. For instance, a preschooler can toss covers aside or move to play in a shady area out of direct sun; an adult can stick one foot out from under blankets or adjust the thermostat in a home to change the conditions of the larger environment. The daily or routine actions of bathing and dressing can also support or challenge a young infant's temperature regulation.

Daily bathing is not recommended or needed for most young infants and toddlers. Their skin can be sensitive to soaps and lotions with fragrances, in addition to water that is too warm or cool. Daily bathing and extended bathing sessions can also dry out their skin. Current recommendations by the American Academy of Pediatrics indicate that three times a week is fine for very young infants and toddlers, and sponge baths for newborns may be preferable, at least until the child's umbilical cord falls off and heals.

Dressing and keeping a young infant comfortable temperature-wise may be challenging for new parents. Infant stocking caps and full body sleepers or sleep sacks, along with regulating the temperature in their environment, keep the infant's body warm without adding in blankets, which are NOT recommended in an infant's sleep space. If the environment is warm, short onesies and options for fewer clothing layers are fine. If the environment is very warm, parents may need to watch for heat stress and take steps to cool the environment (e.g., using a fan). Families may be living in a location where there are wide-ranging temperature changes from day to night, like the high desert. Learning to adjust for these fluctuations with bathing and dressing can take some time.

Common Skin Conditions and Care

The skin is the largest organ on the human body. It is active in helping us stay cool or warm and generally protects everything that is underneath it. It is also a body system that needs some time to regulate its different jobs, such as glands that produce oil and sweat working with hair follicles. There are a few typical skin conditions that infants may experience as their bodies are sorting out how to regulate all the internal and external systems. Some of these are more likely for infants under 6 months, for example: cradle cap, intertrigo (rash around the neck and chin area), eczema, neonatal acne, and milia (little white bumps). These conditions typically do not need professional medical treatment.

Reputable web-based information can be found at:

- https://www.mayoclinic.org/healthy-lifestyle/infant-and-toddler-health/multimedia/baby-rashes/sls-20076668
- https://www.babycenter.com/101_visual-guide-to-childrens-rashes-and-skin-conditions_10332129.bc

Cradle Cap – Also called seborrhea, it often looks like crusty dandruff on the scalp and eyebrows, and sometimes neck and chest.

What to do: A bit of baby or olive oil can be rubbed into the area to soften it. You can talk to your healthcare provider to see if there are other recommendations.

Intertrigo – Typically develops in the skin folds of a young infant's neck and is due to the moisture from drool and spit-up that does not get air to dry out. It is more common in chubby babies.

What to do: Clean the creases of skin with warm, soapy water. Pat dry and apply a zinc oxide (diaper rash) cream.

Eczema – Dry patchy areas of skin that may turn red, raw, and crust over. More common in infants and young children when there is a family history of skin allergies.

What to do: Clean with a gentle (fragrance-free) cleanser and then use a moisturizer—again fragrance-free. Talk to your healthcare provider if it does not improve.

Neonatal Acne and Milia – Both of these skin conditions are common in newborns and can last a few months. Neonatal acne is thought to occur because of exposure to maternal hormones prenatally. Milia are caused by blocked oil glands.

What to do: No treatment or special cleaning is needed. As the infant's brain and body get better at regulating their hormones and skin protection, these conditions will resolve on their own.

Prickly Heat (Heat Rash) – Usually seen on the head, neck, and shoulders of infants, it looks like small red pimples across the skin. This usually happens when the infant is dressed too warmly or in very hot weather and is caused by blocked sweat glands.

What to do: Remove layer(s) of clothing and cool the child. Within 30 minutes the rash should improve.

Diaper Rash – The groin area of young children is exposed to constant irritants through pee and poop. In the U.S., this area is rarely exposed to open air for extended periods of time. This creates a prime opportunity for skin irritation. Diaper rash is often red and looks inflamed.

What to do: Change wet or soiled diapers as soon as possible and complete careful cleaning. Use of a zinc oxide cream will address most diaper rash. Allowing the area to dry without a diaper so that the skin gets air is also helpful.

If diaper rash does not respond to the above treatment, have it checked by a healthcare provider. It could be a sign of yeast infection that will need a prescription medication.

Seek medical care for a skin condition if you see the following:

- The condition does not respond to gentle cleansing and moisturizer.
- A rash is NOT localized (only in a certain spot, like intertrigo) but spreads to significant portions of the body, including torso and back.
- A rash is accompanied by any of the following: swelling, hives, blisters, fever, or vomiting.
- A rash appears on palms of hands, bottoms of feet, or in the mouth.

Developing an Early Sense of Personal Style

As young children move toward greater independence in their second and third years, the *Everyday Moments* of dressing (and re-dressing!) can become a challenge point. Decisions about what to wear, how long to wear it, and what does or does not go with an item can create opportunities for young ones to express their opinions and preferences to the people who are trying to direct them and get everyone out the door or dressed appropriately for an event or weather condition. Toddlers and 2-year-olds are watching the people around them and are starting to learn associations of who people are, what they do, and what they wear. These early associations are often simple, but they help children create models for understanding the people, places, and experiences of their world.

Think about the dress-up play areas in many child care settings and the toys and props that are available for pretend play. Firefighters wear big hats and rain boots. Doctors wear white coats. Dancers wear tights and tutus. Superheroes wear capes and masks. Movie stars wear shiny tops and shoes. Young children *try on* social roles through a variety of means, and clothing is one way of learning about different roles and jobs. A young child with older siblings may want to wear the same clothes as them to show they are big too or because they want to be like their older brother or sister. Around the 3rd birthday, there will probably be conversations that include ideas about what boys do and wear and what girls do and wear; these conversations are part of the learning process of one's social world. Thus, exploring social and gender roles is normal. However, that doesn't mean that a particular dressing moment will be easy. Sometimes a toddler or 2-year-old just doesn't care that the favorite shirt is in the laundry or that those sparkly red shoes are too small. They are the best shirt and shoes EVER and they need to be worn NOW.

If parents are facing a situation that feels challenging, a home visitor can help guide the conversation to see what the parents' ideas and expectations are and what their young child is feeling in these moments. Working with families to assess what is important to insist upon, such as safety and appropriate layers, can be helpful to diffuse clothing battles. Parents can be encouraged to choose thoughtful and supportive language and convey respect for the child's choices. Sometimes those choices become a one-and-done—the shoes hurt his feet after a few minutes, or it is really uncomfortable to wear all her pretty dresses at the same time. Sometimes those choices last for a few weeks or a season or transform into long-term preferences like wanting to wear colorful shirts or favoring blue.

Through a Young Child's Eyes

Bathing

0-6 months	6-12 months	12-18 months
Let's start with sponge baths. In a few weeks, we can use the sink or a small plastic tub.	We have to figure out the best way to wash my hair. Let's experiment. Maybe I can lean back sitting on my small tub. Maybe I am OK leaning forward and holding a washcloth over my eyes. Please use a no-tears baby shampoo, and keep water from getting into my ears. We're going to have to be creative and work together.	When I start to outgrow my baby tub and am a strong sitter, you may want to give me a try in the big tub. Give me some time to get used to such a big, open space. We might want to start with putting my baby tub into the big tub.
In the first few weeks, I need to have some special care around my umbilical cord until it heals. Follow directions from my healthcare provider to keep it clean, dry, and protected.	After a bath, rub baby lotion over my body. It feels so good! (And will keep my skin from getting dry.)	Let's play. No need to buy anything. Plastic kitchen containers and cups will do.
Don't be surprised by the appearance of some mild skin irritations. My skin is very soft and sensitive, but these irritations will resolve over time with gentle care.	We may have figured out that I like baths at a certain time of day, mornings or evenings. Let's make this a regular schedule.	Let's have playtime, then bring on the baby soap and shampoo and a rinse. Staying in soapy water can give me a urinary tract infection.

Through a Young Child's Eyes

Bathing

18-24 months	24-30 months	30-36 months
You may have to remind me to stay on my bottom. "No standing in the tub" is a good rule for us to have.	I may challenge you when you say, "It's bath time." I like choices, though. They make me feel like a partner, and I may offer a deal of doing my bath later—after I finish what I'm doing..But give me a time!	I have skills and opinions about this bath stuff. I may bargain with you about hosing off outside in the summer with a bar of soap or ask to use the shower like you do.
And remind me to keep the water in the tub. Splashing is fun! It makes me feel powerful to move my body and make waves.	I can also do some things myself—wash my face and hands, dump rinse water over my head.	My self-cleaning skills are getting strong. You help me notice where I need to pay attention—between the toes, behind my ears and knees, my private areas. You can support me and also help me learn about setting my own privacy about my body.
Keep it short to keep my skin from getting dry and itchy. 10-15 minutes.	Remember that I may be confident, but I should not be left alone in the tub! Never ever! Empty the tub right away after my bath. I may want to continue playing while you are not watching. It only takes 2 inches of water for me to drown.	

Through a Young Child's Eyes

Dressing

0-6 months	6-12 months	12-18 months
Please move my body gently so that you don't twist or hurt me.	I love it and hear different sounds of words when you tell me about what you are doing.	I want to be on the move—and that makes it hard for me to stay still and to have you move my body when dressing me. I'm not trying to be bad when I fuss. I want to move. Try to distract me. Make dressing fun. Most important, make it fast.
Dressing will be easier for both of us if you dress me in clothes that are easy to put on and off, like onesies, shirts with openings that can expand, pants with snaps so you can change my diaper easily.	I may start showing you my preferences for certain textures of clothing and how many layers I like to wear to keep comfortable.	I'm also developing some preferences for how I like my clothes to fit on me—sometimes I like to feel like I can stretch and stretch! Other times, I like to have clothes that hold me close to my center and make me feel safe and snuggly.

18-24 months	24-30 months	30-36 months
Do you know how I want to do things my way? When I want? It is the same with dressing. Sometimes I know there is no choice, and I have to get dressed no matter what. But when you can, it will be easier for the both of us if you can allow extra time, be patient and keep your sense of humor. One day I will be dressing myself. I promise.	When you give me choices between two options, I learn about making choices and feel competent and proud. (For example: Do you want to wear your red shirt or your yellow one?) If you give me choices, please let me wear what I choose, even if my green polka dots and red stripes are not your fashion choice.	Will you help me learn dressing skills? Teach me how to flip my coat over my head. If you start it, I can do the rest of my zipper. Let's see if I can make a snap go *snap*.
I may be able to pull off my shoes, socks, or pants. Once you get my shirt over my head, I may be able to pull it down. If I can't do these things yet, I will do them soon. Keep watching.	Watch. Can I unbutton large buttons? Do I try to put on my socks? What other new skills am I working on?	Keep a lookout and see my new skills growing. With a little help, I may be able to put on my shoes (they might be on the wrong feet), pull my pants with an elastic waist up and down, and zip or unzip my jacket if you get it started.

Why Bathing and Dressing Matter to Families

For most parents, dressing and bathing can feel like daily chores to be hurried through to get to more important parts of the day. It can be easy to forget that a child will dress and bathe themselves soon. But, for a baby, toddler, and 2-year-old, bathing and dressing can be fascinating learning opportunities. Children have the chance to master new skills and gain new understandings about themselves, their bodies, and the world around them. By working with a child as a partner, taking a few moments for fun, and watching to see and appreciate the development of new skills, parents can make these tasks less stressful and more positive for all—at least some of the time.

Most families also have to operate on a budget, and young families may have particularly tight budgets. Young children grow out of clothing at a rapid rate, and, when there are distinct seasonal changes, specific clothing can be more difficult to purchase multiple times (e.g., winter coats, boots). Working with families to make the most of their dollars and to identify if there are social pressures to have the latest cute outfit or style for their child can be helpful to set realistic expectations and healthy money management practices. Families can benefit from learning about resale, thrift, and other second-hand shops in their communities.

Boots on the Ground: Everyday Moment Conversations with Families

Parents' experiences with and expectations of bathing and dressing

- *Parental Resilience* is nurtured when parents are able to develop healthy and age-appropriate language for conversations with their child about her body, personal care, and self-expression.

Bathing across the ages

- *Knowledge of Parenting and Child Development* allows parents to meet their infant's or toddler's hygiene needs while also building routines that create safe and nurturing interactions.

Dressing across the ages

- *Knowledge of Parenting and Child Development* and
- *Social and Emotional Competence of Children* assist parents in making sure that their child is appropriately dressed for his physical environment (e.g., cool/warm, wet/dry conditions) and to be partners in supporting their young child's dressing skills and self-expression.

Safe bathing and dressing

- *Parental Resilience* and
- *Knowledge of Parenting and Child Development* provides parents with skills to establish safe and healthy bathing routines and identify potential safety issues with clothing.

Family Pages

A series of *Family Pages* on *Bathing and Dressing* have been created to support your conversations with families while you are visiting and to become a resource for parent to refer to between visits. These include the following:

- Bathing and Dressing from a Child's Point of View
- Bathing Across the Ages
- Dressing Across the Ages
- Safe Dressing and Bathing
- Focus on You: Looking Back and Moving Ahead with Your Child
- Practical Applications for Families: Figuring It Out Together

Related One-on-One Activities

These are suggested activities to promote good practices around bathing and dressing your young child. A broad selection of one-on-one activities are available in the Activity Card deck.

- Notice and Wonder: How does your child partner with you in bathing and dressing?
- Dressing with your child: Pretend playing scenarios of dressing dolls or stuffed animals.
- Practice skills like snapping and buttoning big buttons on a piece of clothing.

Book suggestions:

- *Where is Baby's Belly Button?* by Karan Katz
- *Pete the Cat and His Four Groovy Buttons* by James Dean

Additional Resources

Community and health connections may include:

- Pediatrician's Office, other Healthcare Providers
- Child Care Personnel

Everyday Moments 6.2 Young Children's Play and Exploration

Children are born curious and ready to learn and engage with the people and things in their world. As they play and explore, they gather information. At first, babies experience the world through their senses. As they begin to move and do (in other words, get into things), their learning and sense of self as a learner continues to grow—always at a child's own pace and in his or her own way. Later children gather information from words. Bit by bit their images grow of themselves and how the world works.

Infancy and toddlerhood is also a learning time for parents who find themselves in an ongoing juggling act when it comes to finding the just-right balance between promoting exploration and learning and, at the same time, keeping their young children safe. This is a time when parents guide behavior and set limits for their children in nurturing ways. As parents discover what works for their child and for them, the trust between parent and child grows. Children begin to view themselves as respected, competent explorers and learners when they are supported by trusted adults. This is a good foundation for personal satisfaction and success in school and life.

In this section, you will find chapters that will support you in conversations with families as you discuss how to support children's exploration and learning; build trusting relationships; and provide nurturing guidance in ways that balance the styles, expectations, and needs of both adults and children.

6.2.1 Exploring and Learning about the World

Children learn about themselves, others, and the world around them during play and daily routines. Play gives children opportunities to experiment, explore, pretend, observe how things work, develop and practice new skills, solve problems, and figure out how to get along with each other. Daily routines invite children to investigate the extraordinary learning opportunities of ordinary daily life events. This chapter talks about why and how parents are children's first and most important teachers and discusses how they can keep children safe and support exploring and learning during play and daily routines.

6.2.2 Building Trusting Relationships

When parents show their children they can be trusted, children begin to learn what trust is and how to be a person who can be trusted. Children learn they are safe when their needs are met. Children feel valued and cared for. Children who feel good about themselves are more likely to be more successful—in school and in life. They are more prone to feel free to explore, experiment, take risks, question, and learn. This chapter offers parents insights into what trusting relationships are, why they matter, and strategies for building the trusting relationships their children need to be confident and capable learners.

6.2.3 Nurturing Guidance and Discipline

Nurturing guidance and discipline goes beyond getting children to stop certain behaviors. These strategies encourage children's development of the self-control that will guide their decision-making about how to behave throughout their lives. Learning to guide a child's behavior in positive and nurturing ways can take time. This may require parents to question and make decisions that differ from those made by their important adults when they were growing up. In this chapter, parents are invited to reflect upon their childhood experiences and are provided with information and insights to help them consider how they want to guide their child's behavior.

Everyday Moments 6.2 Chapter 1: Exploring and Learning about the World

Main Elements

Content Areas

- Teaching About Children's Exploration and Learning: *Protective Factors* and *Trauma-Informed Principles*
- The Science: Sensory and Experience-Based Pathways of Development in Cognition, Language, Movement, and Socio-Emotional Relationships; Supportive and Safe Physical Environments; Supportive and Safe Caregiving Environments; Exploring and Learning Through Play
- Why it Matters to Families: *Everyday Moments* as Natural Opportunities; Child-Centered and Parent-Centered Play; Play Dates and Other Planned Opportunities; Distracted Parenting; Supports for Families Who Have a Child with Special Developmental Considerations; Supervision Challenges
- Home Visit Activities and *Family Pages*
- Important Safety Supports and Knowledge: Exploration and Safety; Family and Neighborhood Pet Safety; Poison Control, Choking Hazards, and Car Seat Safety

Teaching About Children's Exploration and Learning: Protective Factors and Trauma-Informed Principles

Infants are born ready to learn and engage with others. They are born with the basic abilities to connect to others, learn about their caregiving and physical worlds, and express emotional reactions to experiences. These first few years are intense for everyone! Infants, toddlers, and young children need constant support, high supervision, and parents and other caregivers who can establish a safe and supportive environment while also allowing children to take reasonable risks.

Sometimes it is not possible to create or maintain an environment with all those qualities. How can the home visitation process strengthen parents' decision-making about balancing exploration and supervision needs? How can home visitors provide insight into how everyday routines and different play opportunities provide sensory and learning experiences that help build young children's social and emotional competence?

This chapter helps to address the following *Protective Factors*:

- ***Concrete Supports of Families***
- ***Parental Resilience***
- ***Knowledge of Parenting and Child Development***
- ***Social and Emotional Competence of Children***

6.2.1 Exploring and Learning about the World

Teaching about *Children's Exploration and Learning* offers opportunities to model the following *Trauma-Informed Principles* in the parent-child and parent-home visitor relationships:

Safety – Infants, toddlers, and twos need safe and supportive environments in order to grow and thrive. Parents and other primary caregivers are responsible for creating and maintaining these environments. This means they must be able to assess children's abilities and interests and elements of the immediate environment that create opportunities for learning and exploring and/or pose safety risks. Key characteristics of thinking about safety with families include exploring parents' *supervision* and *child-proofing expectations*. Supervision conversations can include topics of when, where, and for how long parents believe it is OK to let their young child(ren) explore or play without direct visual contact by an adult (e.g., in a child's room, bathroom, kitchen, a vehicle, outside).

Questions and conversations about *whom* is an appropriate supervisor in different situations are also important; would an older sibling, a family friend, grandparent, or a babysitter from down the street be OK? Supervision and safety are being assessed when parents think about what types of safety features need to be in place in their own home or homes they frequent, such as putting things out of reach (e.g., pet food dishes, table clothes that are grabbable and could pull down items on the child), using electric outlet covers and cabinet and toilet locks, and keeping cereal and other child friendly foods in a *safe* area (e.g., not in an upper shelf over the stove or refrigerator and separate from cleaning products).

Within these conversations, home visitors can learn about parents' tolerances for risk and expectations for children learning from *natural consequences* (e.g., if you hug the kitty too tightly, she may scratch or bite you). Some parents are likely to be proactive in maintaining a safe daily environment, monitoring and assessing risk before problems arise, and being responsive to changes. Other parents may allow quite a bit of latitude in open exploration and only intervene if a clear danger is apparent or if something negative happens. Yet other parents, who feel like their family's daily environment is not safe, may show behaviors that look intrusive to a child's ability to explore even when a specific environment is safe. Probing the underlying reasons for behaviors around safety and supervision can give a home visitor insight into the parents' understanding of their circumstances.

6.2.1 Exploring and Learning about the World

Trustworthiness and Transparency – Trustworthiness is connected to young children's sense of safety in exploring and learning. Very young children seek out information from their trusted adults to learn what is and who is safe or risky. Young children who trust their parents' responses adjust their actions to continue exploring or to draw back. Parents and important others who are absent, inconsistent, or give inaccurate information in their responses undermine their children's sense of trust and security in exploring and learning. *For more on developing healthy parent-child relationships, please see the chapter on Building Trusting Relationships.*

Within the parent-home visitor relationship, there may be on-going conversations focused on how a family can better support their child's exploration and learning. Parents who need extra support to understand their child's development, who may not have had good models for appropriate supervision, or who may not understand some of their child's safety needs can benefit through a strong, trusting, and transparent parent-home visitor partnership. Difficult or challenging topics are more easily approached as parents' sense of trust in their relationship with the home visitor increases.

Peer Support and Mutual Self-Help – Parents; caregivers; and significant others, like older siblings; are often a young child's *more skilled partner* in an exploring or learning moment, which means these individuals bring particular knowledge, skills, and abilities to the interaction. Young children can benefit from having partners at different levels of expertise. Each person engages with the child in a slightly different way and ultimately shows the child variations in learning and growing. For example, a parent may read with a toddler and may voice the different parts of the book and point out details in each picture. An older sibling may read the same book and make up new sounds or parts of the story, which gives the toddler a different experience, but the parent and the sibling are sharing language, communication, and connection with the toddler.

Learning and exploring is also a significant part of young children's first friendships with same-age peers. As young children are given opportunities to be in social settings with others their age, they learn to work and struggle together, show care, and develop empathy with peers who are *similarly skilled partners*.

Depending on the families with whom you work, you may be the *more skilled partner*, and, at other times, you may be a *more equal partner*. Regardless of differences in the knowledge or skills you and the family members bring to the relationship, you are working together to ensure the family is building or maintaining safe and supportive environments that foster children's development and learning.

Collaboration and Mutuality – Young children are learning to be partners with their parents and important others. This means they are learning give and take rhythms within relationships, play, and daily routines. Engaging with young children during play and daily routines by asking questions, drawing attention to their responses or abilities, and following their lead in what they are interested in doing models collaboration and partnership.

Collaboration and mutuality are relationship characteristics that grow out of a sense of trust. Sometimes, home visitors have to work around the edges of unknown challenge points that parents may have to help lower barriers parents have or feel in becoming partners with their children. When the home visitor is able to take time to reflect on the information and cues a family is sharing, the home visitor can see different ways of engaging, which can help foster a collaborative parent-home visitor environment that then flows into the parent-child relationship. For example, you may work with parents who are very limited in their experiences playing and interacting with infants and toddlers. Other parents may have strong expectations that specific kinds of opportunities need to be scheduled in order for their young child *to be successful*, which could be defined in a lot of ways. You may be able to help parents recognize how everyday interactions are opportunities for learning, play, and exploration for their child.

Empowerment, Voice, and Choice – Very young children can flourish when their parents and important other adults are able to establish and maintain safety and support across a variety of environments (e.g., home, community, early care). Safe and supportive environments can change how parents and caregivers talk to children about exploring, trying new things, and being safe.

In a safe environment, there are more opportunities for the adults to say "Yes" and "It's OK—go for it!" when the adults know that the situation is one with few risks or things to worry about. Children, in turn, have more opportunities to practice making choices, exploring, and having conversations about things they CAN do. When adults are not able to establish or maintain elements of safety in a child's environment, the interactions they have with their young child may be more directive and rule-oriented, so more "No" and "Don't" limits are set. While parents are working to keep their child safe, there can be unintended consequences for the child's ability to build a strong sense of being able to choose actions, seek out new experiences, and associate fear or anxiety with exploration and learning.

Home visitors work with parents from a broad range of life experiences, and all families can benefit from a home visitor-parent relationship that reflects belief in each family's resilience. When parents come from backgrounds where their home life or larger environment were not always safe or supportive, it will likely take time for them to build responses that foster positively-phrased language and interactions with their children. An example of this shift in language is changing from "Don't run in the house" to "Use your walking feet." Investing in the parents' work to recognize what areas of their daily living environments and parent-child interactions are changeable to improve their and their children's lives is powerful and empowering.

Cultural, Historical, and Gender Factors – Parents may have different perspectives on what comprises a safe environment due to their unique cultural values and own experiences as a child. For example, parents who grow up in high-density, urban housing may expect to use local parks for outdoor play, connect with neighbors for short-notice child care, or keep children inside most of the time to keep them safe from harmful elements, like traffic or strangers. Parents who grow up in suburbs and more rural areas with land surrounding homes may feel their yards are suitable play environments and expect older children to watch over younger ones.

Every culture also brings gender roles and expectations into exploring and learning. Parents may have ideas about which toys and types of play are appropriate for their child based on their gender. Boys may be given more freedom to explore but less freedom to express emotions and needs. Girls may be encouraged to play nurturing roles in pretend play or be expected to play more quietly.

Parents bring their histories and expectations into the parent-child relationship, and home visitors bring their own histories, expectations, and training. Engaging in conversations around these contexts can help parents make active choices in shaping their children's exploration opportunities while keeping them secure.

The Science: Understanding How Children Explore and Learn

Infants, toddlers, and twos gain an enormous amount of information about their world from their senses. Learning occurs through using their senses, experimenting (e.g., dropping spoons off the high chair), observing others (e.g., watching parents using a tablet), and imitating (e.g., barking like their dog). Young children combine different modes of learning to master knowledge, like colors, words, and shapes and to master skills, like feeding oneself, riding a tricycle, and hopping on one foot. There is a great deal of developmental change during the first 3 years, and everything is new, interesting, and unknown. Parents may feel like they are always at the edge of preventing an injury, figuring out what needs to be child-proofed next, or wondering what their young one is getting into when out of sight! Very young children need strong relationships with caregivers and safe physical environments in order to develop their motor, socio-emotional, language, and cognitive skills in ways that foster their lifelong potentials. These environments shape the experiences available to young children and will have lasting impact on their lifetime potentials.

Sensory Development in Children's Exploration and Learning

Newborns are amazing and potentially intimidating to new or new-again parents. During the last few months of gestation, infants can hear their closest people talking, reading, singing, or playing music for them, and they've been flexing muscles, feeling a parent's rub of the belly, or their own hiccups. Their senses of hearing and touch are useful from their very first minutes after birth. Their senses of taste and smell are close behind; newborns just a few days old can recognize the smell of their mothers and taste differences in breast milk and formula. Their least developed sense is sight; it will take almost the first 12 months for an

infant to develop adult-like vision of 20/20 and see variations in colors and shades of colors. The following paragraphs describe several different ways sensory development changes over the first 3 years. All of this is dependent on a combination of the infant's own capacity to grow and learn and the quantity and quality of opportunities within their caregiving and physical environments. These things shape and tailor each infant's brain to his or her specific experiences.

Throughout all aspects of building their sensory abilities, young children are immersed in language with their parents and other important people. The way parents and other people communicate with and to them by using language, emotions, and body expressions guides young children's understanding of themselves and their world. This social environment, whether rich or restricted in language and emotional connection, structures young children's' opportunities to build skills across their cognitive, language, socio-emotional, and physical skills.

Coordinating Sight and Hearing

Around 4 months of age, infants are beginning to coordinate their senses and the different information that each sense gives them about an experience. For example, a 4-month-old will begin to turn to a sound (hearing) and visually scan for the source of that sound and will anticipate certain people or things (e.g., the family dog) if it is a common sound. If the sound is novel or unexpected, they may do extended looking. By 8 months, the same infant can listen to multiple voices and pick out which voice goes with which person by visually matching each person's mouth movements to the voices. If adults try to fool or trick the infant by mouthing different words while a person next to them is talking, that infant will focus very hard on trying to sort out what is really going on. An adult example of this matching experience would be if you are watching a movie and the sound track is off by a second or more—it is disorienting to have the sound and sight not match!

Coordinating Touch (and Taste/Smell) and Sight

By about 8 months, infants' sight is much improved. It is still not the expected 20/20, but things and people who are within reach to about 10 feet are clear and interesting; about 8 months is also when infants are learning to roll, scoot, and crawl (whether army, backwards, or typical style) to get to interesting things! Before 8 months, infants will grab an interesting object like a book or soft toy and immediately put it in their mouths because the level of sensitivity to learn about that object by mouthing is very high.

The tongue, lips, and gums have lots of experience touching things, and that is the quickest way to figure out important things about this object: Does it have a flavor or smell? Is it bitable? Is it smooth or bumpy, soft or hard, cold or warm?

Around 7 to 8 months, infants will bring an object to their mouths and then pull it back out to look at it. They switch back and forth between feeling and looking and gradually add in both hands to explore new features. By 12 months, infants' sight has improved to the degree that they will look and explore objects by sight and hands before bringing the objects to their mouths. By 18 months, a toddler can identify known toys and objects by touch alone (hand)—without needing to see it. *However, using the mouth as a way to explore and learn lasts throughout early childhood and into the elementary years, so safety around choking hazards and non-edible or dangerous items, like household cleaning products, is critical!*

Touch, Sight, and Mobility

The most sensitive and useful aspects of touch are around infants' mouths and cheeks at birth and are intended to help them learn to nurse. However, young infants soon learn to recognize additional kinds of touch as they are held and cared for throughout their days and nights by one or more important caregivers. Infants also begin exploring their environments by feeling with their fingers as they grasp a parent's hand, shirt, or hair and as they move around in their cribs, car seats, or swings. Starting around 3 months, infants are beginning to learn that they can affect their environment by moving. At this age, infants may seem very wiggly when they are awake and engaged. These whole-body movements can be observed during tummy and floor play times with arms and legs moving; hands opening and closing; and legs pushing against a surface, which perhaps builds momentum to complete that first flip from back to tummy or, more likely, tummy to back. When they are in settings like a crib with a mobile hanging overhead or a play mat/seat with an arching set of toys, they will start to move their bodies to make the toys on the mobile move. From 3 to 6 months, infants are practicing reaching and grabbing, which makes their fingers more sensitive to details and differences and gives them more information about things they hold and touch. The bottoms of their feet can also become more sensitive to feel different floor and other surfaces (e.g., bedspreads, crib sides, jeans while they are standing on a person's lap).

Improving vision helps infants see more things and drives their interests in exploration. But, getting to those interesting things can be a challenge! In many ways, sensory input helps drive motor skills. Hearing and seeing interesting things or wanting to move away from things that are uncomfortable, are actions that play a part in encouraging children to move to their next level of mobility and balance in the first 12 to 17 months. Those next levels can include holding up their heads, sitting upright with support and then independently, rolling over, supporting themselves on belly and hands and moving to knees and hands, figuring out how to coordinate all body parts to move towards a goal without falling on one's face, pulling to a stand, cruising around a coffee table or couch, and taking those first wobbly steps of independence. For infants who may have sensory impairments or developmental delays, often they can make developmental progress and many will still reach these milestones, but their physical and caregiving environments must be adapted to support and encourage their explorations and learning.

Infants and toddlers who are moving to their next level of mobility test their physical environments in many ways, and, when a type of environment is new, like stairs, they typically do not show any fear or

understanding of danger. It's a case of "they don't know what they don't know"! For example, an almost or new walker has not yet learned to scan the walking surface and make adjustments for changes in flooring from carpet to tile. If this child is wearing socks, booties, or shoes, he cannot feel the surface change directly. As children gain experience with each level of mobility, they incorporate their touch and visual senses into their experience and learn to look for hazards, like a toy in their path, and test surfaces through movement by tapping their feet or touching with hands to test before moving forward. Being able to be barefoot as an exploring cruiser and almost walker helps infants move toward independent walking by helping them develop touch sensitivity to different walking surfaces through their feet. Some studies have shown that infants in northern climates, where bundling up is necessary in colder seasons, walk about 1 month later on average than their peers who are in climates that stay warmer year-round. Weather conditions, like ice and snow, and wearing different clothes, like shoes, boots, socks, and layers of warm clothing can impact how easy or difficult it is to learn to walk. So, seasons and weather are ways that the physical environment can impact a young child's development!

Supportive and Safe Physical Environments

Home visitation and related early childhood programs have made information about safe living environments part of their educational focus, and there are several high-quality, home safety checklists used across the United States. Addressing each of the listed elements can be intimidating.

In addition, considerations need to be made for various outdoor environments, other people's homes, and things needed for different types of transportation—WHEW! That's a lot of safety to try to manage along with daily parenting life. But, stay vigilant—the job is not done when outlets are covered, shelves and dressers are secured to the wall, and safety gates are installed. Parents still have to decide how to talk about safety, set and maintain rules for behaviors with their children, and get other adults to partner in using a consistent set of strategies across caregiving situations.

The *Family Pages* for *Exploring and Learning* make the range of safety needs manageable and meaningful for parents. The goals of these pages are to help families see how safety and supervision go hand in hand in creating physical spaces that are safe for children to explore, play, and grow in. It is a bit like building up each parent's *child safety and supervision toolkit*. Parents who can identify and adequately address physical safety needs in their homes ahead of time have a great start to creating a space that allows free exploration by young children. Safety needs change as children grow; reassessing and planning ahead of time helps prevent injury and accidents and supports proactive instead of reactive responses.

6.2.1 Exploring and Learning about the World

Through a Young Child's Eyes

Exploring and Learning

0-6 months

When I am born, I can see about 8-15 inches away—just the right distance to see your face when you hold me. Over the months, I will be able to see more. I will turn my head to follow an object or person. When I see you coming, I might kick my feet and coo with excitement.

I start to bring my fingers and toys to my mouth.

When I smile or coo and you respond, I learn that I can make something happen. You will respond. I am learning how relationships work.

I am learning I can make things happen, like when I kick in my bath and splash us.

6-12 months

I like to study and explore objects around me. I might turn my toy caterpillar over and shake it many times.

I almost always bring things to my mouth to learn about them. My mouth is sensitive and can tell me about how something feels and tastes. So, please watch to be sure I am only mouthing things that are safe and good for me. Try the toilet paper roll test: if something is too big to fit through the cardboard roll, it is safe. If it slips through, keep it out of my reach. It could choke me.

I remember things. I might turn my head away when I see my washcloth in your hand because I know you are going to wipe my face.

I expect that when I squeeze my toy it will squeak. When I turn the can over, the clothespins will fall out. If something different happens it is a big surprise.

I am beginning to move from place to place. I am eager to explore everything—the outlets, the electrical cords that I can reach (and pull on), and the breakable items on low shelves. It is time to childproof if you haven't already. Keeping our space safe is one of the most important ways you can help me explore and learn.

Through a Young Child's Eyes

Exploring and Learning

12-18 months

I love to experiment and explore. I like to push, pull, bang, fill and dump and fill, and taste things. You might call it "getting into things" or "making a mess," but for me, it is learning.

I can use my hands now to grab and hold something to explore and to wave and play patty-cake with you. I can pick up pieces of cereal and banana from my high chair tray to eat. I can and will pick up crumbs and other small things like buttons or coins that you drop on the floor and eat them, too. So, please pick up what you drop. We will both be happier and healthier.

I remember how things happen. I might imitate how you put on your hat or the way you stir milk into a pretend cup of coffee. I notice when our routines change and might get upset if we go away and I have to sleep in a new crib.

I try the same things over and over again. I know what will happen, at least most of the time, like when I drop my spoon off my high chair tray and wait for you to pick it up again and again! It feels good to make things happen and to know what to expect next. That is why it can be hard for me to stop dropping the spoon or banging the pot lids—even when you ask me to.

Watch me play. I am putting together my picture of the world. I might pretend to make a call on a toy phone—just like you do. Or use a wooden spoon to stir in a pan—like you.

I can move from place to place easily and quickly. I can crawl up the stairs, go over and stick my fingers into an outlet, and pull myself up a bookshelf.

So, please be sure our home is safe for me. This is one of the most important ways to help me explore and learn. Plus, if everything dangerous is out of the way, you won't have to tell me, "No," so often.

Through a Young Child's Eyes

Exploring and Learning

18-24 months

I want to explore and learn about everything. When you explore with me or I find something very interesting, you will see that I can have a long attention span. I check out things carefully and with focus.	I can walk, run and climb now. I love to jump and dance, throw, and push things around. I learn about myself and the world by moving. So, please be sure I am in a safe place whether we are indoors or outside.
I am learning to use my hands and eyes together to do many things: turn the pages of a book, string large beads, or explore putting together a puzzle or scribbling with a crayon. Keep your eyes on me—just in case I decide to suck or chew on something that isn't food.	Watch me play. Let me help you with chores. I am learning about our daily life. You might see me singing our goodnight song to my doll before laying her to sleep or sorting the blue socks from the green ones.
I remember what is supposed to happen at certain times. Knowing what to expect helps me feel secure and safe. It gives me a sense of control in the big world around me. That is why I can get upset when we change routines. It is why I ask you to sing the same song and read the same book over and over. I know it may be boring for you sometimes, but routines and repetition help me learn how things work.	I love to try things in new ways. You may see me bang a pot lid on the hard kitchen floor and then the rug in the living room to make different noises. I may push my truck in and out of the cardboard box garage you made for me to learn more about how my truck, even though I cannot see it, is still there.

Through a Young Child's Eyes

Exploring and Learning

24-30 months

Thanks to all the chances you have given me to explore and play, I am beginning to understand ideas or concepts of color, same and different, big and little, heavy and light, now and later.	I am learning how things are the same and different. I may want the same color marker as my big brother or notice my friend has more crackers than I do. I still love to dump, pour, fill, pull things apart, and put things together.
I am getting more skilled at doing things with my fingers and hands. So, let's explore painting, simple puzzles, rolling the ball back and forth, and drawing with crayons or markers. (I'll try not to eat them—but I may need a reminder.)	I love to move and am learning more new skills. You might see me tiptoe, gallop, or jump with two feet off the ground. I may be able to climb higher on the jungle gym in the park, though I may need help getting down. So, please be sure I am in a safe place
I am beginning to plan to make things happen. I may ask you if today Grandma is coming or push my blocks together to make a road for my car. I can decide what book I want us to read or show you the shirt I want to wear today. I still count on our routines to help me feel secure.	I love to do things for myself now and may protest if you try to help me. Watch and you may see me take off my jacket, peel my banana, carry napkins to the table and put one at each place, and pull off my socks. I need practice and your patience to get better at these tasks. Warning: Our *Everyday Moments* may take longer now.

Through a Young Child's Eyes	
Exploring and Learning	
30-36 months	
I am curious about everything I come across—and that's a lot. I notice details, like the door on my toy car or the snail in the tank at child care. I love to pretend and build. I am getting good at matching and comparing things. I can see how things are the same and different.	I am doing more planning. You might see me making cookies out of playdough, pretending to bake them, and serving them to my stuffed animals. Or, I might see if my friends want to make a zoo by pretending to be zoo animals with me.
My eyes, fingers, and hands work together even better now. I enjoy tearing paper, gluing, using playdough, counting and arranging big bottle caps or beads, and doing puzzles. I may still need you to remind me not to put things into my mouth.	I am getting better at doing things myself and may insist, "My do it!" I may want to dress, feed, and bathe myself, though I will need some gentle assistance from you. I may be very clear and firm about what I want to and won't eat. Please be as patient as possible and pick your battles. Does it really matter if I don't eat my carrots today?
I am getting better at figuring things out—though I still need your help. I might ask you for help when my jacket zipper gets stuck or look behind the sofa to find my missing car. You can help me learn to problem solve by giving me words for what is happening and ideas for what I might try.	Watch and you will see that I still love to move. I am beginning to have a goal in mind more often when I move and do. I might gallop with my friends, so we can be a herd of horses, or ride my push toy and pretend I am a truck driver delivering packages.

Parents' supervision knowledge and decisions extend safety across different living and learning environments. Parents and their children benefit from building routines and language for supervision as part of an overall focus on safety. In many ways, the foundations for quality supervision include being physically present and aware of one's child across situations and contexts. These actions are followed closely by being able to assess risks for a child's safety and make decisions that encourage exploration (and even failure!) without letting the child be in danger. Distracted parenting is linked with lower supervision and increases in children's injury risk. Research indicates that almost everyone thinks they are better at multi-tasking than they really are. Close proximity and vigilance by adults are positive strategies to minimize serious risk and quickly intervene when problems arise. Young children are curious explorers who do not know what could cause them harm or injury. Stairs, water, swinging doors, and random small objects on the floor are just a few of the common household items that can pose risks for young children. The presence of animals and water features (e.g., pools, ponds, hot tubs) or the absence of secure outdoor recreation space require additional attention by parents.

Several daily care routines need to integrate safety and supervision, such as diapering, bathing, and feeding. Each daily routine requires caregivers to set up safe environments for completing the daily routine, including choosing a safe space for diaper changes, ensuring bathing water is not too hot, making sure the child is always supervised and supported when near water, and offering bite-sized choices to prevent choking. While many safety needs are addressed in the details of daily routines, there are also safety and supervision expectations that parents should use in the other environments their young children explore. For example, parents should make sure their child's sleeping spaces and practices are safe at a relative's home or that their

church nursery has shelves that are secured to the wall to prevent them being pulled over by curious climbers. Being able to communicate those expectations clearly and address differences between caregivers are important. If there are still differences between parents and other potential caregivers, those differences could be a deal-breaker for leaving an infant in their care whether these individuals are paid or not. Some co-parents and caregivers have different tolerances for risk and may perceive risk very differently. Sometimes, parents simply do not understand what can be risky for their child. This could be due to lack of experience or not appreciating their child's developmental abilities and limits.

Lastly, parents and other caregivers can incorporate safety language into their ongoing communication, which creates a communication style that helps young children understand what behaviors are desired rather than what needs to stop. Building a communication pattern of positive guidance with very young children fosters their emerging skills for self-regulation and control. These skills are necessary for later school readiness and social and emotional competency. For example, when a 10-month-old child crawls into his grandparent's kitchen and rattles the cabinet doors, PopPop can join in the moment with a "We knew you were coming, and we made sure you would be safe! We have the safety locks on, and you noticed right away!" Parents can talk with their 20-month-old fast walker and can say, "We hold hands for our daily walk down the street." These simple sentences incorporate safety language into everyday conversation and help young children develop expectations for themselves and of their important adults.

Of course, there will be times when there is urgency to keep a child from harm, and times when there is only one choice for a child. You can help parents realize that their supervision and safety strategies and language can and will change based on specific situations. With each milestone their child meets and experience their child has, there will be opportunities to make or adapt their strategies and language. *For more on positive language, please see the chapter on Nurturing Guidance and Discipline.*

Supportive and Safe Caregiving Environments

The section on *Trauma-Informed Care* included opening information about parents becoming a young child's collaborator and helping their child learn to be a partner as their child learns and explores. Supportive caregiving means that parents and important others are tuned in to the child's actions, emotions, interests, and needs and are able to respond appropriately and in a rhythm that continues an interaction or completes it with satisfaction on both sides. Caregivers who struggle to effectively tune in, interpret, and respond to their young children are less likely to report that they feel warmly

connected to their children and more likely to report that their children are difficult to soothe, please, and play with enjoyably.

These struggles can negatively impact parents' sense of competence and satisfaction. In more serious cases, continued struggles to connect with and create a sense of safety for their children can become warning signals of risks for parent and/or infant mental health concerns and child maltreatment (i.e., neglect and/or abuse), which can include a marked lack of empathic and nurturing behaviors.

Infants, toddlers, and twos develop a range of strategies to build their learning and exploring partnerships with parents and caregivers. These seeking behaviors typically include staying physically close to a parent, venturing out to explore and coming back to check in with the parent, looking at a parent's face and body motions for emotional and verbal cues for reassurance or concern, and vocalizing and pointing to a new or unfamiliar object or person to make sure the parent is paying attention to the situation. Based on previous experiences, positive and negative, young children will adjust these strategies and the important adults they seek out. *For more information about these first relationships, please see the chapter on Building Trusting Relationships.*

So what are some ways that a parent can create a sense of psychological safety and support in an everyday interaction with their young child? As you read the next few paragraphs, you will see parents can use a range of behaviors to create that sense of safety and support.

What might a parent who is struggling do that would look and feel different? Again, there are many ways that a struggling parent might present, including showing a lack of engagement or interest, being intrusive (forcing interest on what the parent wants), and using harsh or neglectful actions and/or harsh language.

6.2.1 Exploring and Learning about the World

Let's think about a 12-month-old whose favorite stuffed toy is Elmo. She is not quite walking. She babbles and says about three words for purposeful communication with her parents. She sees her father come in to the living room after a tough work shift. She smiles at him and picks up Elmo, shakes the toy at her dad and says, "da-da-da" with excitement.

Supportive and Safe Example #1

Dad could respond positively with a return smile and ask, "Where is Elmo's nose? Did you and Elmo have a good day?" Dad becomes a collaborator with the child and extends the interaction she started and helps her learn more about herself and her world.

A home visitor could highlight how this parent is connecting and building his child's social world, building on her lead, and giving her a sense of safety and support.

Supportive and Safe Example #2

Dad gives a tired smile and a pat on her head before saying, "I need to change my clothes—be right back." He drops his gear and returns a few minutes later and tells his daughter, "Hey, Peanut. It's good to see you. Can I give you and Elmo a hug?" Dad is still a collaborator because he connects with her initially, tells her what he is doing, and returns to connect with her in a way that builds on her actions.

A home visitor can emphasize the different ways that this parent initially connected with his child, took the time to explain what he was doing to help stay connected as he completed some quick self-care tasks, and then made choices to re-engage at the child's level with what she wanted to share.

Struggling Example

Dad looks at his daughter but walks past her without saying anything. He says, "Hey! I'm taking a shower," loudly enough for everyone else in the house to hear. Fifteen minutes later, he returns to the living room, sits down, and turns on the TV. His daughter, still there, crawls to him with Elmo and pulls up on her Dad's leg. But, Dad tells her, "Not now. I'm watching the news." Dad has not responded in ways that recognize or encourage interaction with his daughter.

For a home visitor, it is time to try to find out more information. It is possible he did not know or recognize this was an opportunity to build connections; perhaps he is actively trying to stop the interaction his daughter wants. It could be that he sees the interaction as too much effort or work at that time or that her wanting to connect does not match what he thinks a child that age should be doing. Finding out more helps you to understand what is important to share and what ways you, as the home visitor, can support a parent's own growth and development.

Supporting Exploring and Learning through Play

Play is a key mode of exploring and learning for very young children, yet not all exploring and learning will be play. Play is defined in many different ways, but at the heart of it, whether something is play is how the person—child or adult—feels about the task and actions. This means that play comes from within each person even though there are many ways to share in a play opportunity with others. Play activities are those that are self-selected and self-directed. Yet, not everything may look like typical play to an adult.

For example, a 5-month-old may spend 15 minutes of floor time on a mat with toys and an overhead mobile kicking, rolling, reaching for interesting objects, and noticing what he can make happen with his body motions. He coos and shrieks when he can make interesting things happen and when he reaches a toy. If a parent joins in and follows his lead and pushes a toy closer, describes the toy and actions, or helps position him to better reach and explore, all of these actions are play.

Likewise, a 2 ½-year-old might see her older sister mixing cookie dough, ask to join in, and push her step-stool to the counter. Measuring, pouring, and mixing are sensory experiences that are enjoyable, and there may be satisfaction that comes from working with her big sister and doing big girl things. This is also play!

Anyone who is playing, whether alone or with others, is free to stop at any time. If the 5-month-old's play partner tries to force the infant to squeeze a toy that squeaks instead of letting him grab and mouth it, the baby will likely disengage, and that play moment is over. Similarly, the 2 ½-year-old may get frustrated if the rules for making cookies are too difficult for her to meet, like there can be no spilling or putting hands in the bowl. This moves the activity from play to work. She may continue to engage, but the playfulness and goals of her engagement are diminished in order to meet someone else's goals rather than her original intent to enjoy the moment and processes.

Safe and secure environments allow a variety of play opportunities for young children to do the following:

- Try out new things, such as exploring sounds in language through babbling or pretending to be a cowboy;
- Discover new properties of items, like playing in a mud puddle after the rain or observing which toys bounce;
- Test out new and emerging skills, like balancing on one foot or wiping down the table after snack;
- Learn to get along with others through agreeing to rules, such as how we treat each other and how to take turns; and
- Build coping skills by envisioning different outcomes for situations that were stressful or difficult, such as pretending a doll needs hugs and a Band-Aid after a toddler scraped his knee.

Sometimes, play is quiet; sometimes it is loud and boisterous. Play is, sometimes, a quick moment and other times an elaborate production. Sometimes, play is solitary, and, sometimes, it is with one or more partners. One young child may stay focused on a particular interest for

an extended time, like sorting toys by color or pretending to care for a baby doll. Yet, another young child is always on the move, scanning, touching, or moving lots of different things in the play area but not focusing attention on one thing.

TRHV provides a set of activities that can be play opportunities for solo and partner play. These activities are in a card deck format that families keep and can select from when seeking out a new or different way to join in with their child. These activities offer, whenever possible, ideas that can be done without having to buy something special. Games, puzzles, and toys are fine, but, when families are on a budget, it is helpful to model how common household items can provide everyday play, learning, and exploring options.

Why Learning and Exploring Matters to Families

Everyday Moments are naturally occurring events in every family's life and provide experiences for children to grow and learn. Routines can incorporate play and playful elements to make daily tasks more engaging and build a sense of working together. Some parents may believe they need to buy certain things or enroll their child into specific kinds of experiences in order for their child to do well. Home visitors can help parents see the extraordinary in *Everyday Moments,* and household items can alleviate the sense of pressure to have the latest and greatest things for their child.

Each child's immediate physical and caregiving environments create and constrain opportunities for exploring and learning, and families often have the most influence on what these environments are like. Parents make decisions each day about activities, routines, living and playing spaces, who is around their children, and how they themselves choose to join in with their children at any given time. The degree to which parents and caregivers are aware of these choices will vary within and across families. It is not uncommon for a choice to be made for a very good reason, with unexpected consequences later on. This could be a fairly significant family decision, such as opting to have one parent stay at home after an infant arrives because the cost of child care is equal to or greater than the current salary earned, and then realizing there are very few social learning and play opportunities outside of a child care setting in the community. Or, there could be several small, daily moment decisions to use playpens, cribs, bouncy chairs, and strollers for so much of a child's waking hours that there is little opportunity for a young child to do free exploration and large motor skill activities. Parents could have some well thought out reasons for keeping their young one in restricted spaces, but they may not understand how these decisions shape their child's experiences and development.

Families can struggle in a variety of ways that impact their children's opportunities for exploring and learning. Learning more about the decisions and assumptions parents make open communication about how children grow and learn and how families can support their young children's development.

Boots on the Ground: Everyday Moment Conversations with Families

This section highlights content and skill-building strategies you can use as you plan your home visits. For the *Everyday Moment* section of the visit, you will find a list of topics to choose from and to explore in conversations about building strong and healthy relationships. For each topic, you will find the associated *Protective Factors* and *Trauma-Informed Principles* addressed. *Family Pages* designed to support your conversations are listed next.

In addition, you will find suggestions of related one-on-one activities to choose from for the parent-child interaction portion of the visit.

There are several *Exploring and Learning* topics to choose from as you plan a visit to a family, and you should tailor the conversation to that family's specific needs and interests. You may find that you discuss one topic now and come back to discuss another in a month or two depending on certain circumstances.

Using the information you have about a family's *Protective Factors*, you can guide your curriculum choices to tailor the home visit discussion and activities. Ideas are presented below with their associated icons to highlight how they correspond to meeting a family's needs and building each family member's resilience.

These include the following:

Parents' experiences with and expectations for exploring and learning

- *Parental Resilience* may be enhanced when parents reflect on their own early experiences of exploring, learning, and playing. These reflections can guide parents' decisions about what they would like to carry forward with their own children or do differently to support their child's development and curiosity.

Supporting your child's exploring and learning

- *Knowledge of Parenting and Child Development* and
- *Social and Emotional Competence of Children* are supported through exploring and learning in ordinary daily moments, which can be extraordinary to young children. As their child's first teacher, parents construct the physical and caregiving environments for play and exploration.

Keeping a child safe while learning, exploring, and playing

- *Knowledge of Parenting and Child Development* and
- *Social and Emotional Competence of Children* help parents address safety and supervision needs for their young child so that she may explore, learn, and play with confidence.

Family Pages

A series of *Family Pages* on *Exploring and Learning about the World* have been created to support your conversations with families while you are visiting and to become a resource parents can refer to between visits. These include:

- Exploring and Learning from a Child's Point of View
- Exploring and Learning Happen All the Time
- What Do You Notice and Know About Your Child?
- You are Your Child's First and Most Important Teacher
- Keeping Your Little Explorer and Learner Safe
- Distracted Parenting: When Media Connections Become Disruptive
- Focus on You: Looking Back and Moving Ahead with Your Child
- Practical Applications for Families: Figuring It Out Together

Related One-on-One Activities

These are suggested activities to promote exploring, learning, and play. There is a broad selection of one-on-one activities available in the Activity Card deck.

- Notice and Wonder: How does your child explore and learn about his/her environment? What kinds of play does he/she enjoy?
- Peekaboo
- Create an obstacle course
- Sensory bag (guessing an object by feel)
- Finger paints

Book suggestions:

- *Star in the Jar* by Sam Hay
- *Kite Flying* by Grace Lin
- *Where the Wild Things Are* by Maurice Sendak
- *Pat the Bunny* by Dorothy Kunhardt
- *Brown Bear, Brown Bear, What Do You See?* by Bill Martin

Additional Resources

Community, Physical, and Mental Health connections may include:

- Community/County Health Department
- Parks and Recreation
- CDC Developmental milestone charts/app for 2 months to age 5 years old: https://www.cdc.gov/ncbddd/actearly/milestones/index.html
- Take Root Home Visitation Child Safety Checklists
- Pediatrician
- Early Head Start

Everyday Moments 6.2 Chapter 2: Building Trusting Relationships

Main Elements

Content Areas

- Teaching About Trusting Relationships: *Protective Factors* and *Trauma-Informed Principles*
- The Science: Brain Development, Chronic Stress, *Failure to Thrive*, Attachment, Temperament Influences
- Why it Matters to Families: Challenges in Early Relationships
- Home Visit Activities and *Family Pages*
- Important Safety Supports and Knowledge: Baby Blues and Postpartum Depression, Emotional and Physical Safety Plans, Family Care Plans (Military-Specific)

Support Connections

- Pediatrician's Office
- Parent's Healthcare Provider(s)

Teaching About Trusting Relationships: Protective Factors and Trauma-Informed Principles

Trusting Relationships are a cornerstone of healthy individual and family development. Infants are born ready to connect and communicate with others. Their earliest reflexes, coos, and cries support connection and safety as they learn about their new physical and caregiving environments. Their families and other significant caregivers provide the first models of what a relationship is and how to be in a relationship with others. Every person who interacts with a young child passes along relationship expectations and assumptions, whether they realize it or not.

Home visitors are in a position to model healthy relationship building with every member of the family from the adults to their young children. Relationships are dynamic, and they can run smoothly or can wobble. Building trust in parent-child and parent-home visitor relationships takes time and shared experiences, including learning one another's preferred interaction styles and being able to recognize and appreciate what each person brings to the relationship.

Home visitors bring their own relationship and caregiving history into their work with families. Being able to reflect on and recognize your own experiences can be helpful in maintaining a strengths-based stance when working with families.

Everyday Moments 6.2.2 Building Trusting Relationships

The families you serve will bring their collective relationship experiences and expectations into this current partnership. Some parents will have challenging histories, while others may be new and inexperienced. You may also have families who need a boost of support and connection because of current trials in their lives. Some parents may have already done a significant amount of work to identify and address issues from past caregiving experiences or intimate relationships. Other parents may be at the very first steps or in the *messy middle* of such work. You may work with families who have a strong sense of how they want to parent and care for their young child, whereas other families may only know what they DON'T want to pass along to their children.

Meeting each family where they are in their parenting journey requires several skills, including listening, compassion, and discernment. The overall topic of *Building Trusting Relationships* can stir up old feelings and memories, which may be warm and comforting for some parents but painful or conflicted for others.

Be sure to connect with your colleagues and supervisors if you believe a family needs a higher level of support for relationship work and potential parent or infant mental health than is provided through home visitation.

This chapter helps to address the following *Protective Factors*:

- ***Parental Resilience***
- ***Knowledge of Parenting and Child Development***
- ***Social and Emotional Competence of Children***

Teaching about *Building Trusting Relationships* offers opportunities to model the following *Trauma-Informed Principles* in the parent-child and parent-home visitor relationships:

- ***Safety –*** Very young children experience their first feelings of safety by how consistently and effectively their daily needs are met. Parents who can anticipate and respond to their child's needs appropriately and in a timely manner foster their child's sense of security, connection, and positive stability.

  Parents who struggle with appropriate, consistent, or timely responses can generate a sense of insecurity and doubt in their children's budding understanding of their caregiving world. The care young children receive shapes their sense of being a relationship partner and understanding who can be relied upon to meet their needs.

  Parents who have a low sense of safety, whether physical or emotional, can transmit those stressful feelings to their young children. Helping parents and other family members identify ways to increase their sense of safety fosters a healthier daily environment for young children and their caregivers.

  Examples of increasing safety include knowing where to go or who can be contacted for support with a particular need and building problem-solving skills and strategies.

Trustworthiness and Transparency – Trustworthiness and safety are intertwined for infants and toddlers. The consistent, appropriate, and emotionally connected care they receive through daily routines give very young children critical information about the people they can rely on in good or stressful times. Parents and other significant care providers become literal *touch points* for young children as these children encounter new environments and people and seek out physical and/or visual connections for reassurance while they explore. Children who trust their parents and care providers will check in for reassurance visually, vocally, and physically. These check-ins serve to give young children a *second opinion* about how to interpret and explore or avoid a new experience.

For parents, there may be some important moments in the home visitation experience that demonstrate how they can rely on you, as a trustworthy professional, to support them and their family. Your openness to discuss difficult topics and remain engaged and honest if a disclosure requires you to engage other professionals or start a mandated reporting process can model healthy relationship development and repair between adults.

Peer Support and Mutual Self-Help – The parent-child relationship is one of the most intimate and long-lasting relationships possible. Parents are most often their child's first supporters as they meet their infants or toddlers at their developmental levels and give support to help their children solidify and expand their skills. Meeting children at their developmental level may look like parents letting their 11-month-old grasp their fingers to support first steps or talking with their toddler to determine who will pour the water into the dog's dish.

Within the parent-home visitor relationship, you may become part of the family's *Circle of Support*, a person with whom the parents can discuss opinions during decision-making processes or disclose something that is troubling them. Families can gain confidence in building their own positive parenting and family life practices as information and experiences are shared in the parent-home visitor relationship.

Collaboration and Mutuality – Young children's relationships are built through routine interactions with their caregivers, whether parents, siblings, extended kin, or caregivers. Each early relationship develops unique rhythms of *give and take* and styles of interaction. Both persons in the dyad—infant/toddler and partner—build what their relationship looks and feels like through their collaborative actions. These actions, which are repeated, adjusted, and emphasized, over time give feedback to each participant. This feedback includes how one should treat another, expect to be treated, and what one can do if something unexpected happens within the interactions. Parents and other important persons are more skilled and knowledgeable about relationships and can foster collaboration and mutuality to help build healthy first relationships for the young child(ren) in their lives.

Home visitors and parents are more likely to be able to foster a relationship that is closer in power than the parent-child relationship. This is an intentional relationship with the home visitor and parent working and learning together for the benefit of the family. As with every relationship, it will take time to develop a rhythm and build trust. Experiences are created through sharing power and decision-making for the family's goals and needs.

Empowerment, Voice, and Choice – Very young children's earliest sense of self—who they are in the world—comes from the relationships that guide their first few years. Infants and toddlers thrive when their caregivers notice and promote their budding abilities, use descriptive words to help explain what is happening around them, and consistently offer caring responses. These kinds of supportive interactions promote young children's confidence in exploring and learning about their world, finding their early voice in expressing themselves, and becoming a skilled social partner. When caregivers are inconsistent, harsh, or unengaged, very young children learn adaptive behaviors to minimize their distress. These behaviors, while adaptive to such an environment, work against building healthy social and emotional skills that connect them to others, which can have long-term negative impacts on multiple areas of children's development.

Home visitors who work from a strengths-based foundation with families are able to help promote *Protective Factors* and reflect a belief in a family's resilience. The parent-home visitor relationship can provide a pathway for new or high-need parents to see themselves as capable of building their parenting skills, increasing their resilience, and effectively handling challenges. Thinking about change and exploring new ways of building relationships can be daunting for some families and make them feel uncomfortable. Using a strengths-based approach can help families see how their small steps and new practices are working toward their goals.

Cultural, Historical, and Gender Factors – All relationships carry cultural, historical, and gender-based characteristics and expectations. First relationships are no different. Infants and toddlers receive subtle and not so subtle messages about their culture, their family's history, and their gender by their parents and extended family and caregiving systems. Families immerse their young children in a larger social world in many ways, including the following:

- Inclusion in communities of religious and cultural identity;
- Using care strategies that carry meaning from previous generations of their family;
- Choosing clothing and other visible markers that give other people cues about the child's gender that shape interactions and expectations; and
- Promoting gender role development through expectations for coping with stress, emotional expression, language, and early interests in types of play.

Home visitors and families each come into this relationship with their respective cultures and histories. Being aware of and reflecting on potential biases or gaps in understanding one another can be helpful in being respectful as this partnership grows.

The Science: Understanding How Trusting Relationships are Built

First relationships are critical to the survival and well-being of infants and toddlers. The ways in which parents and other caregivers respond to an infant's daily needs shape an infant's brain at a structural level and create lifelong building blocks of understanding the world as a safe or threatening place. High-quality caregiving relationships are one of the three pillars of healthy brain development: sleep, nutrition, and supportive and safe caregiving and physical environments. So how do these first relationships impact a child's brain development, and what happens if there are challenges to healthy attachment and caregiving?

Brain Development and First Relationships: Is My World Safe or Threatening?

The most rapid and detailed brain development in humans occurs during the first 3 years of life. Supportive and safe care is one of the three pillars of healthy brain development during this key period of development. The three pillars are sleep, nutrition, and supportive and safe caregiving and physical environments. The infant's brain is working hard:

- to set up all the basic infrastructure to process, connect, and make sense of sensory input;
- to develop pathways to build and control body movements and functions; and
- to build the basic working models of relationships through interacting with important people in their lives.

More specifically, early brain development focuses on the parts of the brain that develop emotion, connection, and the assessments of and responses to people and things as either safe or threatening.

The first 3 years are critical for building the child's foundation of how and when to engage with others, explore their world, and seek support. From the preschool to early elementary years, ages 3 to 8, brain development shifts to parts of the brain that focus on thinking, pattern-building, and problem-solving. These skills are necessary for school readiness in reading, math, and music. The brain continues to specialize and adapt throughout one's life. Yet, early experiences build the base for later changes.

Safe, stable, appropriate, and responsive caregiving environments promote early brain development and growth that foster flexibility in learning and remembering. Young children in healthy caregiving environments are more likely to be able to learn to *flexibly* adapt (i.e., cope) with challenges and regulate their emotions and behaviors in ways that positively support their growth and learning. These positive responses to challenges include seeking out important others for help (e.g. parents, teachers, friends) and building an early sense of self as a person who can solve problems (early self-efficacy). Early high-quality care environments provide a strong foundation for brain development in the preschool and early elementary years. Such experiences nurture the social and emotional skills needed to make friends, get along with others, and trust early care and school professionals.

Conversely, unsafe and unstable caregiving environments and caregivers who do not respond in an appropriate and/or timely manner to young children can raise infants' stress hormone levels. This can trigger a fight, flight, or freeze response. This means that young children are learning they cannot depend on others for safety or support. Children's early brain development and growth focus on building survival responses that discourage building social connections. Each of these responses can be important for survival at any given time. But, if young children's caregiving and physical environments remain threatening or neglectful, their potential to develop positive, trusting social connections and a healthy early sense of who they are becomes inhibited.

6.2.2 Building Trusting Relationships

Early and chronic exposure to neglectful and threatening caregiving and physical environments has measurable long-term impacts on developmental outcomes. For example, children who live in these environments have more difficulty as they enter the preschool and early elementary years. Young children may find it difficult to make friends and get along with others, due to limited positive social and emotional skill opportunities, and they may have developed a sense of mistrust or wariness of unfamiliar adults. The skills they have learned to survive in their environment do not promote exploration and engagement with new people or experiences, including formal learning (e.g., reading, math, music).

Chronic exposure to threatening or neglectful caregiving and physical environments keeps the stress hormone cortisol raised in a person's body. In very young children, this prolonged activation suppresses their immune systems and physical growth and increases the formation of memories related to stressful events and situations. These types of environments can put a very young child at risk for a condition called *Failure to Thrive* (*FTT*). *FFT* can have underlying medical causes or psychosocial causes. Clinically, it is diagnosed as malnutrition. While diagnosis is not within the scope of practice for most home visitation programs, it is helpful for home visitors to have a basic understanding of the characteristics of *FTT*, so referrals and recommendations to other service providers can be coordinated.

FTT is most commonly identified by a healthcare provider during a well-baby visit. Infants who do not meet the 5th percentile of height and weight standards for their age or who have negative growth changes across two major growth percentiles at a visit would be assessed further. The next step in assessment is to determine the underlying causes of poor growth, so appropriate interventions can be identified:

- *Medical causes*: Under-nutrition; infection; digestive system problems; issues, such as a cleft palate or food intolerances.
- *Psychosocial causes*: Caregiver/parent mental health or physical health challenges, including substance use, lack of knowledge about healthy feeding, or understanding the infant's needs.

Once an initial assessment is completed, the child's healthcare provider will start the process to connect the family to other professionals who could be involved in treatment, such as nutritionists, social workers, home visitors, and physical or occupational therapists.

Attachment: *Building Trusting Relationships* Through Behaviors, Thoughts, and Emotions

As you learned in the previous section, there is a lot going on inside a child's mind that is influenced by one's caregiving and physical surroundings. But attachment is more than those pieces of brain development. Attachment is relational; each partner brings skills and needs for connection to the collaborative effort. The attachment relational system includes behaviors, thoughts, and emotions by both partners.

Attachment describes a dynamic relationship between two persons that is built, maintained, and influenced by both partners. It is primarily used to describe parent-child relationships, yet it has been expanded to include other important relationships children develop, such as with paid early care providers, extended relatives, and siblings. A key feature of attachment is the intention of creating and maintaining a sense of closeness with one another. Closeness can be physical, like a parent holding, cuddling, and soothing a young child, or a toddler who clings to his teacher at a park for a while before venturing out to explore. Closeness can also describe the emotional connection when a parent and child both squeal in excitement as they reunite at the end of a work day, when a 2-year-old hears her grandpa's voice on the phone, or when an infant drops a cup off the high chair to try to get her big brother to laugh and pick it up so she can do it again.

A healthy attachment with one or more parents/caregivers can provide opportunities for young children to build their abilities to develop more sophisticated coping skills within a protective relationship with a parent/caregiver. Let's look at the graphic on the next page to see the behaviors and skills that infants, toddlers, and twos can bring into an attachment relationship.

Through a Young Child's Eyes

Trusting Relationships

0-6 months	6-12 months
Reading my cues to understand what I am telling you is key to our trusting relationship.	Around 6 months, I may have some people who are at the top of my list: parents, maybe an older sibling, a child care provider. I will look for these people first—I know I can count on them.
Crying is my first way of communicating how I feel and what I need. If you listen closely, you will hear different cries for different needs.	Other people I see occasionally may be OK, but I have stronger routines and histories with my main people.
When I'm a newborn to about 2 months, I will respond to everyone who gives me care and comfort. I recognize the voices and smells of the people who care for me and talk to me, but I am not picky about who takes care of my needs…yet.	I kick my legs or reach for you with arms or catch your eye and smile to say I want to be with you.
	I reach for you for comfort when I get hurt or upset. No one else will do.
As we get to know each other better, I will start to coo, smile, and squeal when I see and hear people I feel connected to.	I trust you. I look to you to tell me if I am OK when I get a little bonk or fall onto my bottom. If your face and words say I am OK, I keep going. If you are upset, I get upset too.
By 4 months, my vision has improved, and I can look to see if you are coming before I start crying.	If I meet a stranger, I will look at you to see if this person is OK. I may still bury my face in your shoulder and stay close to you.

Through a Young Child's Eyes

Trusting Relationships

12-18 months	18-24 months
I rely on you as my home base of security. When I wander off to explore or play, I check in with you. I may come over and touch you or look for your smile and nod across the room.	As I grow more active and move more, I need you to be there so I can check in with you more.
When you are nearby, I am more comfortable playing with a new toy or trying a new activity, like doing an obstacle course.	When you are close by, I feel safe to move and do, explore, experiment, and learn.
I may interrupt you when you are talking on the phone or with a friend in the park. I am not trying to be bad. It's that I want you to be with me. You make me feel safe.	Sometimes I put my toys in your lap or try to eat food from your plate or pull your face to look at me when you are talking with someone else. Why? I love you and trust you. I want to be with you.
I may fuss and cry when you drop me off at child care—or even at grandma's house. After a while, with that person's help, I'll settle down.	Please help me take care of my *lovey*. If we lose it, chances are I won't accept a substitute. My *lovey* lets me carry you with me, and I want and need it.
I may have a special object like an old t-shirt of yours, a stuffed animal, or a blanket that you've used when you comfort me. That may become my *lovey*, something to remind me of our relationship when we are separated.	If there is a change in my daily routines, I may protest about it because I rely on things I know to help me understand and predict my world. You can help me learn about flexibility when things feel bumpy.
I talk to my stuffed animals in a kind, gentle voice and pat their backs when they are upset—just like you do with me.	

Through a Young Child's Eyes

Trusting Relationships

24-30 months	30-36 months
Even though I insist on doing things myself—even when they are too hard—you are still my base of security.	I may seem very grown-up, but I still depend on you to be there for me, reassure me, and help me know I am safe.
I may stay close to you, then go to see a new toy in the park, then come back and want to sit in your lap.	I am learning to be like you. You may see me singing to my baby doll just like you sing to me at bedtime.
I am learning what your words and expressions mean when you talk with me, and I can change my goals to match yours—or I may challenge them!	I am starting to form my first friendships. What I've learned from you will help me understand how I should treat others and how I want to be treated.
I am learning that other adults help me feel safe too. I may look for a smile and nod from my teacher before I run through the sprinkler for the first time.	I may teach you a nursery rhyme I learned in child care and be patient like you are when you teach me something new.
I may be testing the limits of my skills and safety. That can make me frustrated. And, sometimes, I may take chances that aggravate or frighten you. You help me learn I can have negative and scared feelings and still be loved.	When we are apart, I might pretend to call you on the phone (a block) or paint a picture of us together.
I look at family pictures, and it makes me feel safe and happy.	

The examples on the previous pages show how young children can experience positive and healthy social and emotional development when they have healthy attachment with their parents and caregivers. Young children are continually learning and growing from their experiences and building their understanding of the world around them.

Research on Attachment in the U.S.: Understanding the Quality of the Relationship Through Child and Parent Interactions

When attachment is studied in research and clinical settings, the quality of a parent-child attachment system is assessed by determining how very young children organize their attachment behaviors to find a balance between their need for protection and reassurance and their desire to explore their environment. Parents' actions are also assessed for the different ways they may engage with or draw back from their child. For example, is a parent able to recognize signals that a child is seeking help, or does the parent miss or misunderstand signals for help? Does a parent communicate that he or she is available to support the child either physically by opening up his or her arms to lift the child or emotionally by responding to soothe, reassure, or otherwise connect? Does the parent communicate he or she is not available by actions that close him or her off from the child or through language that dismisses, ridicules, or rejects the child's efforts for support?

Lastly, parents' behaviors have been studied to better understand how parents work to match their child's needs and signals, so the interaction between parent and child continues. Sometimes, parents and their children have very different temperaments or preferred ways of engaging with others and environments. These differences can make it challenging for parents to learn how to connect with their children in ways that they both find positive.

6.2.2 Building Trusting Relationships

While home visitors are not expected to provide a clinical diagnosis for an attachment disorder, it is helpful to be able to recognize the kinds of behaviors young children and parents display that give insight into their relationship. The quality of the parent-child attachment system in the general U.S. population is usually categorized as one of the three below:

- ***Secure Attachment:*** The parent consistently provides sensitive and nurturing care, which, in turn, promotes the child's ability to organize his or her responses to stressful situations and seek out the support needed to lower distress. This is thought to occur in about 55% of the general U.S. population.
- ***Anxious Attachment:*** The parent does not provide sensitive or appropriate care. In both situations outlined below, the child develops an organized response to distress, but the parent-child attachment system does not provide protection or support.
  - *Anxious-Ambivalent:* Parents' responses to their child are inconsistent or unpredictable, and the infant is not able to build trust or rely on the parent for help (about 8% of the general population). The child develops an organized system to try to reduce feelings of distress. Some young children will exaggerate extreme emotions and reactions to distress because they are trying to emphasis the seriousness of their needs and elicit a parental response. Other young children become quite passive and show a sense of helplessness. When the parent does respond to either of these strategies, the child is less likely to be able to be soothed.
  - *Anxious-Avoidant:* Parent responses are negative and rejecting, which deter the child from seeking help when distressed (about 23% of the population). The child develops an organized strategy that includes avoiding the parent instead of seeking support and comfort and trying to minimize showing negative emotion in front of the parent.
- ***Disorganized Attachment:*** Young children who are disorganized in their strategies are unable to seek out support from their parent or rely on their own strategies to reduce their distress. Estimated to occur in about 82% of high-risk populations and in about 15% of low-risk populations, these children may look disoriented or show contradictory behaviors (e.g., flight *AND* fight), and their coping behaviors may look more typical and healthy when their parent is removed from the stressful situation.

  This type of attachment is strongly linked with families that have a traumatic history and parents who display atypical parenting behaviors (e.g., frightening the child, showing fear of the child, sexualized or dissociated behaviors).

6.2.2 Building Trusting Relationships

Recognizing some of the basic patterns of parent-child interactions can help a home visitor assess whether a family would benefit from more visits that focus on strengthening attachment relationship(s) or may be a good candidate for more intensive, clinical support.

Families bring a variety of traditions and expectations into their caregiving relationships with young children. You may work with families where it is very unusual for infants or toddlers to be separated from their mothers or grandmothers. Some families may have expectations that young children need calm and quiet daytime environments, which might look like the family offers very little exploration and stimulation at first glance. Other families may have fathers who provide the primary daily care for their young children. Observing, listening, sharing experiences, and asking questions provide openings to better understand how parents and caregivers are building trusting relationships with their young children. You may also be able to provide new insights into a young child's behavior that is difficult for a parent to see or appreciate.

Temperament and Trusting Relationships

Each person is born with preferred ways to respond to people and experiences in one's environment. This is called temperament. At its foundation, temperament describes individual differences in how people react to their social and physical worlds and how they regulate or moderate their reactions. Temperament is fairly stable over a lifetime, but people usually continue to refine and expand their regulation skills as they gain experiences and learn from others around them.

Young children are at the very beginning of learning about themselves, others around them, and their physical world. This means young children are born with basic patterns of responding to the world but are very limited in regulating or modifying those patterns. They need time, experience, and supportive environments to build those skills!

Young children's early patterns of responding to new situations and people include the following:

- *Activity level* – is a child always on the move, exploring new things, and meeting new friends, or does a child wait for new people or things to come to him or her and wait before venturing out to new experiences?
- *Positive feelings* – how often or easily does a child show positive emotions (e.g., smiling, laughing, giving affection) with others?
- *Negative feelings* – how often or easily does a child show negative emotions (e.g., fearfulness, anger, frustration, sadness)?
- *Reactions to the unknown* – how comfortable is a child with unfamiliar people or situations?
- *Attention and concentration level* – how well can a child pay attention and focus on a task?

Each member of the family can have a different temperament, which can be challenging at times. You may work with families where the parents are very outgoing and active, but their toddler struggles when there are more than two or three buddies at a play date and prefers to find a quiet space to play with puzzles. You may work with a parent who is pretty easy-going and yet is bewildered by how reactive and easily distressed his 2-year-old may become when there are changes in daily routines, such as taking a bath before dinner rather than after.

Whether parents and children share similar temperaments or seem to be opposites of one another, every child and parent can build a trusting relationship that respects each person's individual styles. Parents and other caregivers are the more skilled partner in this relationship. They carry the responsibility of learning about their young child's early response patterns, so they can create opportunities to connect in ways that support continued interactions. This is sometimes called *tuning in* or the *dance of attachment*. No matter if young children appear to be easy-going, slow-to-warm-up, or feisty, the trusting relationships they develop with their important people provide opportunities for them to practice adapting and regulating their responses in a safe environment.

Why Building Trusting Relationships Matters to Families

Who a child becomes depends in large part on their early relationships. When the important adults in a child's life work to form trusting relationships with a child and with each other, children will learn that they are valued and loved. When their adults listen and respond to their needs, they learn they are effective communicators and someone is paying attention to them. Through daily interactions, they learn to respect others, try to understand what others are feeling, and cooperate with others. These are attitudes and skills that will help children form lasting, trusting relationships with friends and family throughout their lives. These earliest relationship experiences provide a lifelong foundation for how children will engage with the world and what types of relationships they will seek to build and maintain as they grow through childhood into adulthood.

Some families will face significant challenges in developing trusting relationships with their infants, toddlers, and twos. Sometimes, their specific challenges are beyond the scope of practice for home visitors. It is important to know what your practice's professional boundaries are and when to alert a supervisor or another professional to a family's need. Clinical and other interventional support(s) may be advised when there is a presence of mental health conditions, including postpartum depression, *Failure to Thrive*, substance use or misuse, and issues of immediate safety—whether due to living conditions or volatile family dynamics.

All families are going to experience bumps and wobbles that can impact parent-child relationships. Bumps are experiences or circumstances that can be short-term, like everyone in the household coming down with stomach flu or, longer-term, like living in a community damaged by a fierce storm or having a close family member who struggles with anger and self-control.

Wobbles can be more particular to a parent-child dynamic due to the characteristics each brings into the relationship. For example, maybe a toddler acts just like a family member who always seems to be in trouble and has a few of that person's behaviors! On the other hand, a family could be overwhelmed with an infant's diagnosis of a developmental delay. Home visitors can support families and help them find their rhythm again or build a rhythm that works better with their changed circumstances.

Boots on the Ground: Everyday Moment Conversations with Families

This section highlights content and skill building strategies you can use as you plan your home visits. For the *Everyday Moment* section of the visit, you will find a list of topics to choose from and to explore in conversations about building strong and healthy relationships. For each topic, you will find the associated *Protective Factors* and *Trauma-Informed Principles* addressed. *Family Pages* designed to support your conversations are listed next. In addition, you will find suggestions of related one-on-one activities to choose from for the parent-child interaction portion of the visit.

There are also several *Trusting Relationship* topics to choose from as you plan a visit to a family. You should tailor the conversation to that family's specific needs and interests. You may find that you discuss one topic now and come back to discuss another in a month or two depending on certain circumstances.

Using the information you have about a family's *Protective Factors*, you can guide your curriculum choices to tailor the home visit discussion and activities. Ideas are presented below with their associated icons to highlight how they correspond to meeting a family's needs and building each family member's resilience. These include the following:

Parents' experiences with and expectations of trusting relationships

Parental Resilience may be covered when parents are invited to reflect on early relationships they had and think about what they want to do as parents, whether the same as or different from the adults who cared for them.

Connecting and communicating across the ages

Knowledge of Parenting and Child Development and

Social and Emotional Competence of Children Parent-child relationships are like a dance. At first parents are in the lead, but, over time, children add in steps of their own, and experiences will shape how both partners change over time. Relationships can wobble when partners are out of sync, but there are ways to regroup and become stronger.

Keeping children safe when life gets bumpy

Parental Resilience and

Knowledge of Parenting and Child Development allows parents to use their strengths and identify resources to make plans that keep their children physically and emotionally safe.

Family Pages

A series of *Family Pages* on *Building Trusting Relationships* have been created to support your conversations with families while you are visiting and to become a resource parents can refer to between visits. These include the following:

- Building Trusting Relationships from a Child's Point of View
- Your Trusting Relationship Dance with Your Baby
- Your Trusting Relationship Dance with Your Toddler On-the-Move
- Your Trusting Relationship Dance with Your Two-Year-Old
- Thinking About Temperament: Your Child's and Yours
- All Relationships Wobble Sometimes
- Keep Your Child Safe: Use the Protective Factors
- Keep Your Child Safe: Provide Emotional and Physical Safety
- Keep Your Child Safe: Create a Family Care Plan
- Focus on You: Looking Back and Moving Ahead with Your Child
- Practical Applications for Families: Figuring It Out Together

Related One-on-One Activities

These are suggested activities to promote trusting relationships. A broad selection of one-on-one activities is available in the Activity Card deck.

- Notice and Wonder: How does your child show trust in you and others?
- Singing and dancing together
- Peekaboo and Hide-and-Seek

Book suggestions:

- *Mr. Seahorse* by Eric Carle
- *Is Your Mama a Lama?* by Deborah Guarino
- *Full, Full, Full of Love* by Trish Cooke

Additional Resources

Community, Physical, and Mental Health connections may include the following:

- Pediatrician's Office, other Healthcare Providers
- Community/County Health Department

Everyday Moments 6.2 Chapter 3: Nurturing Guidance and Discipline

Main Elements

Content Areas

- Teaching About Nurturing Guidance and Discipline: *Protective Factors* and *Trauma-Informed Principles*
- The Science: Children's Development and Positive Parenting Practices, Nurturing Guidance and Discipline; Children's Development and Harsh/Neglectful Parenting Practices, Physical Punishment, and Psychological Punishment; Helping Families Move Toward More Nurturing Responses; Punishment and Child Maltreatment
- Why it Matters to Families: Addressing Challenging Behaviors; Temperament Differences Between Parent and Child; Parents Who Experienced Physical and Psychological Punishment
- Home Visit Activities and *Family Pages*
- Important Safety Supports and Knowledge: Shaken Baby Syndrome, Crying/Colic, Signs of Maltreatment

Teaching About Nurturing Guidance and Discipline: Protective Factors and Trauma-Informed Principles

Parents are their children's first guides. They introduce their children to their physical and social worlds and show them how things work and connect. Everyday routines provide a system for parents to guide their young children, which teaches expectations about relationships and establishing family rhythms. Guidance is infused in the big and small interactions of these rhythms and relationships. Discipline is a specific part of guidance. It has many uses, including redirecting young children's behaviors, helping them feel and process big feelings, keeping them safe, helping them discover connections between actions and consequences, and helping them learn to respect others.

Nurturing Guidance and Discipline are a set of applied behavioral strategies that support young children's efforts and development toward self-regulation of their emotions, responses, and social competence. It is grounded in the belief that parents and other important adults can partner with children to help them figure out how to make good choices, manage frustration, and learn how to be a skilled social partner in ways that do not harm, belittle, or ignore children's experiences of events. At the core of *Nurturing Guidance and Discipline* is the recognition that parents and other caregivers understand that there are power

differences between them and the children in their care, and this power is used in positive ways to protect children and promote healthy development and learning. These positive and nurturing strategies are non-violent, thoughtful, and keep in mind long-term goals of helping young children grow into socially and emotionally competent and connected adults. Yet, parents and caregivers can often find themselves in cycles of using strategies that focus only on stopping certain behaviors in the moments they occur without encouraging a child's development of self-control or more desired behaviors.

Families can come into a home visitation program with a wide range of discipline experiences in their own childhood and family systems. Often, they use power the way it was used to enforce or guide their own behaviors when they were young:

- Some parents may have grown up with non-violent strategies as their norm, having never been spanked or had other harsh punishment (e.g., pinching, slapping, belittling);
- Other parents may have experienced unpredictable discipline from one or more caregivers;
- Some parents may have grown up with very few limits and little supervision;
- Other parents may have had indulgent and permissive parents who shielded them from consequences; and
- Some parents may have experienced fear- and punishment-based strategies to try to force behavioral change, including mild to harsh physical, verbal, emotional, or sexual maltreatment.

Building a set of nurturing guidance and discipline strategies takes time and practice as does understanding each child in one's care. Adults come into parenting and caregiving roles with some patterns well established from their own experiences. These can become default responses, whether positive or not.

Parents, no matter their own childhood experiences, can benefit from developing a deeper awareness of their own past and what strategies they fall back on when parenting under stress or *in the moment*. Recognition of these patterns is a beginning point to making decisions about current and future practice that can guide their children's behaviors for long-term, positive outcomes. Parents' nurturing guidance and discipline skills can and need to be integrated into the ongoing work of building safe and secure trusting relationships with their children and significant others.

This chapter helps to address the following *Protective Factors*:

- ***Concrete Supports of Families***
- ***Parental Resilience***
- ***Knowledge of Parenting and Child Development***
- ***Social and Emotional Competence of Children***

Teaching about *Nurturing Guidance and Discipline* offers opportunities to model the following *Trauma-Informed Principles* in the parent-child and parent-home visitor relationships:

Safety – Young children are in their early stages of learning self-regulation and social expectations for their behaviors. Nurturing discipline and guidance strategies help keep young children physically and psychologically safe as they learn to feel big emotions, experience stressful situations, and develop relationships with others.

Trusting relationships provide a safe environment in which young children can experience challenges in ways that support them and help extend their abilities to cope. Strategies that rely on psychologically or physically harsh responses weaken young children's sense of safety within relationships and can lead to reduced social and emotional competency.

Parents who have a low sense of safety, either for themselves or their children, may respond inappropriately or inconsistently in situations where guidance or discipline is needed. For example,a parent who has grown up experiencing chaotic or unsafe living situations may have an outsized reaction to her toddler's exploration of a new (safe) play space and may panic and yell for him and pick him up if he moves out of her sight.

Or the opposite could be true—the parent may perhaps appear uninterested in the child's exploration even if there are potential dangers, which can lead to the child feeling physically and psychologically unsafe with the parent. Working with families to increase safety and awareness of each member's fear-based and safety-based responses can create possibilities for significant movement toward nurturing strategies.

Trustworthiness and Transparency – Trusting relationships with parents and other important adults help buffer children's tough or stressful experiences. When parents are able to share in their children's highs and lows of the day, acknowledging and labeling these feelings and experiences, they are helping young children learn more about themselves and how to make different choices, if needed. These actions help build trust in the child's relationship while also providing supportive guidance. Providing words to describe feelings and states of being (e.g., tired, hungry, overwhelmed) helps young children learn to recognize their own experiences, which makes feelings and states visible.

Parents who talk to their young children about their own (i.e., the parents') feelings and needs help build children's understanding of other people's emotional and physical states. Open communication and explanations of why one does or does not do certain things helps children link actions to emotions, accomplishments, and consequences. Open communication can also help parents reconnect positively with their children if an interaction does not go well. Being able to acknowledge mistakes or responses that were not helpful models the truism that everyone makes missteps and can learn from them to do better next time.

Peer Support and Mutual Self-Help – Nurturing guidance and discipline strategies can be integrated into everyday routines where parents partner with their very young children to help them learn about the world around them. These routines build children's partnership and connection skills as they acquire a range of daily living and self-help skills. When parents and other important adults use guidance strategies that build and maintain trust and safety, children's confidence and competence grow in learning how to be in healthy relationships, understanding how their behaviors affect others, and making choices. Nurturing guidance promotes supportive connection between partners when one or both are feeling big feelings and potentially experiencing friction between one another.

Parents and home visitors can build a supportive relationship in which each person can provide and receive information and assistance to meet a family's goals in nurturing guidance and discipline. When the parent-home visitor alliance is grounded in connection and support, difficult conversations about harsh or ineffective discipline techniques and/or family histories of violence or harsh punishment are possible.

Collaboration and Mutuality – Young children learn how to negotiate, share, and be actively engaged in activities with others when parents and important adults model these behaviors in their own interactions. Nurturing guidance and discipline encourages children to connect what they feel—emotionally and physically—with how they respond to situations and how others respond to them. These strategies help young children build a sense of *being in this life together* with their important people, which can help maintain connection when life is bumpy.

Home visitors may be in a position to model collaborative decision-making with families that have never experienced such. Working with families who may have difficult histories or practices around guidance and discipline requires home visitors to listen, observe, and learn in order to find a common starting point for conversations. Modeling how to meet others who feel or believe differently can create opportunities for parents to explore and test nurturing practices while minimizing feelings of judgment, guilt, or fault over past and/or current practices. Intentional practice to foster a sense of working and learning together can be powerful for families.

6.2.3 Nurturing Guidance and Discipline

Empowerment, Voice, and Choice – Infants, toddlers, and twos are discovering so many things about themselves and their world. As part of this learning and growing, they are developing likes and dislikes—and how to communicate about them!

They are learning about choices, consequences of actions, and limits—whether limits of their abilities or limits placed on them by others. Parents and important adults can use nurturing guidance strategies to help young children work through these experiences and help children build their growing skills of self-regulation and confidence as they work through challenges.

Families may feel uncertain or overwhelmed when thinking about changing discipline and guidance strategies. Helping parents recognize current patterns and reflect on their long-term goals for raising healthy, resilient children creates chances to make different guidance and discipline choices for their family.

Change, while often uncomfortable and not straightforward, can empower parents to make conscious decisions and be proactive in guiding their children instead of relying on habits or being reactive after something happens.

Cultural, Historical, and Gender Factors – Multiple aspects of one's culture, life history, and gender influence beliefs and attitudes about guidance and discipline, such as how to provide it, who should or should not provide it, and what behaviors warrant it. Young children are immersed within their family's culture(s) and the larger community culture. In some families, guidance and discipline may be a primary responsibility of grandparents who live nearby as part of an extended family system. In other families, women may provide early guidance and discipline for boys and girls with fathers taking more primary roles with their sons as they enter elementary school years.

Family discipline histories can play a significant role in shaping new and emerging parenting roles. The strategies established in one's own childhood are the most practiced, most automatic, and easiest to use when a need arises for guidance or discipline—even if those are NOT the strategies that a parent WANTS to use moving forward. It takes time, practice, and a willingness to feel vulnerable to learn different ways of guiding children and providing discipline when needed. It is literally rewiring a caregiver's brain connections to think and act differently.

The Science: Why Nurturing Guidance and Discipline?

The early years are full of firsts for very young children and their parents. Children's self-regulation of their emotions and behaviors is a topic that is typically of high interest to parents of toddlers, twos, threes, and children who are in the early elementary school years. It is fairly common for parents to overestimate young children's abilities to control their emotions and actions in ways that adults and society expect. Parents also get a lot of advice regarding their children's behaviors, whether they have asked for input or not. Parents most often have to employ guidance or discipline *in the moment* as behaviors are happening. Yet, those immediate responses may not work well for longer-term, self-regulation goals or be the strategies that the parent would choose if he or she could think about it ahead of time.

From very young children's perspectives, all experiences are novel. Their knowledge of limits, safety, expectations, and social connections across life experiences is very limited. It will take years—literally—for them to develop a self-history and self-awareness that can provide insight and practice opportunities to regulate their own emotions and reactions from the inside. Each experience is shaping their unique memory and response pathways in their brains, which connects emotions and people to experiences that are positive and negative and intense and subtle. Infants, toddlers, and twos rely on their parents, extended family members, and other important adults to be their external partners in helping them successfully negotiate their emotions and responses to every day and novel experiences.

The strategies parents and caregivers use to provide guidance and discipline matter! The research on using consistent, positive, and nurturing guidance strategies continues to show positive short- and long-term developmental outcomes for young children. Research on the use of physical and power/fear/shame-based strategies, whether occasional or routine, strongly indicates that there are no positive developmental outcomes, short-or long-term, for children's healthy development. Rather, developmental harm occurs due to the punitive and harsh nature of these strategies, which interrupts young children's abilities to build healthy social and emotional regulation skills and influences their brains, so learning and engaging are more difficult.

Developing a routine of using nurturing guidance and discipline strategies requires that parents understand what their child's behaviors are communicating. It also requires parents to recognize their own reactions to their child's behaviors and the situations in which they occur. Parents must anticipate challenges before they happen, think through their response choices, and reflect on past and current experiences to make decisions about future responses.

A quick note about intentional language used in this chapter: Discipline versus Punishment

Discipline is used to describe strategies that are instructive and constructive, which means they do not physically, verbally, or emotionally harm the person who is the target of the discipline. The goals of discipline are to guide the targeted person to a desired alternative behavior, not just stop the unwanted behavior, and to do so in a way that shows respect and meets the person where they are in that moment. Discipline is non-violent and combines empathy and firmness to redirect and teach.

Punishment is used to describe harsh, neglectful, or abusive strategies that may be intended to hurt or humiliate the targeted person; the goals are often to *make a person pay* for misconduct through physical and/or emotional pain and usually only focus on getting the undesired behavior to stop. At times it can be violent. Violent or not, punishment comes from a place of power to coerce a person to bend to another's demands without regard for the target person's dignity.

Children's Development and Positive Parenting Practices

The most rapid and detailed brain development in humans occurs during the first 3 years of life. Supportive and safe care is one of the three pillars of healthy brain development during this key period of development. The three pillars are sleep, nutrition, and supportive and safe caregiving and physical environments. During the first 3 years of life, the infant's brain is working hard to do the following:

- Set up all the basic infrastructure to process, connect, and make sense of sensory input;
- Develop pathways to build and control body movements and functions; and
- Build the basic working models of relationships through interacting with important people in their lives.

More specifically, early brain development focuses on the parts of the brain that develop emotion, connection, and the assessments of and responses to people and things as either safe or threatening. The first 3 years are critical for building the child's foundation of how and when to engage with others, explore their world, and seek support.

From the preschool to early elementary years (i.e., ages 3 to 8 years old), brain development shifts to parts of the brain that focus on thinking, pattern-building, and problem-solving. These skills are necessary for school readiness in reading, math, and music. The brain continues to specialize and adapt throughout the lifespan. Yet, early experiences form the basis of later changes.

Nurturing Guidance and Discipline

Nurturing actions are part of building a safe and supportive caregiving environment. Nurturing guidance and discipline strategies help parents anticipate safety issues, set expectations of themselves and others, and identify elements/situations that are likely to catch their children's attention (whether the child engages or disengages) across environments, such as their own home, grocery store, or playgroup. Nurturing guidance and discipline strategies try to help children learn from and make connections between actions and consequences with the longer-term goal of helping them internalize their own regulatory language. There are several different strategies parents can use and practice and different ages at which these strategies will be more effective.

It is important to understand that discipline strategies, if applied when adults' emotions are running high, can turn into punishment. For example, a dad may use a *time out* to remove his 2-year-old from a fight over a toy with her older brother. Dad can make this a *time in*, a moment of connection when feelings are big and hard to handle, by directing her to sit in a quiet place for a couple minutes, sitting and talking with her, acknowledging her feelings, and helping her remember she can use words to tell her brother she wants a toy.

The actions of the dad in this response are appropriate, nurturing, and supportive. However, if this dad puts his 2-year-old into time out and then makes her stay there for an extended time (e.g., more minutes than her age in years) before letting her get up and does not explain why she shouldn't hit and yell, the time out has become punishment. Other elements can bring greater or lesser degrees of punishment into the time out action, such as use of shaming or belittling words (e.g., "Quit being such a brat") or threatening and/or using physical force to keep the child in the time out space.

Some types of age-appropriate discipline strategies and nurturing examples of each follow below. Notice how each example is constructive and shows respect for the young child, even if the child is having a hard time showing respect to a parent or others.

Exclusion: separating a child from an activity or group of peers where a problem is occurring

- Time in/out, as used in the earlier examples, is a form of exclusion. Setting limits also creates exclusion by putting boundaries on an activity, such as limiting how many minutes an activity, like playing with videos or blocks or being on a swing, can be done.

Redirection: changing a child's focus and attention to a different activity

- When a toddler is interested in pulling things out of containers and has found the trashcan, redirecting her to the kitchen cabinet with storage containers lets her continue to explore without the hazards of trash items. Parents can describe clean things to play with and that leaving trash or dirty things in their place is important.

Natural consequences: child experiences the direct results of his or her actions

- A 2 ½-year-old wants to wear his footie pajamas to day care because they are superhero *jammies*. But it is summer, and these are thermal. It is OK for him to wear them and experience being hot. Parents can talk to his teachers, and they can make sure he has a change of clothing and drinks plenty of water. This addresses potential safety issues while still letting the child learn from his choices.

Related, logical consequences: the consequences are related to the actions of the child, but the adult is the one imposing them and the one who needs to explain how the discipline is related to the child's actions

- *Deprivation* – the child loses access to a toy, activity, or privilege
  - A 2-year-old is throwing blocks, even though the family rule of not throwing things has been said many times, "We don't throw things in the house." You walk to him and gain his visual attention, and direct him to stop because this is not OK in the house. "If you want to play with blocks, you cannot throw them. If you want to throw the blocks, I will put them away because it is not safe." Parent then follows through with the actions needed.
- *Logical consequence with social reciprocity* – the consequence is related to the child's action and directed by the parent, which models how others will change their responses based on what the child does
  - A 3-year-old pours milk from her cereal bowl onto the floor. Her parent responds, "Hmm, looks like there is a bit of a mess to clean up. What do you need to clean up the milk? Let's figure out the steps together." The parent continues the conversation to direct the child through the cleanup process. If the child refuses to clean/help clean, the parent can tell the child that cereal may not be a meal option again until she decides to practice being careful and, if a spill happens, is willing to help clean it up. Messes and accidents are going to happen, but we can learn from them and be helpful when they happen.

Nurturing guidance comes through in the language used in everyday interactions and routines, the efforts parents and caregivers take to create environments that minimize having to say "No!" or that are unsafe, and the ways that parents reflect their own emotional experiences back to their children. These strategies, the language, and the tone of delivery convey a sense of respect for the child and his or her experiences while also guiding the child toward a more desired behavior and/or through practicing early coping and comfort strategies. When young children know and trust that their important adults will be their partners through tough times, it lowers their stress reactions and lets them stay connected and feel safe even though things are hard.

For example, a mama who integrates partnership language into daily routines by talking to her infant about how he is participating in feeding and bathing times is practicing positive, connecting language that conveys respect through tone and words. When a child drops food off his high chair to see what happens, mama can show nurturing guidance in many different ways. She can use words to describe what is interesting about dropping things and having someone pick them back up and maybe hand him a toy to drop instead of more food or place the high chair in a spot where dropping is not going to be a problem for cleanup. She can also start talking about how many more times she will pick it up, which is the beginning of communicating limits.

This example, above, is one that is *low stakes* and has no imminent danger factor that could intensify the responses of the parent. What might a *higher stakes* example with potential danger look like with nurturing guidance? Let's say this little guy loves water and bath time as he becomes more mobile. One day he toddles off to try to play in the toilet water, so his mama can talk about safety and express how the infant's playing in water scared her. She can show how she keeps him safe and talk about how he needs a buddy like his mama anytime he wants to play with water. Then, she can redirect his attention to supervised water play or plan such a time in the near future.

As these experiences are likely to happen again, repeating the similar types of guidance and redirection provides consistency for her child and guides him away from certain variations of these actions and towards safer variations. Nurturing responses require thoughtfulness and emotional management of the parent's own reactions. Repeating and using similar strategies across appropriate situations also helps this parent become more skilled in using these strategies and in learning when they may be more or less effective, depending on the specifics of the context.

Children's Development and Harsh/Neglectful Parenting Practices

Harsh practices weaken the parent-child relationship in several important ways that may not always be visible at the moment of their use. As defined above, these practices generally *are* viewed as punishment—causing harm and distress to the young child in order to stop a specific behavior. Whether the strategies use physical violence or not, harm occurs through the intention to cause physical or psychological pain. The intention to cause pain, using the power of being bigger, having authority, or using the parent-child relationship to coerce change, damages the child's sense of safety and trust for the person inflicting harm. Such practices may stop the undesired behavior, but they fall short in guiding a child to acceptable alternatives. They also do not show a young child better options one could choose next time.

Harsh practices also make children's emotional distress more intense instead of providing a supportive connection that helps them feel their big feelings, learn to recognize them, and then start learning how to regulate those feelings with help from their parents. It is important to realize that violent and non-violent punishment are harmful. Further information about both forms of punishment follow on the next pages.

If young children's caregiving environments are threatening or neglectful, their potential to develop positive, trusting social connections and a healthy early sense of who they are become inhibited. Early and chronic exposure to neglectful and threatening caregiving environments has measurable long-term impacts on developmental outcomes. For example, children living in these environments have more difficulty as they enter the preschool and early elementary years. It can be more difficult for them to make friends and get along with others due to limited positive social and emotional skill opportunities, and they may have developed a sense of mistrust or wariness of unfamiliar adults.

The skills they have learned to survive in their environment do not promote exploration and engagement with new people or experiences, including formal learning (e.g., reading, math, music). In fact, children who receive punishment strategies are more likely to become aggressive towards others, including bullying other children, have higher anxiety and lower self-esteem, have lower self-regulation of emotions, fear their parents and caregivers, and have an increased risk of behavioral and mental health problems.

Physical (Corporal) Punishment

Research over the past 50 years, across the United States and around the world, has consistently shown that no form of physical punishment has positive outcomes for improving children's behaviors, self-regulation, or responses to challenging situations. This body of research has informed school and public policies and even national law in global communities. Spanking and other forms of physical punishment have been removed from the disciplinary options in many schools and treatment facilities and have been completely outlawed in 59 countries between 1966 and 2018 (e.g., Iceland, most of South America and Northern Europe, Mongolia, New Zealand, South Africa, Kenya, Israel, Spain, Portugal). This connection between physical punishment and poor short-term and long-term outcomes for children holds true, whether parents or caregivers use it occasionally or as their consistent disciplining response. The degree to which children experience adverse outcomes is related to how often punishment is used (e.g., about once a month or at least weekly/daily) and how harsh or violent the strategies are (e.g., sending a child to bed without dinner [that is, withholding something that is needed] versus hitting—with or without a tool).

This information can be tough to share with parents who are immersed in the broader U.S. culture. It could even be a bit challenging to some home visitors and other parent educators. Even though use of physical punishment has dropped over the past 20 years in the United States, many parents still think of it as an option in their disciplinary toolbox. Even more adults have a belief that moderate/light spanking and other *light* versions of physical punishment are OK in the long run. Usually adults who voice this belief add in something similar to "I was spanked, and I turned out OK." Or, "Scriptures say 'Spare the rod, spoil the child' and 'I don't want my kids to be brats.'" These types of statements are important windows into parents' discipline belief systems.

They are also opportunities to start conversations that may have a lot of emotions and memories that parents did not know were there or were going to come out.

Adults who grew up in an environment with physical punishment often have some discipline beliefs that link power, love, and violence together. Sometimes, particular emotions shown by parents are mentioned when reflecting on their histories, typically anger, fear, and/or shame. However, many adults who experienced physical punishments, including spanking, pinching, slapping, bruising holds, or being made to eat soap or hot pepper, do not register those actions as violence. Adults often reflect on the power difference (e.g., I was just little, I didn't know how to control myself) and the love they associate with the action (e.g., she slapped me because I was rude and she wanted me to be respectful). It is actually not surprising that adults might not recognize these actions as violent.

Most parents and caregivers love their children, and children start to link the punishment strategies they receive with that love, *which builds one's belief from an early age that physical punishment is a normal part of love.* It becomes part of the young child's socialization and normalizes that certain violent acts are acceptable within a trusting, loving relationship. Becoming aware of thoughts that link love, power, and violence and deciding to put aside those thoughts and build new ones using nurturing guidance and discipline are big tasks.

Psychological Punishment

Not all forms of punishment cause physical distress or pain. Parents and caregivers may use fear or shame-based strategies that focus on causing emotional distress to stop an unwanted behavior. These might include threatening to take away an object that is important to the child or withholding something that is necessary for her well-being, like a favorite comfort toy or withholding food until the next meal if she wasn't hungry at an earlier meal. Isolating a child for an extended period of time, like initiating a time out, using emotional blackmail by threatening love withdrawal, yelling, manipulating the moment to place blame on the child for how the parent reacts, and saying humiliating or shaming things to a child are all tactics intended to inflict emotional pain. Again, the desired result is to stop an unwanted behavior, but the use of psychological power and coercion undermine a child's sense of safety and trust in ways that are very similar to using physical punishment. There are long-term, negative effects for children when parents use emotional distress to try to control behaviors.

Adults who have experienced psychological punishment also often have unhealthy connections among love, power, and violence. In these instances, the violence is at the emotional level. Parents may describe how their parents would coerce them by saying things like, "Don't you love me anymore? You better straighten up, or you will regret it." Or, their parents would shame them by saying something like, "Why are you crying like a baby? I told you to put that truck away. Stop that crying. This is what you get when you don't listen." Adults with this kind of disciplinary history often recognize at least some of their memories as harmful and state intentions to parent differently with their own children.

Helping Families Move Toward More Nurturing Responses

One way to approach conversations that discuss punishment is to talk about building feelings of safety and stability in the caregiving relationship. For very young children, feelings of safety and stability are strongly linked to their understanding that they can depend on their parents and important caregivers for support. When parents respond to a child with their own anger, fear, or other intense emotions leading the response, the child's stress levels increase and they try to sort out whether to fight, run away, or freeze. It is a double whammy of survival emotions for each partner.

When they are angry, afraid, or emotional, parents tend to fall back on actions to stop a behavior that are part of their life experiences. These memories are the most familiar to them and most accessible in their minds. Parents' well-established response pathways hold years of personal experiences with guidance, discipline, and punishment. Helping a parent move toward nurturing responses and away from punishment is the work of helping rewire the parent's brain, laying down new response patterns, and reinforcing these patterns through practice.

Here are some examples of experiences that could provoke a range of responses and potential responses to those behaviors. We know young children are curious and do not have a keen sense of danger or how their own actions can impact others. There are all sorts of near misses that can happen throughout a day, and, as parents and children experience other stressors or hassles, reactions and responses can build up. A reactive, punishment response is given first, and a nurturing discipline alternative is given second.

A toddler tries to push a fork or stick into an electrical outlet to see if it will come out on the other side of the wall.

Punishment response: His mom sees the danger in this action, rushes over, and slaps the toddler's hand away from the outlet while yelling, "NO! Don't do that!"

Nurturing response: His mom sees the danger in this action, rushes over, and picks up the toddler thereby removing him from the current danger. Mom holds him close and explains that what he was doing was not safe, and it scared her to see him in danger.

She finds the outlet cover and puts it into place and tells her son these covers help keep him safe. If he is persistent in wanting to explore, she may find some other activities in which he can practice pushing his stick or fork into nonharmful items.

6.2.3 Nurturing Guidance and Discipline

A 2-year-old has a meltdown after a swim lesson at the YMCA. It is naptime, and she is tired. She wants to be carried to the car, but dad is juggling a bag full of swim gear, wet towels, and paperwork for the next set of classes and asks his daughter to walk beside him instead. She falls down onto the sidewalk weeping intensely.

Punishment response: Dad shifts what he is holding, grabs his daughter by the arm, pulls her up, and tries to walk with her resisting and crying. "Get up! It's only a few feet, and you can walk that. Don't make me spank you!"

Nurturing response: Dad stops and sits next to his daughter on the sidewalk. He puts down all the things he is holding and gathers his daughter into his lap, letting her lean into him to share her big emotions. "It's OK. I know you are tired, and it is hard to do things when you are tired. I'm going to hold you right here until we both decide we can finish the next few steps to the car. I will buckle you in and then you can relax. I'll drive us home for naps."

A 7-month-old bites her mother's nipple with her new teeth that are coming through during a nursing session.

Punishment response: Mom stops the nursing session completely, swats her infant on the bottom to get her attention, and says "You don't bite Mama. If you bite again, I'll swat again!"

Nurturing response: Mom stops the nursing session for a moment and distances her infant so she doesn't bite again. Mom runs her finger across the baby's gums, "I can feel your teeth and you are learning how to use them. Let's learn to be gentle. Biting hurts Mom." Each time her infant bites, she pauses the nursing and pulls baby away to remind her not to do that during nursing.

Through a Young Child's Eyes

Guiding Behavior

0-6 months

I can feel when you are calm, and I can hear and feel the tension in your voice and arms when you are upset or angry. When you are calm, it can help me feel calm and safe when I'm upset.	My crying can stir up deep feelings. It can feel like I am *trying to get you*, but that is not true. Please hang in there. Try to understand what my crying is telling you and respond. Sometimes, I just need you to hold me and be supportive. I will figure this out with your help.
Crying is the main way I *talk* with you. You can also watch my expressions, listen to my sounds, and watch how I move—for example, when I look away. This may mean that I need a little break from talking and playing together.	The research is in. There is no such thing as spoiling a baby. Please come to me when I cry and try to figure out what I need and help me with it. Your supportive responses help me build trust and feel safe in our growing relationship.
Crying can be hard to be around. I may cry a lot during these months and that is normal. I'm doing a lot of growing, and it can be hard to regulate myself when things are changing so quickly.	When you soothe and comfort me, you are helping me begin to learn how to soothe and comfort myself when I am upset.

Through a Young Child's Eyes

Guiding Behavior

6-12 months

You are the center of my world. I pay attention to what you say and do—with me and others. I repeat actions and sounds back and forth with you. Showing me how to behave is even more powerful than telling me how to behave.	When you soothe and comfort me, you are helping me continue to learn how to soothe and comfort myself, when I am upset.
Crying is still my main way of communicating. I watch you to see if I need to cry to get your attention. I can also move to you, reach for you, and point to things I want. I can let you know you are helping me by snuggling, smiling, babbling, and cooing. We are creating our conversation style as we go back and forth.	Baby proofing our home can cut down on telling me "No!". When our home is safe, life is easier for both of us.
You've become an expert in understanding my cries, but they can still stir up deep feelings. I still only have a few months of practice in being a partner. I am not trying to hurt your feelings. I need you to gently guide me. I'm exploring and learning and can get overwhelmed with my discoveries. Please hang in there. Try to understand what my crying, fussiness, or distress is telling you.	With your help, I am learning how to control my own behavior. Notice and comment when I do so. For example, when I shake my head and push a spoon away at breakfast, ask "Are you finished? Would you like to get down? Thank you for letting me know you are full. Let's clean hands and get out of the high chair."

Through a Young Child's Eyes

Guiding Behavior

12-18 months

You are my safe base of exploration. I want to know where you are as I explore and check in with you every few minutes. I check to see if you think I'm safe. I mimic your actions and expressions. Showing me how you feel helps me understand how I feel.	I have more skills to get into things that can be risky for me. Updating the toddler-proofing in our home can cut down on telling me "No!". When our home is safe, life is easier for both of us.
I'm not crying as much, but my cries still tell you important things, like I'm tired and need support; I'm frustrated because I can't figure something out; I'm overstimulated and need to relieve some stress; I'm feeling anxious or scared and want to stay close to you; I'm not feeling well and need you to figure out what is wrong.	Encourage me to share but know it will take me time to get good at it. When you share with me and others, I learn sharing is important.
When you soothe and comfort me, you are still helping me to learn how to soothe and comfort myself when I am upset. Using emotion words for your feelings and my feelings helps me know what I am feeling. Showing me how you calm down shows me ways to help myself.	With your help, I am learning how to control my own behavior. Notice and comment when I do so. For example, "I notice that you were able to stop digging in the flower pot when I asked you to please stop. Thank you."

Through a Young Child's Eyes

Guiding Behavior

18-24 months

You are my social bridge, helping me learn to make friends and play as a partner. I want to be like you and will copy you. I watch you to see how to connect to others and how to treat others. Showing me how to behave and describing respectful behaviors helps me understand how to adjust my behaviors, like using gentle touches and trying simple words like "No" and "Stop" when I'm upset instead of hitting or screaming with anger.	It helps me when you use words to describe what you think I am feeling and how things also affect you. I am learning more about how I feel and how to respond to challenges and joys.
	As I get to be 2, I want to be a big kid and a baby all at the same time. It can be a time of push and pull and intense feelings. I may say "No!" even when I want the cookie you are offering me. Hang in there. No matter how confusing my behavior may seem to you, it is just me figuring out who I am.
My crying is usually pretty specific and tells you that I've reached the end of my coping abilities and I need some support. I'm making progress in managing myself for longer periods of time. But I may have a meltdown after I get home from childcare because I feel safe enough to ask you for support.	I'm still exploring and trying new things! Child proofing our home and setting up my play area, so my curiosity doesn't create problems (like safely storing markers that might end up being used on walls and floors) can cut down on telling me, "No!" When our home is safe and hassles are minimized, life is easier for both of us.
You may have helped me build some soothing routines in our 2 years together. If you start the routine, I can often find my part and we can connect and find our rhythm. Calming and soothing routines help each of us settle when we are out of sorts.	Encourage me to share but know it will take me a few years to get good at it. When you share with me and others, I learn that sharing is important. When I don't want to share something, such as a bite of food, you can show that you respect my choice by letting me keep my bite.

Through a Young Child's Eyes	
Guiding Behavior	
24-30 months	
My social connections are growing, but you are still my most important person. I want to be like you and will copy you. I'm picking up your conversational phrases of how to say hello, goodbye, "Yes, please," and "No, thank you," just like you do. If you say, "That's not nice," you can be sure you will hear me say that too!	You may feel like you are a referee, sorting out conflicts and talking a lot about what is and is not OK. It's a lot of work to let me feel big feelings and learn to manage them in healthy ways. Stick with me!
If you complain about drivers when we are going to the store, I will start to do that too! I will try out those words in different situations and in my pretend play.	I still may want to be big and little at the same time. This is a hard position to be in since that is impossible. Expect that I will have many strong feelings that I don't know how to handle yet. This is a time of testing and temper tantrums.
My crying is still a good indicator of me thinking or feeling that something is not right. I am developing a strong sense of fairness and starting to become possessive of things that are mine…or that I just really like and want. I need you to help me learn how to be fair, recognize when I am not fair or kind to others, and connect the feelings of fairness and unfairness to actions.	Sometimes my feelings are so big, I don't know how to control them. I might love playing in my bath so much that I splash you as I kick the water. I might get so angry that I hit, bite, or have a temper tantrum. With your trusting, kind, clear, and firm help from the outside, I will learn to control my feelings from the inside. It will happen slowly and surely over the next few years.
	With your help, I am learning how to control my own behavior. Notice and comment when I do so. For example, you could say, "I notice that you said, 'I am angry!' instead of hitting your friend. That was great use of your words."

Through a Young Child's Eyes	
Guiding Behavior	
30-36 months	
My social connections are growing, but you are still my most important person. Showing me how to behave and talking to me about my and other's behaviors helps me become a skilled social partner.	Keep encouraging me to share but know it will take me a few more years to get good at it. Assure me that some things I do not have to share, like my special book on dinosaurs. When you share with me and others, I learn that sharing is important.
My crying has really dropped off as I've learned other ways to communicate my emotions. I may do a quick cry-yell or screech to get a person's attention and then use my words to share what I'm feeling. When I'm overwhelmed, I will fall back on crying, because that is my strongest and most practiced coping skill.	Sometimes my feelings are so big, I don't know how to control them. I might love riding on the strider at school so much that I go too fast and run into a classmate. I might be so overstimulated from a birthday party at the park that I just can't manage myself when we stop at the grocery store. I'm not really that upset about not getting my favorite box of cereal; that is just the thing that set off my meltdown from a full day.
I'm becoming more skilled at sharing and understanding other's feelings. But I will make mistakes. Sometimes, I will try hard to get a friend to do what I want because I feel very strongly about it and I may run right over their feelings.	With your trusting, kind, clear, and firm help from the outside, I will learn to control my feelings from the inside. It will happen slowly and surely over the next few years.
Continue to show me how to be kind and fair and respectful of myself and others.	With your help, I am learning how to control my own behavior. Notice and comment when I do so. For example, you could say, "I notice that you shared part of your sandwich with Grandma. That was being very kind."

Punishment and Child Maltreatment

There are some specific safety concerns for young children whose families plan to use, or who are already using, strategies that inflict physical or psychological pain, fear, or shame to control their young child's behaviors. As a home visitor, you are very likely a mandated reporter. As such, it is important to (1) recognize observable signs of maltreatment from neglect to abuse; (2) know who you need to notify in your practice and beyond; and (3) what to do if you believe an urgent response is needed to address immediate safety needs of the child(ren), other family members, and/or yourself.

Observable signs that could reflect maltreatment of infants, toddlers, and twos are listed below and the list starts with one that is particularly important for this age group: Shaken Baby Syndrome. Some caregivers may have little understanding of their own reactivity to hearing an infant, toddler, or two cry. In an effort to get the crying to stop and lower their own distress (e.g., anger, frustration), caregivers may resort to shaking a child.

Within the birth to 5-year age range, signs of neglect or abuse are not always easily and quickly recognized. Very young children may be pre-verbal and, therefore, unable to use words to describe what they are experiencing. For young children who are becoming verbal, the words they choose and actions they describe can be a window into their experiences that communicate there is something atypical occurring. Young children's behaviors are also forms of communication. Crying and other distress behaviors signal needs that adults should view as part of understanding a young child's sense of safety within her caregiving environments. Work closely with your supervisor and colleagues to understand what your legal and ethical responsibilities are and which observations and parent-child interactions may highlight potential maltreatment concerns.

Some observable, physical indicators that neglect or abuse of a very young child may be occurring include the following:

- *Failure to Thrive* (*please see more information in the chapters on Building Trusting Relationships and Nutrition and Feeding*)
- Chapped or bruised skin around the mouth area
- Unexplained bruising, burns, black eyes, cuts, bite marks, broken bones
- Chronic diaper rash and/or yeast infections, urinary tract infections, pain, bleeding, or bruising in the genital area
- Difficulty walking or sitting, potentially due to genital or anal pain
- Repeat injuries

Some observable, behavioral indicators that neglect or abuse of a very young child may be occurring include the following:

- Changes in normal behaviors, such as becoming withdrawn, angry, or afraid of parents or other adults
- Crying and other protests when it is time to go to a regular place, such as day care or appearing frightened of their caregiver(s)
- Avoidance and distress behaviors (e.g., avoiding eye contact, hand flapping, rocking, arching back when held, shunning affection by parent)
- Regression in development (e.g., stopping talking or communicating, developing a stutter, losing progress in toilet learning)
- Reluctance to take off layers like coats/sweaters or insist on wearing multiple pairs of undies, vigorous protest of diaper changes
- Demonstrate sexual knowledge, curiosity, or behavior beyond typical age-appropriate interest
- Complain of stomachaches or other body aches without known medical causes

Shaken Baby Syndrome (sometimes referred to as Abusive Head Trauma and Shaken Impact Syndrome):

The average age of victims are 3 to 8 months old; the highest risk window is when infants typically cry more often (i.e., between 6 and 8 weeks old). It is the leading cause of death in child abuse cases in the United States; 1 in 4 cases of Shaken Baby Syndrome result in death in the United States. This injury occurs when a caregiver forcibly shakes a child or strikes the child's head against a surface. Infants have very little neck and head control and muscle strength, which makes this type of injury particularly severe and concussive to their brains.

Normal activities with a very young child, like bouncing on a knee, using a soothing technique that gently bounces a baby while being held close to a caregiver's chest, or riding securely in a stroller will NOT cause these injuries. Never shake a baby under any circumstances. https://kidshealth.org/en/parents/shaken.html

Your practice may use materials from the National Center on Shaken Baby Syndrome, called The Period of Purple Crying. These materials explain crying in healthy infants and how to support a crying baby while also showing parents how to care for themselves when distressed by their child's crying. https://dontshake.org/

There are legal and ethical aspects to reporting suspected child maltreatment established in each community (e.g., state, territory, and district in the United States; each country around the globe). Within your specific home visitation practice, there should be clear processes to support the safety of the child and potentially other family members and home visitors. Communicate with your supervisor and organization to make sure you and your colleagues are trained in following the required reporting protocols for safety and reporting and to determine if home visitation will continue during an open inquiry or if the report is substantiated.

Why Nurturing Guidance and Discipline Matters to Families

Nurturing guidance is the process of guiding children's behavior from the outside in ways that promote children's ability to guide their own behavior. Parents model and provide clear, firm, kind, and consistent limits as opposed to using punishment and shame as they respond to challenging behaviors. For many parents, this may be different from how they were raised. Becoming familiar with the idea of guidance that promotes self-esteem and awareness, even as limits are set, provides parents with another option to consider. This is important because, when emotions run high as they often do when parenting a young child, parents are better positioned to make decisions about what to say and do instead of reacting on auto-pilot and following methods their adults used to respond to them.

Children may have different temperaments than their parents, which can lead to frustrations on both sides when reactions are very different across situations. When parents are able to understand their own way of engaging with the world and recognize how their child engages, whether similar or not, this awareness provides the opportunity to pause and consider guidance strategies that are more effective in supporting their child. Growing one's reflective and perspective-taking skills takes time and practice. A parent who responds in a nurturing manner to her toddler's challenges at breakfast may have a moment of melt-down at the end of the day when everyone is tired and her toddler cannot soothe himself to get to sleep and stay asleep. Parents benefit from learning their own self-management strategies to cool down, take a moment, and choose nurturing guidance and discipline options over angry and frustrated reactive strategies.

Some parents you work with may be survivors of child maltreatment and/or family violence. Often in survivors, there are strong, interconnected experiences between expressions of love, power, and violence. These connections can run deep and can create a need to spend some time untangling how to show love and healthy relationship connections while providing guidance. Some parents who are survivors may be quite hesitant to do any guidance or discipline because they believe all options could be hurtful to their child. Other survivor parents may not realize that love, power, and violence are connected in their thinking until they react to a discipline situation with physical or verbal force. These parents may benefit from relationship or counseling work that is beyond the scope of home visitation. As a trusted partner in the home visitation relationship, you may be able to facilitate the referral of such parents to appropriate resources while you continue to work with them to build their skills in using nurturing guidance and discipline in the caregiving context.

Boots on the Ground: Everyday Moment Conversations with Families

This section highlights content and skill-building strategies you can use as you plan your home visits. For the *Everyday Moment* section of the visit, you will find a list of topics to choose from and to explore in conversations about nurturing guidance. For each topic, you will find the associated *Protective Factors* and *Trauma-Informed Principles* addressed. *Family Pages* designed to support your conversations are listed next.

In addition, you will find suggestions of related one-on-one activities to choose from for the parent-child interaction portion of the visit.

There are several *Nurturing Guidance Behaviors* topics to choose from as you plan a visit to a family, and you should tailor the conversation to that family's specific needs and interests. You may find that you discuss one topic now and come back to discuss another in a month or two depending on certain circumstances.

Using the information you have about a family's *Protective Factors*, you can guide your curriculum choices to tailor the home visit discussion and activities. Ideas are presented below with their associated icons to highlight how they correspond to meeting a family's needs and building each family member's resilience. These include the following:

Parents' experiences with and expectations for nurturing guidance

Concrete Supports of Families can be vital for families that have a history or risk of violence. Knowing local resources for safety and support and being able to access them if or when needed can reduce risks of family violence, including harsh and punitive discipline strategies.

Parental Resilience is built when parents are able to reflect on their early experiences of guidance and discipline and make decisions for how they want to provide nurturing guidance and discipline for their child(ren).

Why nurturing guidance matters

Knowledge of Parenting and Child Development and

Social and Emotional Competence of Children can help parents recognize that children's behaviors, whether positive or challenging, have meaning and that these behaviors are ways children can communicate what they are experiencing and connect to a trusted adult.

Keeping a child safe while guiding behavior

Parental Resilience and

Knowledge of Parenting and Child Development can reduce parents' risks of reacting to challenging behaviors in ways that cause harm. Parents who can recognize their own emotions and reactions are better able to manage their responses in constructive and supportive way and build a set of discipline strategies that show respect for their child while also addressing challenging behaviors and situations.

Family Pages

A series of *Family Pages* on *Nurturing Guidance and Discipline* have been created to support your conversations with families while you are visiting and to become a resource parents can refer to between visits. These include:

- Nurturing Guidance from a Child's Point of View
- Crying
- Temper Tantrums, Hitting, Grabbing and Biting: Toddlers and Twos
- Testing Limits: Toddlers and Twos
- Sharing
- First Friendships
- Screen Time
- Partners in Teaching Cooperation
- Focus on You: Looking Back and Moving Ahead with Your Child
- Practical Applications for Families: Figuring It Out Together

Related One-on-One Activities

These are suggested activities to promote nurturing guidance and discipline. There is a broad selection of one-on-one activities available in the Activity Card deck.

- Notice and Wonder: How does your child respond when testing a limit (e.g., a rule like being kind to others) and how do you guide his behavior to help him regulate his actions and emotions? What words and actions from you help him?
- Introduce games that teach about following directions: Simon Says; Red Light, Green Light; Hokey-Pokey.
- Play with bubbles, practicing breathing and calming strategies when emotions are big.

Book and TV suggestions (*watch with them!):

- *Daniel Tiger's Neighborhood* (PBS) and the *Daniel Tiger* book series focuses on emotion regulation with practical strategies
- *Alexander and the Terrible, Horrible, No Good, Very Bad Day*, by Judith Viorst

Additional Resources

Community, Physical, and Mental Health connections include:

- Childhelp National Child Abuse Hotline 800-422-4453
- Period of Purple Crying https://dontshake.org/
- All Babies Cry (Parent-focused website with videos and practical tips from The Children's Trust) http://www.allbabiescry.com/
- Child Welfare Information Gateway "What is Child Abuse and Neglect? Recognizing the Signs and Symptoms" https://www.childwelfare.gov/pubpdfs/whatiscan.pdf

Everyday Moments 6.3 Parenting Life

Parents are the magic ingredients young children need to THRIVE. The parent-child relationship is one that will last across the miles and years. This doesn't mean parents have to be perfect. There is no such thing as a perfect parent…or a perfect baby…or a perfect anyone. It also doesn't mean parents can or should try to do it alone. Every parent needs the support of other adults.

Raising a child is an awesome, challenging, exhausting, rewarding, demanding, life-changing task. Over time, parents continue to learn about their child(ren) as they interact during daily routines and play time. Together, each parent and child create their own unique *dance* that reflects their temperaments, preferences, interests, and culture.

In this section you will find chapters and *Family Pages* that will support you in conversations with families as you discuss transitions to and in parenthood—whether parenting solo or as part of an extended parenting and caregiving team; parental self-care; and living and parenting through loss and grief.

6.3.1 Co-Parenting and Sharing Care

Parenting together and finding trusted partners to share in the care of children are significant tasks of parenthood. These important others often include extended family members, close friends, healthcare providers, early care providers and teachers, and neighbors. When co-parenting and extended care relationships are healthy and stable, they build parents' sense of safety and connection and provide additional early models of healthy, nurturing, and trusting relationships for very young children. In this chapter, parents are invited to consider reasons why co-parenting and sharing the care can evoke strong feelings, and they learn how to build genuine partnerships with a shared focus on the best interest of the child.

6.3.2 Parental Self-Care

Parents taking care of themselves is a win-win for parents and children. This is true for moms and for dads. Self-care activities help parents refuel their emotional and physical energies. It can help parents be healthier, more focused, and optimistic—even when the road of life gets bumpy. In this chapter, parents are invited to see that self-care is not about being selfish but, instead, about being aware of what they already do to support their well-being and building upon this as needed.

6.3.3 Loss, Grief, and Growth

Parents and young children can experience a wide range of losses and adversities during the early years of family life. It can be helpful for home visitors to understand the ways in which grief can impact individual and family functioning. Home visitors may need to offer information to families about ways very young children process losses compared to their parents and even older siblings. It can also be stressful for home visitors to work with grieving families, so this chapter offers ways to provide empathic, trauma-informed support while not taking on the role of a bereavement counselor. In this chapter, parents are invited to learn about their own grief processes and those of their young children. In addition, parents can learn about the ways that loss and grief can be catalysts for change—big or small—that can support individual and family well-being despite adversity.

Main Elements

Content Areas

- Teaching About Co-Parenting and Sharing Care: *Protective Factors* and *Trauma-Informed Principles*
- The Science: Diversity in Families; Transitions to Parenthood; Co-Parenting, Fathering, and Gatekeeping; When Relationships End
- Why it Matters to Families: Building a Team of Care Support; Reducing Conflict
- Home Visit Activities and *Family Pages*
- Important Safety Supports and Knowledge: When Co-Parents or Other Caregivers are Not Safe

Teaching About Co-Parenting and Sharing Care: Protective Factors and Trauma-Informed Principles

Parenting together and finding trusted partners to share in the care of children are significant tasks of parenthood. Many parents will parent together as part of their committed relationships. Other parents will spend time parenting alone; parenting alone while connected with a partner who is geographically distant (e.g., due to military temporary duty or deployment, long-haul trucking); or working to parent together while not being in a romantic, legally committed relationship with each other. In addition, some parents will make decisions to sever a co-parent relationship, legally, emotionally, or both. However, a family's parenting system is configured, parents still rely on important others to help provide emotional and physical care for their young children. Important others often include extended family members, close friends, healthcare providers, early care providers, teachers, and neighbors.

These relationships are vital for parents and their children and contribute to the well-being of the family system through good times and bad. When co-parenting and shared-care relationships struggle, parents have to assess whether to maintain, change, or dissolve connections that are important to themselves, their children, and/or extended family members. When co-parenting and extended care

relationships are healthy and stable, they build parents' sense of safety and connection, and they provide additional early models of healthy, nurturing, and trusting relationships for very young children.

The act of co-parenting is an intentional effort between two or more parents to coordinate daily care and living tasks and family roles and responsibilities, to make family decisions and work through differences while keeping children's interests at the center, to share knowledge of a situation or topic that a partner might not know or appreciate (e.g., the teacher in a child's classroom is ill and a long-term substitute is coming in or styling their two-year-old's pony puffs for picture day), and to support one another when a partner needs a moment (or several) of relief from a high-stress parenting situation. Co-parenting relationships are developed across all family types when there are two or more adults who assume a primary caregiving role in a family system. Here are just a few examples of family members who could be part of a co-parenting team:

- A heterosexual couple, living together and legally married, no previous marriages/children;
- A same-sex couple, living together and legally married, maybe a previous marriage and maybe with children from that marriage;
- A single parent whose ex-partner has remarried, with shared custody and step-children, all parents providing emotional and physical care;
- A single parent whose own parents are actively helping raise their grandchild(ren);
- A married/committed couple who only lives together part-time due to work, with the non-traveling partner carrying the parenting load as a geographically single partner, maybe with virtual connection (e.g., Face Time, Skype) routines for the traveling partner;
- A married couple who both travel for work and have formally (but it might be informally, too!) designated close friends or family members to provide daily emotional and physical care for their children when both are not at home; and
- A single parent who has siblings actively providing care and nurturance for their nieces or nephews.

Many of the principles of co-parenting also apply to extended caregivers. Within each shared relationship, parents need to be able to coordinate with another person to ensure their young children receive care, nurturance, safety, and exploration and learning opportunities.

Differences in styles of care may be more expected and visible within these extended relationships, such as the teacher's expectations that 3-year-olds change their own shoes when arriving or leaving preschool compared to Mami putting on and taking off the child's shoes at home because it is more time efficient. There is typically a range of differences that parents accommodate when coordinating with co-parents and extended caregivers, but safety is one of the first issues parents often highlight as a significant challenge when there is disagreement or concern, such as safe sleeping arrangements or supervision on a playground.

TRHV can help parents recognize key features of sharing care of their very young children with others and keeping their children's well-being at the heart of these relationships. This means home visitors need to be able to listen to how families describe themselves and their relationships, ask questions that encourage trust when there may be discord within or concerns about a co-parent's or caregiver's practices, model how to advocate for children when exploring new or potential caregiving relationships (e.g., talking with the child care director before selecting their care), and engage in constructive discussions when there are different expectations or practices between co-parents and caregivers.

This chapter helps to address the following *Protective Factors*:

- ***Social Connections***
- ***Concrete Supports of Families***
- ***Parental Resilience***
- ***Knowledge of Parenting and Child Development***
- ***Social and Emotional Competence of Children***

Teaching about *Co-Parenting and Sharing Care* offers opportunities to model the following *Trauma-Informed Principles* in the parent-child and parent-home visitor relationships:

Safety – Safety is a key characteristic of healthy relationships, physically and psychologically. Parents who feel unsafe within important relationships are likely to use strategies to reduce their sense of vulnerability and dependency on others. This could include limiting or reducing the number of co-parent and extended caregiver relationships or developing a family safety plan, which gives direction to resources and steps a person can take in a crisis situation to address current situations in one's daily life.

Home visitors are often mandated reporters, and it can be helpful to parents to remind them of this status and what it means for working together and building healthy parameters for relationship and caregiving safety. When parents feel safe, they can reach out to others more freely. In turn, an increased sense of safety for parents can positively influence young children's sense of safety and enlarge their caregiving *Circle of Support*.

Trustworthiness and Transparency – Healthy co-parenting and extended caregiving relationships are honest, stable, and supportive. Parents believe they can trust that their co-parents or other caregivers have similar goals in caring for their child(ren). In healthy co-parenting and extended family relationships, discussions about care, nurturing guidance, and concerns are open, and decisions are shared and then supported. When caregiving partnerships have low trustworthiness or transparency, parents tend to feel more uncertain and anxious about the quality or consistency of the care their child is receiving. Trust can be negatively affected when there is miscommunication between care partners, whether intentional or unintentional. Parents may make decisions to limit or end a caregiving situation if trust cannot be (re)established.

Home visitors can work with parents to help them define what they see as trustworthiness and transparency for sharing the care of their child. Sometimes parents will disclose a difficult or traumatic experience in the course of home visitation services. Home visitors are often mandated reporters; therefore, they must clearly state what a disclosure may mean legally and ethically. When a home visitor's actions match what is stated by the home visitor, parents realize this is a relationship that can be trusted—even if difficult actions may need to be taken.

Peer Support and Mutual Self-Help – Healthy co-parent and care partnerships offer support to each person in the relationship. This support is built and strengthened through mutual focus on the well-being of the child. For example, a co-parent can step into a more active role for a sick child and give his or her partner, who typically does more intensive care, a break; a partner can support the co-parent's autonomy to decide on what activities are chosen for one-on-one time with the child instead of leaving a list of preferred activities; or a child care director can say, "Let's go talk for a moment. I'm noticing some behavior changes and would like to learn if we can do some things better for you and your toddler." When there is a lack of mutual support, one or more care partners may feel the relationship is one-sided and dictated by the partner who has more power or influence.

Home visitors and parents can build a relationship that honors and respects what each person brings into the relationship. Home visitors may have information that parents do not, such as using coaching strategies to show parents how they can advocate effectively for their child's needs. Parents can share information that is specific to their family circumstances. When each can offer the other something useful and valuable to this partnership, the work and focus on the family becomes more relevant and tailored.

Collaboration and Mutuality – Parents often manage multiple caregiving relationships in regard to their young children, and these relationships may not all have equal power between the persons. Even if there is a power difference, if those partners are willing to share their power and promote joint decision-making, the relationship dynamic becomes more collaborative. For example, if a 30-month-old has started biting his classmates when he is upset, the power difference between the early care professional and parent could be emphasized by a decision to remove the child from the program for poor behavior. Alternatively, the power difference could be minimized if the early care professional approaches the parent with a problem-solving mind-set. They could work together to understand what might be going on that is leading to the problem behavior and strategize how to address it.

Home visitors and parents each have goals in building their partnership. As information about healthy caregiving partnerships and a family's specific parenting and caregiving arrangements are shared, each partner can identify and make choices that will keep the child and the family at the center of the work.

Empowerment, Voice, and Choice – Families will enter this program with a wide range of relationships, including co-parenting and extended caregiving partnerships. Almost everyone will have a mix of positive and negative experiences. Some parents will use positive experiences they have had to model their own parenting behavior or be able to identify current strengths they have in their family system that support healthy co-parenting. Other parents may have had more negative experiences. Current family and co-parenting dynamics may be uneven; one partner may assume more power and exercise his or her voice and choices over those of the co-partner. It can be daunting to make changes in a co-parenting/caregiving relationship even though those changes are likely to result in a healthier partnership. For example, parents who often find themselves in positions where they are not valued, where their ideas and actions are not respected, or where they are not allowed to make decisions, may be hesitant to step into a more active role. In the same way, parents who are used to taking the lead and making decisions may struggle to become more collaborative and support their co-parent or other caregiving partner in finding and exercising self-advocacy skills and decision-making.

Home visitors may be able to identify daily care and living routines that could become more collaborative and highlight how doing things differently from one parent to another can be positive for everyone, baby included. Sometimes, helping a parent become aware of ways he or she reacts to a co-parent's efforts is enough to start a shift toward more positive responses.

Cultural, Historical, and Gender Factors – Multiple aspects of one's life, gender, and cultural history and identity can influence ideas and expectations of how co-parenting and sharing care should be done. While cultural expectations change over time, there are still strong associations for what a good dad, mom, parent, and parenting relationships looks like.

Likewise, families with blended or less widely understood cultures (e.g., U.S. Caucasian and Korean American co-parents, parents who adopt a child internationally) are more likely to need to talk about cultural expectations for caregiving (e.g., grandparents as important caregivers, a father's role seen as primarily a breadwinner rather than active caregiver).

Sexual minority families are families with at least one parent who identifies as orientation diverse (whom one is romantically and/or emotionally attracted to) and/or identity diverse (one's innermost sense of self as male, female, neither, or both, regardless of assigned gender at birth), may not have been legally recognized or supported prior to 2015 in the United States. Parents in these families benefit from being able to talk about parenting role expectations for their own families and how orientation or identity may influence the ways they want to parent. Parents who identify themselves or their children as part of a minority group may experience additional burdens and pressure to explain or justify their experiences, ideas, traditions, and expectations to well-intentioned, but naïve, care partners, home visitors, and other professionals.

When working to support diverse families, word choices matter. This is particularly true when discussing co-parenting relationships. Reflective practice can help home visitors reduce implicit biases in attending to cultural characteristics, gender/sexual identities and orientations, parenting roles, and histories. In addition, sexual minority families in the United States continue to face legal and cultural stigmas about their family composition, such as legal recognition of parentage for a non-biological parent and societal expectations of gendered parenting roles (e.g., asking a lesbian couple which person is going to be the *father figure* or questioning if a gay, single male is competent enough to adopt and parent a girl). It is important to listen to and work with families to incorporate their preferred ways to talk about culture, gender, and cultural influences (past and present) on co-parenting and sharing care needs and expectations.

The Science: Diversity In and Keys to Co-Parenting

Diversity as a concept covers a lot of ground, including racial/ethnic/cultural aspects, age, sexual identity and orientation, religion, education, socioeconomic status, and abilities. Families identify and operate within these multiple aspects of diversity and may point to certain aspects of identity that shape their family experiences, formations, and values.

In addition, people become parents through many pathways, including natural conception, assisted reproductive technology (ART) (e.g., Donor Insemination [DI]; In Vitro Fertilization [IVF]), foster care, adoption, and through stepfamily formation. Home visitors may or may not know any of these important pieces of information ahead of an initial family meeting.

While today's families in the United States are more diverse, there are some significant gaps in the available research on parent education programming and curriculum with diverse families. These research gaps include understanding how well specific programs and/or curricula work for culturally blended families and families with parents who identify as part of lesbian, gay, bisexual, and queer (LGBQ) community. Yet, home visitors typically strive to be inclusive in their work with each of the families in their caseload and believe parent(s) and their young children benefit from integration of culturally important content and the important, identified members.

This section focuses on how current research can be useful for home visitation practice with regards to understanding the following:

- Diverse families and their transitions to parenthood,
- Co-parenting and gatekeeping patterns within families, and
- How to reduce barriers to participation in home visitation.

Diverse Families: Who is Parenting and What Circumstances Have Shaped Family Formation?

Co-parenting expectations are influenced by the parents' own history of being parented, family and professional goals, cultural and gender role expectations, and their family's unique characteristics and resources. Becoming a parent and taking on the daily and long-term tasks of parenting are similar across family forms. However, research indicates there are some specific family characteristics that often influence co-parenting relationships and engagement in parent education. Research on family composition and typical relationship tasks of new parents is summarized here for their influences on developing healthy co-parenting relationships.

Family Composition

Within the U.S. population, two-parent, first marriage families have declined from a high of 73% in 1960 to 46% in 2014. The percentage of two-parent, remarried families has remained stable during these same years, between 14% and 15%, while single-parent families have increased from 9% in 1960 to 26% in 2014. However, 2016 Census data indicate the majority of children in the United States still live in two-parent households, whether opposite-sex or same-sex, first marriage or remarriage. Here are the percentages of household types where children live:

- 63% in two-parent households,
- 23% in single-mother only households,
- 4% in single-father only households, and
- 4% do not live with any parent (e.g., extended family/foster care households).

Additionally, about 16% of children live in blended families in which there is a step-parent, step-sibling, or half-sibling. The rate of children living in blended families has remained stable since the early 1990s.

Research in the United States does indicate that two-parent families are more resource-stable than single-parent families and are able to provide more consistent, quality care for children. In many ways, this makes logical sense. Having a reliable partner spreads resources and reduces risk when one parent may not be able to share in the daily tasks and long-term commitments children need. This enables two people to cooperatively provide income for family security. However, single-parent families are more likely to build formal and extended caregiving networks to help with the daily needs and to make significant adjustments in work and family life to craft extended care arrangements that meet both their children's needs and parent's employment needs.

Single-Parent Families may encounter more barriers to participation in home visitation and parent education than two-parent families due to a lack of co-parenting resources. In two-parent families, parents may make conscious decisions about which parent will participate based in part on work constraints, expectations of caregiving, and the topics that are part of the program—especially if the topics are worded to assume the mother is the primary caregiving parent.

Same-Sex Parent Families Most couple and family research has shown there are few meaningful differences between opposite-sex and same-sex families in regard to partner relationships and children's social, emotional, and educational outcomes. Research currently indicates that when differences are significant, children in same-sex families fare somewhat better along several outcomes, such as better psychological adjustment and lower rates of externalizing problems.

Overall, same-sex parents have more in common with opposite-sex parents in the knowledge, skills, and abilities needed to co-parent and share care in productive and healthy ways. Same-sex single and two-parent families also actively cultivate *chosen families* as part of their parenting support network more often than opposite-sex two-parent families. Chosen families include individuals who are supportive in meaningful ways for the parent(s) and child(ren) in a same-sex family, whether or not they are related by legal definitions.

Transitions to Parenthood: Learning to Share Care

Across diverse families, there are common new parent experiences home visitors can recognize and, then, tailor the curriculum to better fit each family's characteristics. Co-parenting is impacted by the many moving parts of family life, and all families need to adjust when a new child comes into a family's life.

Relationship transitions and support the experiences of a couple's transition to parenthood have only recently been included as an important feature in parent education and home visitation programming. Research studies have identified particular challenges that first-time, opposite-sex parent couples report; these challenges begin in the third trimester of pregnancy and continue through the first year of parenting. These typical challenges are often part of learning that relationships change when children come into the system. First-time parents who are transitioning into a two-parent household report challenges, including adjusting expectations for themselves and their partners as parents, co-parents, and intimate partners; rethinking how family work is divided among family members; and preparing for potential changes in economic resources, such as loss of wages if a previously working parent is now staying at home or if there are additional costs associated with child care.

A few programs that focus on specific relationship skills have been developed and tested as part of home visitation. Findings indicate that first-time, expectant couples benefit from programming focused on strengthening relationship skills that foster positive co-parenting, such as supportive teamwork, effective communication and conflict management, and expectation management of parenting affection and affections between the parents themselves. Specifically, studies indicate that expectant and new parent couples report lower conflict, dissatisfaction, and overall stress after their infant arrives when they can communicate effectively about their own parenting histories and expectations for being a parent, appreciate that multiple family roles are likely to shift in response to the arrival of their child, and think ahead about the choices they will be making to support their newly expanded family.

Most of the current transition to parenthood research recommends adding relationship skill building to the more common parent education foci of strengthening caregiving skills, nurturing attachment in the parent-child relationship, building parenting competence, and practicing appropriate child guidance strategies. However, not all home visitation programs are designed to deliver content specific to some relationship skills, such as conflict management, adult emotion regulation, and effective communication. Along these lines, TRHV does not have a specific section on relationship skills but, rather, is designed to work with programs that can and do offer relationship education in addition to parent education. The curriculum also provides reflection opportunities for home visitors in the *Visit Planning & Reporting Form* where considerations can be documented, appropriate resources identified, and information shared with the family.

Co-Parenting, Father Involvement, and Gatekeeping

Research indicates that the quality of the couple relationship influences the co-parenting relationship and expectations in opposite-sex, two-parent families. In particular, marital (or committed relationship) quality has significant implications for father involvement with children and in building a strong co-parenting system. Research also indicates that mother involvement is more stable regardless of the intimate relationship quality. In addition, the research details a parenting experience called gatekeeping, which originally focused on explaining women's actions to control father involvement in children's lives, often from a negative perspective. Research on gatekeeping continues to focus primarily on mothers but has more recently broadened to also understand the ways in which mothers support and encourage father involvement and cooperative parenting.

Research indicates that children and parents benefit when parents are able to build strong and healthy co-parenting alliances. Some specific actions, attitudes, and expectations foster a healthy co-parenting relationship. Current gatekeeping research suggests elements of control, encouragement, and discouragement shape the co-parent relationship.

Each of these elements influences the tone for the co-parenting rhythm from the mother's actions and roles. The father's responses to those actions and roles start the dynamic movement of the relationship. While the research is currently limited to opposite-sex parents, this information may be applicable to same-sex parents as relationship research indicates these families have a lot in common with regard to couple dynamics.

- ***Control*** describes how family decisions are made and how much direction is imposed on childrearing and family management. *High or low levels of control are not good or bad*; the levels just describe what the mother is doing as part of the co-parent dyad.
    - *Low control* indicates the mother does not try to control father involvement, and parenting is cooperative or father-driven. For example, a father plans his own experiences with his child without interference, or both parents have agreed to their responsibilities for daily care and do not try to control or correct one another. It could also be that the mother has stepped back from the co-parenting relationship due to illness or being the main wage-earner for the family.
    - *High control* would be seen in a family where the mother is the family decision maker for child-rearing and related family management. For example, the mother schedules which activities the father will do and perhaps even supervises to make sure the task is done *properly*. In a family where the father has a demanding work schedule, this mother might plan activities or hand over a daily care task to make sure the father gets to spend time with his children.

- ***Encouragement*** is the degree to which mothers actively support fathers' engagement with their children.
    - *Low encouragement* can be the absence of any positivity or positive feedback. An illustration of this could be a mother who indicates the father is not needed for help, and, if he does help, it is not acknowledged.
    - *High encouragement* shows warmth and support for fathers. This would include things, like compliments, thumbs up, or high fives, offering support when things do not go well, and celebrating days or events focused on fathers.

- ***Discouragement*** is the degree to which mothers actively dismiss, undermine, or show other negative responses towards fathers' involvement with their children.
    - *Low discouragement* means there is no negativity toward fathers and an absence of discouraging actions. For example, if or when a father bathes his toddler differently than the mother would, she does not dismiss his strategy.
    - *High discouragement* involves actions, such as complaining about and/or re-doing tasks, undermining parenting choices, withholding information about children, and eye-rolling. In this case, a mother might be scornful of a father's actions and criticize him in front of others.

Healthy co-parenting relationships take effort and awareness of how one's actions affect others. Co-parenting is just one aspect of family life management that families must juggle and coordinate. It is no wonder that couple relationship skills have been identified as an important early skill set for building a healthy co-parenting alliance. Yet, even parents who believe their relationship is stable can benefit from thinking about how they encourage and discourage their co-parent across the many opportunities in any given day.

Co-Parenting When Relationships End

Healthy co-parenting relationships can be built and maintained even if a couple's relationship dissolves. There are some unique stressors involved in divorce and dissolution and additional stressors that are specific to each separating couple. Research and family court practices often recommend that parents need to focus on the needs of their children first, not the parent's desires for care, custody, and legal/monetary responsibility. In practice, this recommendation can be difficult to achieve. Successful co-parenting during and after divorce is possible with parents who can effectively manage their own distress through the process and interact with one another in ways that encourage respect and trust as a partner in continued parenting. These principles are part of what counselors and therapists call a *good divorce*.

Yet, not all relationships end well. Violence, high conflict, or abandonment can prevent parents from being able to establish or maintain a co-parenting relationship. When working with separated or divorcing parents, a co-parenting plan must take into account safety for the child and safety for other family members. Co-parenting is not always possible or recommended. The courts are not uniform in the application of laws regarding custody, child support, and protection orders. Home visitors should communicate with supervisors when working with a separating family because safety of the family and home visitor may need to be assessed one or more times and because, as a mandated reporter, a home visitor may be called into the legal adjudication of the family's case.

What Young Children Learn Through Shared Care Experiences

In the United States, children from birth to 3 years old have a variety of caregivers even when their family environment is stable. Young children pick up on the feelings and tensions that their caregiver(s) may have when caregiving responsibilities are being transferred to or shared with a different person, such as the morning hand-off from parent to child care provider or the unfamiliar people in a doctor's office. Within their family system, young children begin learning how their parents and other important members coordinate care. Young children notice family and relationship stress and connection. While they don't have words to express feelings, young children still feel those feelings and try to respond to them. The following charts give examples of what young children might be thinking about their shared care experiences.

Through a Young Child's Eyes

Co-Parenting and Sharing Care

What I can learn being with other trusted adults...	Communicate to help me be safe, healthy, and happy with other adults in my life...	Be my bridge to help me feel comfortable with other adults...
There are more people who take care of me. We can have fun together, and I can count on them. We are part of a community.	You know me best so be sure anyone and everyone taking care of me knows how to reach you.	I feel most safe and secure when I am with you. When I can hide behind you or sit on your lap to check out a new person, you help me be more comfortable. When I see you talk and laugh with that person, I learn they are A-OK. They have your seal of approval.
People are the same and different. They care about me and keep me safe. Some of them are tall and others are short. Their hair is different; they may even be bald. Their skin may be different colors. They may speak different languages. I care about them too.	Leave important health information, like a note about my allergies and my doctor's phone number, for anyone taking care of me.	
My important adults don't do things exactly the same way. That is very interesting. Sometimes it is a little confusing and funny too. Why does Grandpa make those funny noises when he blows his nose?	Insist that everyone put me on my back to sleep (until I can roll over myself) and never smoke around me.	Stay with us awhile.
I can learn about new things. My teacher sings me songs in Spanish. My babysitter takes me to the library, and we bring books home.	Tell my other adults about me. For example, share my favorite songs and activities, things that upset me, how you help me calm down, what I like to eat and when, and how you help me fall asleep.	Talk with the other person to show me she or he is A-OK.
Auntie's house looks different than my house. Her kitchen has different smells when she is cooking.		Invite the unfamiliar person to hand me a toy or a cookie or other object. It feels safe to connect that way.
I am safe and welcomed in many different places by different people.		

Through a Young Child's Eyes

Co-Parenting and Sharing Care

Make a visit to my healthcare provider as easy as possible...	Support me with goodbyes and hellos...	What I feel when sharing care is a struggle...
Pretend play with me that we are doctors or nurses or going for a visit. A toy medical kit and box of band aids will make the play more real and fun.	Goodbyes and hellos are a normal and sometimes bumpy part of life that we are all learning to handle. With your support, I can do it.	When my important people struggle, I may struggle too.
	Goodbyes and hellos often stir up deep feelings for everyone. When you try to understand what I may be experiencing, it can help you figure out who is feeling what, so you can support me.	It may be tough for me to be comforted by dadda when momma is not feeling well. I may be fussy because momma does comfort care more often, and she is my first coping choice.
Tell me what will happen. And be honest. When you tell me a shot will hurt for a minute, my trust in you grows deeper.	Routines will help me feel more in control and confident because I will know what is coming next. So, let's make some routines to use! Maybe, we give each other two kisses and a bear hug before you go, or we read a story when you come back.	When my most important people are not getting along, I can feel that. But, I may not be able to tell you with words. I may be clingy, cry easily, or have more tantrums. I may feel like I've done something wrong and try to fix it by showing care.
At our visit, I'll look at you to see how upset you are when I get a shot. If you are upset, I will be upset. We'll cry together. The calmer you can be, the calmer I will be.	If I ignore you when you come to pick me up at child care, I may be telling you I wanted you to stay today. If I cry when you walk in the door, and my teacher says, "But he was fine all day," don't worry and try not to feel bad. I trust you more than anyone, which is why I feel safe to cry or whine or protest when you say we have to go. I know you will be there for me, no matter what I do.	Even when my important people struggle, I can feel when they put my well-being first. That feels good. It shows me that people can disagree and still show love and be loved.

Why Co-Parenting and Sharing Care Matters to Families

Parenting is a huge, amazing, demanding, forever job. Everyone needs support, no matter their age, income level, or how many children they may already have. This support may come from a parenting partner, other family members, friends, healthcare providers, people at community agencies, home visitors, or a combination thereof. Building a team of support is one of the most important ways a parent can support his or her child—and him or herself.

The addition of children into a family system creates a ripple effect across roles, resources, and expectations. It is normal and expected that parents and adults who share the care of a child will experience challenges in their relationships, often because they care so much for a child. By being aware of feelings and differences in parenting styles and expectations, parents and caring partners can discover ways to work together on behalf of their child.

Boots on the Ground: Everyday Moment Conversations with Families

This section highlights content and skill-building strategies you can use as you plan your home visits. For the *Everyday Moment* section of the visit, you will find a list of topics to choose from and to explore in conversations about nurturing guidance. For each topic, you will find the associated *Protective Factors* and *Trauma-Informed Principles* addressed. *Family Pages* designed to support your conversations are listed next.

In addition, you will find suggestions of related one-on-one activities to choose from for the parent-child interaction portion of the visit.

There are several *Co-Parenting and Sharing Care* topics to choose from as you plan a visit to a family, and you should tailor the conversation to that family's specific needs and interests. You may find that you discuss one topic now and come back to discuss another in a month or two depending on certain circumstances.

Use the information you have about a family's *Protective Factors* to guide your curriculum choices and tailor the home visit discussion and activities. Ideas are presented below with their associated icons to highlight how they correspond to meeting a family's needs and building each family member's resilience.

These include the following:

Parents' experiences with and expectations for co-parenting and sharing care

- *Concrete Supports of Families* and
- *Parental Resilience* and
- *Social Connections* are fostered when parents are able to assess their co-parenting and shared care relationships and make choices to maintain or adjust these relationships to support the well-being of their child and family.

Why sharing the care matters

- *Parental Resilience* and
- *Knowledge of Parenting and Child Development* and
- *Social and Emotional Competence of Children* can build parents' sense of safety and connection, which, in turn, provides early models of healthy relationships for their very young children.

Keeping a child safe while sharing care with others

- *Parental Resilience* and
- *Knowledge of Parenting and Child Development* are supported and maintained when parents can clearly state their expectations for supervision and nurturing guidance across co-parenting and shared care relationships.

Family Pages

A series of *Family Pages* on Co-Parenting and *Sharing Care* have been created to support your conversations with families while you are visiting and to become a resource parents can refer to between visits. These include the following:

- Sharing Care from a Child's Point of View
- Co-Parenting
- Partnering with Other Adults in Your Child's Life
- Being the Bridge Between Your Child and Other Caring People in His Life
- Supporting Your Child with Goodbyes and Hellos
- Advocating for Your Child: Problem Solving, Not Blaming
- Building Healthy Relationships: Transitions to Parenthood
- Focus on You: Looking Back and Moving Ahead with Your Child
- Practical Applications for Families: Figuring It Out Together

Related One-on-One Activities

These are suggested activities for sharing care. There is a broad selection of one-on-one activities available in the Activity Card deck.

- Notice and Wonder: How does a care partner(s) connect and interact with your child?
- Co-create a story with your child about time spent with other caregivers.

Book suggestions:

- *Maisy Goes to Preschool* by Lucy Cousins
- *Are You My Mother?* By PD Eastman (Dr. Seuss)
- *The Family Book* by Todd Parr
- *Please, Baby, Please* by Tonya Lewis Lee and Spike Lee
- *First Laugh – Welcome Baby!* by Rose Ann Tahe

Additional Resources

Community connections include:

- Child Care Settings
- Healthcare Providers

Main Elements

Content Areas

- Teaching About Parental Self-Care: *Protective Factors* and *Trauma-Informed Principles*
- The Science: Self-care Practice: What it Is and is Not; Self-care, Emotional Health, and Mindfulness; Giving Help and Accepting Help; When More Support is Needed
- Why It Matters to Families: Each Person's Well-Being Matters; Building a *Circle of Support*; Reaching Out and Resilience
- Home Visit Activities and *Family Pages*
- Important Safety Supports and Knowledge: Anxiety and Depression in the Transition to Parenthood

Teaching About Parental Self-Care: Protective Factors and Trauma-Informed Principles

Expectant, first-time parents face many new demands in their daily family life with the preparation and arrival of their first child. Experienced parents also undertake the reshuffling of family resources and needs with the addition of other children into a family system because a second or subsequent child rarely arrives with all of his or her older sibling's characteristics! When young children come into a family system, parents may struggle to ensure that every family member's needs are met. Because parents have to manage the competing interests and needs of individual family members from day to day, the parental self-care that may be needed often gets pushed to the bottom of the list. When parents are not able to take time for themselves to recharge or recognize when they need self-care, the overall well-being of the family is affected. If short-term decisions to put off parental self-care turn into long-term family patterns, the well-being of one or more parent is at risk; in turn, this puts the children in the family at risk.

Self-care is any activity a person chooses that supports one's own social, emotional, and physical well-being. Activities can include exercising, eating healthy food, getting enough sleep, engaging in prayer or meditation, meeting a friend for coffee or a run, and enjoying a hobby. Self-care activities

help a person de-stress; refuel emotional and physical energy; and recognize when there is a need to connect to others, whether with a supportive friend or a professional in an allied health or family support program. Self-care practices directly promote a healthy *self*. In the context of *Parental Self-Care*, the work parents do to take care of themselves fosters healthy connections with their children. Healthy parents are more available to care for their children and attend to the daily needs of their whole family system.

Parents can face different kinds of pressures regarding their own self-care. Statements friends or family members may say, such as "being there for your child," can be used to criticize parents by implying that their choices that support self-care are selfish. For example, a first-time mother who sets up a child care plan so she can establish a regular workout schedule might be told that her "little running hobby" should wait until her toddler is in preschool because the early days pass so quickly, and she will miss out on that time. Some parents may have some strong self-care practices, such as saying "No" to requests that take away from their available resources (e.g., time, money, energy) or planning regular video calls with family or friends who are important to them. Other parents may have practices that they view as self-care, but, actually, these actions are not helpful in maintaining or improving their well-being, such as drinking a 6-pack of beer after work or doing a bit of *retail therapy* that goes on a credit card.

Home visitors can work with parents to identify activities that are nurturing to themselves as adults and as parents. Part of this work may include helping parents see what kinds of activities are really working for their well-being, and which ones may not be working.

This chapter helps to address the following *Protective Factors*:

- ***Social Connections***
- ***Concrete Supports of Families***
- ***Parental Resilience***
- ***Knowledge of Parenting and Child Development***
- ***Social and Emotional Competence of Children***

Teaching about *Parental Self-Care* offers opportunities to model the following *Trauma-Informed Principles* in the parent-child and parent-home visitor relationships:

Safety – Connections between self-care and safety often are rooted in being able to establish and maintain healthy boundaries. Setting boundaries means that a person identifies limits and acceptable ways others can act toward him or her. It also means setting limits for one's self. Parents who have survived abusive or neglectful care, while growing up or who did not have positive role models, may struggle to set healthy boundaries. In part, this is likely because their attempts to set boundaries for themselves during childhood were not respected by one or more important people. Some trauma survivors may have established very strong boundaries as they separate from unhealthy elements and people. Now, they may want to rethink how those boundaries operate, so they can develop and maintain healthy relationships and life choices.

Physical self-care safety behavior can be as straightforward as setting up evening routines that help parents get the sleep they need to be safe on their work commute and at work. Physical safety and self-care connections can also be subtler. For example, a person who needs to maintain personal space with others may offer a handshake and place one foot forward in order to establish some physical distance between oneself and another person who may like to greet with hugging. Home visitors may be in a position to help parents recognize their current physical self-care strategies that are often done subconsciously.

Boundaries are also evident in many psychological self-care practices. For example, a parent may choose to reduce the amount of time spent with a family member who speaks with criticism in almost every conversation. When parents begin to feel psychologically safe within the home visitor-parent relationship, they become more willing to take steps toward disclosing difficult experiences (past and present) and to be vulnerable and ask questions and seek support.

Trustworthiness and Transparency – Safety, trust, and transparency are strongly linked—trust cannot be built without a first sense of safety, and trust and safety cannot be maintained when transparency and openness are not part of a relationship. Many parental self-care actions are driven by a parent's trust in others or the lack thereof. For example, a self-care behavior built out of broken trust might be to separate finances from a joint account because a partner is spending money intended for monthly bills on frivolous purchases. A parental self-care behavior built on the growing trust between a parent and home visitor might look like a parent who asks about available counseling resources or who

takes a first step to try out a self-care idea they thought of together, like putting electronics away 2 hours before bedtime for a week to see if that helps reduce sleep deficiencies.

When parents are able to build a foundation of trust with home visitors, there can be opportunities for parents to think with their home visitor about current self-care needs and practices, such as deciding to change a practice or a thought that might not be serving them well. Transparency can be demonstrated when home visitors share common struggles they've had or worked with, which lets parents know they are not alone, and there are many different ways to give care to oneself.

Peer Support and Mutual Self-Help – Parents' self-care activities can include building a *Circle of Support*—people who can be counted on to provide a moment (or more) of respite when things are tough. Their support team can include partners, extended family, friends, neighbors, religious mentors, health-care and child care providers, and home visitors.

Parents who build support connections can also provide support to others within their circle, such as trading off afternoons with another parent so each can have a few hours to run errands or sharing empathy with and doing some household tasks for a parent who is struggling with an illness.

Collaboration and Mutuality – It can be difficult for individuals to ask for or receive support from others, but they may be very willing to offer support to those in need. Yet, mutuality indicates that both giving and receiving are necessary in developing peer support. Learning to receive can be challenging for people who are used to showing their care through giving acts. It can also be difficult to ask for and receive help when people have past experiences of support denied or have been told they are not worthy of help. Learning to give and receive support within the parent-home visitor relationship helps move this partnership forward for the benefit of the family's well-being without this progress coming at the expense of others.

Empowerment, Voice, and Choice – Acts of self-care are acts of self-advocacy. As such, these acts can be transformative for parents and families. Making choices to build and integrate self-care practices into one's personal and family life can be small yet big at the same time. Parents already do some acts of self-care, but they may not recognize them as such. For example, using available insurance benefits for eye and dental care and all covered medical checkups, like annual physicals and women's health exams, is an act of self-care. When home visitors can see what parents are doing, they can help parents build on their strengths and become aware of choices they can make to maintain and/or improve their well-being.

Cultural, Historical, and Gender Factors – Self-care practices are influenced by many factors. It can be important to listen to parents when they describe what activities recharge them and keep them going. Those activities might be very different from what you might personally choose. Consider these guiding questions to determine if an action is part of self-care:

(1) is the activity built on compassion for oneself,

(2) is the activity restorative or preventative, and

(3) does the activity cause harm or neglect to others.

Everyone can select self-care practices, regardless of resources, cultural background, or social expectations.

The Science: Parental Self-Care Benefits and Challenges

As mentioned in the introduction, parents who are able to work toward and maintain their well-being are also more able to be present, connected, and engaged with their children. Yet, this knowledge can put pressure on the parents' decision on how to allocate their available resources. Parents often hear messages that seem contradictory, such as "…their children are the most important person to care for within the family system" and "…parents need to work on their own self-care in order to be able to care effectively for their children." These messages can distort internal beliefs about what good parenting is and drive the decisions that parents make for meeting care needs across their family system.

While these statements contain pieces of truth, they do not describe the full picture of caregiving and self-care needs within a family system. If parents feel bound by these two guiding beliefs, they may be making choices for caregiving and self-care in which the parents' self-care needs are continually not or not quite met. In addition, parents may only value their own well-being in the context of their children's well-being and dismiss or diminish the importance of parental self-care as important for themselves as individuals. Home visitors can help parents see themselves as individuals who also need and deserve care and are not just able to care for others. And, by the way, this also holds true for home visitors.

Self-Care Practice: What it is and What it is NOT

The practice of self-care involves awareness of one's thoughts and feelings, the ability to think about oneself with compassion, and the skills and willingness to seek and make use of concrete and emotional support resources. Most self-care literature focuses on what actions

and thoughts provide a direct benefit to the person practicing self-care, such as lowering physical and emotional stress and increasing or maintaining one's physical, social, and/or emotional health.

Coping or Self-Care?

Sometimes people use the terms coping and self-care interchangeably, but they are not quite the same. Both are important for a person's resiliency and well-being, but they operate a bit differently. Coping behaviors are those that a person does on a daily basis in order to meet the demands before them. Coping behaviors include just doing the best one can at the time, like pushing through a tense work meeting by minimizing personal emotional distress and keeping the discussion productive for every team member. Coping behaviors are often adaptive, such as the parent with more work flexibility taking time off to care for a sick child. Coping behaviors can also be self-protective.

For example, a new parent may cut off contact with his own parents because of traumatic or neglectful experiences in his own childhood to which he does not want his young child exposed. These areas of coping are positive and adaptive responses to a range of stressors. Each of these examples may also contain elements of a person actively denying or diminishing his or her own emotional needs and distress. It is this daily responsiveness and the potential co-occurrence of shutting down reflection and awareness of one's emotional states that makes coping different from self-care.

Self-care behaviors are the activities that become regularly scheduled and that help maintain or improve one's long-term well-being. This means that self-care is more preventative in nature and requires a sense of self-awareness, intention to build patterns of refueling, and commitment to keep these activities a priority when other demands on time and resources surface. People who are aware of their responses to stress are in a position to create and maintain regular self-care activities to build up their reserves.

The ability to put self-care into practice also means individuals are able to evaluate the different stressors and circumstances in their life and identify what is within their control to change. When circumstances are beyond one's control, coping behaviors may be a good short-term solution. Yet, if the circumstances continue beyond what is expected or become the *new normal*, coping will likely not be enough, and self-care actions may need to be integrated to counteract the stressors and support well-being. Let's look at two family examples with differing types and intensities of stressors:

Phillip and Casey are new parents in their early 20s. Each has a high school diploma, and Phillip is completing an extensive, paid apprenticeship in welding. Casey has her cosmetology license and rented a chair at a local salon before and during pregnancy, but she let that go after their son was born 4 months ago. Phillip and Casey relied on both incomes to meet monthly expenses, and they know they will need more income very soon or find ways to cut monthly costs. However, each of the options they've explored also has a financial or time cost. Moving to a less expensive apartment requires security deposits and hookup/disconnect costs and time off work for Phillip. If Casey returns to work, they will need to find paid child care, but the costs of child care almost cancel out the additional income Casey's work could provide. So, they are now looking at whether Casey should go back to school to become an office professional. They think this career change might provide more stable income and benefits, such as health insurance in the near future, but the cost of school would be an added burden to a young family with few resources.

What stressors are out of this family's control?

There are several financial stressors: cost of rent for their apartment, expenses for Casey returning to her profession or school, and the costs of paid child care.

What else might be out of their control or very difficult to change?

Their family needs both incomes to maintain their current living situation, so, through exploring options, they've come to realize that their current ideas are difficult financially even though every choice might help over time.

What daily or chronic stressors do Phillip and Casey have to address?

An ongoing need for additional income and the limited options to improve their situation could be frustrating. Decisions about ways to reduce current expenses to save money in order to make changes may also be challenging. They want the best for their child, and they probably feel it's difficult to meet expectations. As one of their goals is attaining a job with health insurance, this family may not be able to afford health insurance currently.

What self-care actions could each parent establish on a recurring basis to help them regroup and look after their own parental well-being?

Framing their current training and jobs as investments in themselves and their family stability can be helpful when things feel tough. Establishing regular family conversations about resources and goals to check in with each other helps each partner make informed choices about how to use and save resources. Phillip and Casey may have friends or family to whom they can turn to share struggles and find support. Reaching out to their *Circle of Support* may provide emotional or instrumental support that they can later return.

How could a home visitor support this family in building their self-care practices?

Many of this family's primary stressors are financial. A home visitor may be able to brainstorm with the parents to identify low and no-cost activities and social connections that help reduce stress and give each of them some space to regroup. There may also be community resources that Phillip and Casey are not using. Checking in to see if they are accessing WIC, SNAP, or food banks could be important in connecting this young family to resources that would ease their monthly budget.

Tim and Neysha are a couple in their mid-30s with two children ages 5 years and 20 months. Their 20-month-old has been hospitalized many times in her short life due to a congenital heart valve defect. This toddler had her first two surgeries at 1-week and 7 months old, and she faces at least one more before she turns 3. Tim and Neysha each work full time, but Neysha's work demands are stricter and include the need to travel on short notice. In addition, the family's insurance and benefits are tied to Neysha's job. Tim has some work flexibility, but he has used all of his sick days for the year. He is, currently, completing paperwork for FMLA leave and asking for sick day donations through his workplace to try to cover the days off needed when his toddler's next surgery is scheduled.

What stressors are out of this family's control?

Their daughter's heart condition and medical needs are certainly stressors. Do you think the parents might consider the limited/maxed-out sick leave a stressor that is out of their personal control? In addition, having another young child with daily needs might contribute to the list of stressors this family must consider.

What else might be out of their control or very difficult to change?

There can be uncertainty around their toddler's daily medical needs, scheduling appointments, and potentially the need to hire or coordinate in-home medical care. Tim and Neysha may both feel locked into their current work situations because a change in work for either one could result in loss of medical coverage and/or flexibility. Family patterns of daily life may also be restricted, and this could wear on each family member in different ways.

What daily or chronic stressors do Tim and Neysha have to address?

While the example does not provide a lot of details, consider the daily ins and outs of this family's life. They must attend to the ongoing maintenance needs of other family members; health needs; school and wrap-around care for their 5-year-old; regular life tasks, like grocery shopping, paying bills, participation in any social or community groups (e.g., religious and local recreation groups); and potential increased job demands due to type of work. There are many considerations to think about and priorities to set.

What self-care actions could each parent establish on a recurring basis to help them regroup and look after their own parental well-being?

Respite care might be an option for setting a regular night out. They might also decide that their ideal routine for family meals could become less time intensive by planning one or two meals a week that provide leftovers or buying pre-made options like a rotisserie chicken or warm-and-serve casserole.

How could a home visitor support this family in building their self-care practices?

There are probably many opportunities to listen to the parents discuss their challenges. Because this family has some very particular needs, a home visitor may be in a good position to make referrals and assess how well the coordination of needs is managed. There may be play groups for their 5-year-old that would offer some time with other parents and give their older child opportunities to take a break from the daily challenges of having a sibling with a serious health condition.

Coping and self-care practices may overlap, but they may also contradict each other because the goals of each are slightly different. Coping is focused more on meeting daily challenges, while self-care is focused on longer-term well-being.

Is self-care selfish?

No! In the introduction to this *Everyday Moment*, a few examples highlighted some ways in which parents come to believe that doing care for themselves is selfish or self-indulgent, and these actions could be taking care away from their children. There are a few clear differences between self-care and selfishness that parents should understand.

Understanding how these concepts are different from one another can help parents who have guilt over spending time on themselves or who feel judged by others for their self-care.

Self-Care	*Selfishness*
• Activities that contribute to a person's well-being, physically, socially, and/or emotionally	• Activities that show no regard or concern for how others are affected
• Focused on long-term well-being that does not come at the expense of others	• Withholding support, resources, or care to use for oneself only
• Preventative and restorative	• Expectations that others should be willing and ready to help, even if it comes at their expense
• Built on a foundation of self-awareness, compassion for oneself, and willingness to seek out resources for support	• May come at a cost, such as spending money that is not in the account, undermining health, or losing relationships

Self-Care, Emotional Well-Being, and Mindfulness

One area of research in well-being is focused on mindfulness: "A mental state achieved by focusing on one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations" (English Oxford Living Dictionaries, 2019, Mindfulness definition). It is a self-awareness practice to be able to see and accept what one is currently thinking and feeling without making judgments about those thoughts and feelings. In general, mindfulness research, the practice of mindfulness, is linked to improved emotional and psychological health. Some recent studies with new parents have shown that mindfulness may be related to reducing parental depression and anxiety and have lasting, positive effects for both parents and infant. In these studies, parents who were at higher risk of depression or anxiety in the perinatal and post-natal period and who received mindfulness training and parent education reported less depressive and anxious symptoms at their child's first birthday than parents who only received information about parenting and child development.

Conversations about sitting with one's thoughts, feelings, and beliefs and holding off on judging one's own actions and abilities can be a starting point for parents to work on their self-care beliefs and practices. These internal changes are more difficult to recognize than outward changes, such as improving one's diet, taking care of medical needs (e.g., physicals, dental cleanings, eye exams), setting up a regular phone chat with a friend, or participating in a game night with other families in the neighborhood. Home visitors can play an important role in supporting parents to facilitate internal changes that may ultimately benefit them and their family.

Self-care practices are often included in work with parents who have clinical and sub-clinical levels of mood disorders, such as depression and anxiety. The transition to parenthood and the first year after a baby arrives are times of higher risk, for mothers and fathers, for mental health disorders. Parents at risk of or experiencing depressive or anxious symptoms can be more easily overwhelmed when thinking about self-care. It may already feel more difficult to accomplish daily tasks, and there may be added feelings that they are not good enough or doing enough, which chips away at parents' self-esteem and sense of competence. Therapeutic intervention is beyond the scope of most home visitation programs, but the program may be able to complement therapeutic support or at least serve as a bridge to help a parent access the appropriate resources. A home visitor may be in a position to share self-care ideas that are low stakes, like a breathing exercise, to help parents reframe their thoughts about being able to do self-care and realize what they are already doing that supports their well-being.

Why Parental Self-Care Matters to Families

There is a saying, "We all do better when we all do better" (Wellstone, 1999). Every person in a family system benefits from practicing self-care, directly and indirectly. Parents who practice self-care model those practices for their young children and instill a sense that personal well-being is important. In families where one parent may experience mental and/or physical health challenges, research indicates that having another healthy parent provides protection and support for young children's development and can also foster resilience and a return to a healthier state for the affected parent.

However, research with families in the first year of parenthood also indicates that when one parent is experiencing a mental health challenge, the partnering parent is at higher risk for developing a mental health need. Early and ongoing mental health screenings for parents—mothers and fathers—can benefit the family system by detecting challenges earlier in their lifecycle, so resources for support and intervention can be identified. While self-care practices are not a cure for mental or physical health difficulties, they are important for maintaining and improving overall well-being.

Boots on the Ground: Everyday Moment Conversations with Families

This section highlights content and skill building strategies you can use as you plan your home visits. For the *Everyday Moment* section of the visit, you will find a list of topics to choose from and to explore in conversations about *Parental Self-Care*. For each topic, you will find the associated *Protective Factors* and *Trauma-Informed Principles* addressed. *Family Pages* designed to support your conversations are listed next.

In addition, you will find suggestions of related one-on-one activities to choose from for the parent-child interaction portion of the visit.

There are several *Parental Self-Care* topics to choose from as you plan a visit to a family, and you should tailor the conversation to that family's specific needs and interests. You may find that you discuss one topic now and come back to discuss another in a month or two depending on certain circumstances.

Using the information you have about a family's *Protective Factors* can guide your curriculum choices to tailor the home visit discussion and activities. Ideas are presented below with their associated icons to highlight how they correspond to meeting a family's needs and building each family member's resilience. These include the following:

Parent's experiences with and expectations for self-care

- *Concrete Supports of Families* and
- *Parental Resilience* and
- *Social Connections* can be enhanced when parents reflect upon early and current self-care practices and maintain or create strategies that support their well-being.

What children learn when they see their parents practice self-care

- *Knowledge of Parenting and Child Development* and
- *Social and Emotional Competence of Children* are nurtured when parents are able to model self-care practices, showing their child that taking care of oneself is important no matter what age a person is.

Developing ones' own practices and recognizing what one already does

- *Concrete Supports of Families* and
- *Social Connections* can be strengthened when parents are aware of their responses to stress and identify concrete and/or emotional support resources that either reduce their current stress or maintain their health despite one or more stressors.

Family Pages

A series of *Family Pages* on *Parental Self-Care* have been created to support your conversations with families while you are visiting and to become a resource parents can refer to between visits. These include the following:

- Taking Care of You from a Child's Point of View
- Nurturing Your Well-Being: Feeling Good About You
- What Fills Your Cup?
- Focus on You: Looking Back and Moving Ahead with Your Child
- Practical Applications for Families: Figuring It Out Together

Related One-on-One Activities

These are suggested activities for self-care. There is a broad selection of one-on-one activities available in the Activity Card deck.

- Notice and Wonder: What does your child see you do or hear you say about your own care and needs? Is your child at an age where you can see her starting to do some of those same actions?
- Share a self-care routine with your child that helps her learn how you care for yourself and how she can value time to care for herself, like going to a park or having a lazy day in which no one needs to rush.

Book suggestions:

- *Listening to My Body* by Gabi Barcia
- *Fill a Bucket: A Guide to Daily Happiness for Young Children* by Carol McCloud
- *ABC Mindful Me* by Christiane Engel

Additional Resources

Community connections include:

- Healthcare Providers
- Community Mental Health

Everyday Moments 6.3 Chapter 3: Loss, Grief, and Growth in Young Families

Main Elements

Content Areas

- Teaching on Loss, Grief, and Growth in Young Families: *Protective Factors* and *Trauma-Informed Principles*
- The Science: Some Common Loss Experiences in Young Families; Understanding Family Processes and Pathways with Loss, Grief, and Growth; Giving Support
- Why it Matters to Families: Each Family Member's Well-being Matters, Building a *Circle of Support*, Reaching Out and Resilience
- Home Visit Activities and *Family Pages*
- Important Safety Supports and Knowledge: When Grief Feels Overwhelming
- Safety Supports: Hospice and Palliative Care, Condition-specific Supports, Compassionate Friends

Teaching on Loss, Grief, and Growth in Young Families: Protective Factors and Trauma-Informed Principles

The individuals and families with whom home visitors work are going to experience loss and grief as part of life, and some losses may stem from a traumatic event. Families may even experience significant loss while participating in home visitation services. In fact, there are some events that lead to feelings of loss and grief that are not unusual in young adulthood and in growing families. Such events can include difficult child diagnoses, whether identified prenatally or after birth; fetal and early childhood losses; fertility challenges; and traumatic childbirth experiences. Parents may have experienced one or several adverse childhood experiences (ACES) (e.g., abuse, neglect, household dysfunction, mental illness) in their own lives and could still be affected by these occurrences as they build their own family systems. In addition, some families in home visitation programs are actively seeking adoption or may be active in their local foster care system. When infants, toddlers, and twos are placed temporarily or permanently with a family, these little ones have, by definition, already experienced one ACE and may have experienced additional adversity, whether known or unknown. Adverse experiences, trauma, and loss can be experienced by any family member and at any age. Yet, resilience and growth after loss and trauma are also possible for every family member—from youngest to oldest.

6.3.3 Loss, Grief, and Growth in Young Families

Understanding the types of loss and trauma common to young adulthood, family development, and for very young children will strengthen your skills, so you can better support your families and meet them where they are. Although loss experiences are unique to individuals and families, there can be a shared sense of grief, growth, and empathic support within and across family systems. Home visitors can become a source of trusted support and can work with families who experience loss and support the grieving and growing processes of parents and young children through *Trauma-Informed Care* (*TIC*), which is a cornerstone of the TRHV curriculum.

Information in this chapter can complement other *Moments* in the TRHV curriculum. For example, when working with parents and other caregiving adults who have experienced loss or trauma, it may be helpful to pull in information from the *Parental Self-Care*, *Parental Absence*, or *Parenting After Injury Moments*. You may also consider using information from the three *Moments* in the section *Exploring and Learning about the World* to support young children and their families through loss and grief.

This chapter helps to address the following *Protective Factors*:

- ***Social Connections***
- ***Concrete Supports of Families***
- ***Parental Resilience***
- ***Knowledge of Parenting and Child Development***
- ***Social and Emotional Competence of Children***

Teaching on *Loss, Grief, and Growth* offers opportunities to model the following *Trauma-Informed Principles* in the parent-child and parent-home visitor relationships:

Safety – Experiencing trauma or loss as a parent, young child, or family system can involve real or perceived threats to one's sense of safety. For example, a parent entering into home visitation services might be facing an unexpected prenatal maternal and fetal health risk, such as placenta previa or diagnosis of a fetal development condition like spina bifida. Such diagnoses can cause a parent to wonder if their body is "safe" and able to fully develop and carry a healthy fetus to term. Very young children can also experience threats to their sense of safety, such as when a sibling or parent becomes gravely ill (e.g., cancer, COVID-19), and death of their loved one is possible.

Home visitors may work with families to help identify areas and moments in which family members can feel safe or can build a sense of safety while also processing their feelings of loss and grief. Parents who have a point of safety (e.g., a person they can turn to, a physical space that is protective, a visualization of a safe place in their mind) are more able to endure distress associated with feelings of loss, trauma, and grief and build personal resilience. In turn, these parents can extend their sense of safety and help other family members, including their very young children, find and access points of safety. A sense of being and feeling safe is fundamental to regulating distress in ways that foster one's well-being.

Trustworthiness and Transparency – Trust and transparency in relationships can be vital for individuals who are experiencing a loss or trauma. A parent might need to connect and communicate with others who have specific information or insight into the parent's current situation, and these individuals may be people with whom the parent is unfamiliar (e.g., NICU medical team, a Military and Family Life Counselor [MFLAC], law enforcement personnel). It can be difficult to build and maintain trust in these new relationships, particularly if there is a perception that the person is holding back information or not being truthful with the parent (or if a parent has had negative experiences in similar situations in the past).

The home visitor-parent relationship may provide a trusting relationship that the parent can turn to during difficult times. While a home visitor may not be the person who has specific information about a parent's situation, the home visitor may be in a position to give empathic support, help identify sources of quality information and community support, and rehearse strategies for communicating about difficult topics. Transparency can be demonstrated when home visitors share common struggles they've had or acknowledge when a loss or trauma experience is new to them, although sharing should be done carefully so that the focus remains on the parent's loss instead of shifting to the home visitor. Both types of responses let parents know they are not alone and that, regardless of previous experiences, the home visitor is willing to be a part of the support system for the parent(s) as the parent processes his or her loss or trauma.

Peer Support and Mutual Self-Help – Parents can benefit from connecting with formal and informal support groups related to their loss and trauma experiences. Connecting to these groups extends one's *Circle of Support*—people who share a common or related experience and who are at various points in their grief and growth processes. An informal group may form and consist of parents who have children in a particular hospital ward at a certain point in time. Some of those parents may also connect with a formal support group that focuses on their child's diagnosis or special needs (e.g., local Down's Syndrome chapters) and offers support, information, and/or respite. One's *Circle of Support* can include partners, extended family, friends, neighbors, religious mentors, healthcare and child care providers, and home visitors. Parents who build support connections can also provide support to others within their circle.

Collaboration and Mutuality – Cultivating a home visitor-parent relationship that values the parent as a collaborative decision-maker helps build parents' skills and confidence in weighing choices, which can be beneficial when parents have to make tough decisions in other settings and with other people. Parents experiencing loss and its aftermath may need to have difficult conversations (e.g., with family members or medical, legal, and insurance personnel) and make tough decisions.

Parents, depending on the type(s) of loss experienced, may have lost access to a trusted partner, friend, or confidant to whom they might normally turn in difficult times.

Home visitors may also become key partners for parents who have difficulty regulating their own emotional states and distress, including those feelings that stem from grief and loss. You may work with parents who have not had healthy role models in handling emotional regulation and managing distress. The home visitor-parent relationship can become a safe relationship to scaffold parents' emotional competence and agility through collaborative interactions that support the well-being of the parent and family.

Parents can, in turn, model collaboration and mutuality with their young children even in times of loss and grief. Young children commonly struggle to regulate their emotional states and feelings, whether positive or negative in origin, and this is developmentally normal. They rely on having one or more partners who are more skilled in self-regulation (e.g., older siblings, parents, teachers) help them through these moments. Grief is a family issue, and emotional distress and dysregulation are part of the processes of grief and growth, regardless of one's age. Parents and other important adults who are aware of and who can describe their own emotional states and reactions can help foster young children's emotional competence and effective coping skills by becoming a collaborative partner in co-regulation. Effective and nurturing co-regulation fosters collaboration—"We can be upset together, and we can calm down together." "I can see you are sad. I am sad, too. It's OK to be sad; we can be sad together and see what might help us feel better."

Empowerment, Voice, and Choice – Parents going through a loss can feel a concomitant sense of loss of power, voice, or choice—feeling that they cannot control, change, or fix their current circumstances. Home visitors may be able to help parents recognize opportunities to exercise control and choice. For example, parents who experience infant loss often have to make multiple, grueling decisions before and after the loss of their child. Parents may find it helpful to identify ways to engage and disengage when working through a myriad of medical, legal, and other (e.g., religious, personal) issues stemming from their loss. An insurance representative may call unexpectedly with a prepared list of questions that feel intrusive, or a medical bill may arrive that triggers traumatic memories and anxiety about the future. Well-meaning individuals may offer platitudes that do not reflect the family's beliefs. The home visitation relationship may be a place for a parent to (re)gain a sense of empowerment. Here they have an active voice about what to focus on in a visit, including discussing what skills and strategies they would like to practice (e.g., ways to handle cold calls, connecting to parent groups or bereavement support) or talking about ways to respond to questions or statements about their loss.

Cultural, Historical, and Gender Factors – Loss, grief, and growth are culturally informed with multiple layers of social and historical influences. Religious, cultural, and gender identities form strong cultural norms about what loss means; what happens after death; how individuals, families, and communities may express grief; and what rituals and traditions are important for honoring or acknowledging people lost and those who remain. There are also culture- and gender-informed expectations for how one processes and resolves or integrates loss into life afterwards. Each family you work with brings their unique set of characteristics, historical and current, into the home visitation relationship—as do home visitors. Work with grieving families may highlight instances where there are key differences between a home visitor and a family. When these differences arise, home visitors should hold their own beliefs and perceptions lightly so that grieving families' processes and rituals remain centered and valued. Home visitors may also be in a position to support individuals and families who may feel excluded from or isolated by cultural and social norms and rituals for grieving. For example, in families with a perinatal loss, one partner may feel as though his or her grief is not as valid or shouldn't be as deep as that of the partner who physically experienced the loss.

The Science: What Do We Know About Loss, Grief, and Growth in Young Families?

Loss, grief, and growth occur throughout the life course, but there are some loss experiences that occur in families in their childbearing (e.g., pregnancy, fertility) and early childhood years (e.g., developmental conditions, fostering and adoption, serious illness, death). Such experiences are likely to happen with families who participate in early intervention home visitation services, and the home visitor may find it useful to have content to support these particular kinds of loss. Since these losses are part of a wide range of potential loss and grief experiences that families can have, this chapter draws from the broader grief and growth literature. In particular, TRHV draws on work that uses the *Dual-Processing Model* of grief (DPM) to give guidance on ways to work with families who are grieving, regardless of the source(s) of their grief.

Loss, Grief, and Pathways to Growth

The research and practice literature around loss, grief, and growth is actively evolving, so it is worthwhile to define a few common terms and identify ways of thinking about bereavement work within home visitation. Some of these terms may be familiar to you from your TRHV training due to the information that focused on *Trauma-Informed Care and Practice* (*TICP*). Some of these terms are also used in the chapters on *Parental Absence* and *Parenting After Injury*.

The term *loss* is used to describe an event that is perceived as negative and has the potential to affect long-term change(s) in one's self-identity, cognitions about how the world works, social situations, or relationships. For example, self-identity, including relationship identifiers, can change when a person loses a pet, changing one's self-identity from being a pet owner or "fur parent" to not being one. A couple who experiences a traumatic loss, such as losing an infant to SIDS, may find their beliefs about fairness and the role of a higher power are challenged or changed. Impacts of the COVID-19 pandemic created a significant shift in social connections and the ability to gather together and affected daily routines and special events.

6.3.3 Loss, Grief, and Growth in Young Families

The loss of a romantic partner, through divorce, death, or other circumstances, can alter relationship labels (e.g., wife, partner, in-law, bonus parent) and connections to others who are part of the relationship system (e.g., "Tom's friends don't talk to me anymore").

Bereavement and *mourning* describe the experience of having lost someone important and the reactions to that relational loss. Bereavement is sometimes defined as being in a state of deprivation "…of the living presence of someone we love or care about." (The State of Queensland Health, 2006, p. 9). Mourning is usually thought of as a set of psychological processes a bereaved person goes through as he or she recognizes the loss and how life will be different without that important person. In fact, early attachment theorists, Freud and Bowlby, wrote about and discussed the work of mourning and grief after the loss of important attachment figures. Contemporary grief researchers and clinicians continue to look at how different kinds of attachment patterns may be connected to how individuals experience grief when those relationships are lost.

Grief is comprised of emotional, psychological (cognitive), and somatic reactions to a loss and includes a wide range of emotions that can change and move from anger, guilt, and despair to relief, bittersweetness, and happiness. It is normal throughout the grieving process to have thoughts that focus on *loss-oriented* stressors (e.g., anger that their child was lost), thoughts that focus on *restoration-oriented* stressors (e.g., what are my roles now that my child is no longer here?), and thoughts that do not focus on the loss in anyway (e.g., activities of daily life). Grief can show up in our bodies in multiple ways: feeling tension, a sense of hollowness or dullness, disrupted sleep or eating patterns, pent up energy tingling throughout fingers and toes, or tear bursts.

The grief process has no clear-cut pathway to a specific resolution, and there is no "right" way to grieve. Early 20th century researchers and theorists (e.g., S. Freud, Bowlby, Lindemann, Kübler-Ross) favored pathways with stages that linked particular feelings or tasks to achieve closure or resolution. One of the assumptions in early literature was that the goal of grief was to find a way to detach and withdraw the energies invested in the connection with the lost person, so the living person(s) could accept the loss and move on in their lives. In the 1980s, researchers and practitioners started challenging these assumptions and focused on the multidimensional nature of loss and grief and the ways that survivors make meaning through building post-loss narratives and performing rituals as they process their loss.

6.3.3 Loss, Grief, and Growth in Young Families

Contemporary researchers (e.g., Bonanno, van der Kolk, Walsh) propose that grief and growth after a loss are not stage specific. Instead, the grief and growth processes are influenced by previous experiences and functioning, current supports, and how individuals/families/communities make meaning of the loss.

Grief is not simple; it is a fluid set of mind, body, and brain responses to deep distress and loss. The DPM of grief posits that individuals move between loss-oriented and restoration-oriented thoughts and coping as they grieve, and they regulate their distress by shifting back and forth in manageable moments. This model has become useful in working with clinical and non-clinical populations and has helped define the DSM-5 description of Prolonged Grief Disorder, sometimes called Complicated Grief. Research using this model indicates that it is expectable that individuals will have more loss-oriented thoughts and coping efforts during the acute phase of grief (the first 6 months to 1 year), and, as time passes, most bereaved folks will experience a shift toward more restoration-oriented thoughts and coping.

Current data indicate that about 60% of individuals who experience the untimely loss of a partner or child are able to move between loss- and restoration-oriented processes and find their pathways for post-loss growth and resilience. About 10-15% of bereaved individuals are estimated to experience complicated grief in which they continue to have a majority of loss-focused thoughts and are perhaps even feeling "stuck." This might consist of extensive ruminating on their loss, reflecting on the "what ifs," yearning to return to the life they had before the loss, and expressing inability to think about the future without the person they are mourning.

Parental grief is considered one of the most intense grief experiences a human can have. The loss of a child violates significant assumptions about how the world "should" operate across many cultures and religious/philosophical viewpoints. Within the United States, there are a multitude of factors that likely contribute to a generalized belief that children will outlive their parents. Therefore, when a child dies, a pregnancy is lost, or a life-altering diagnosis is received, the sense of that norm being violated can come from many directions, and parents may not be consciously aware of all that contributes to their grief. This chapter explores some of these factors in the next section and reviews some of the more likely experiences for young families.

Disenfranchised grief can be experienced by any person when others do not acknowledge the loss that one has experienced, when others minimize the loss experience, or when others shame the person who is grieving. Recent research on perinatal loss indicates that disenfranchised grief is often experienced to some degree by men, same-sex couples, and families who use surrogacy as a pathway to parenthood. The messages communicated often focus on invalidating a person's grief due to his or her role, such as whether the person was the one who was pregnant, and may try to compare one person's grief to another's. These messages can come from people who might otherwise be part of a person's *Circle of Support*, medical personnel, and community members.

Ambiguous loss is a concept that helps explain physical and psychological characteristics of relationship disruptions that may not have a clear path to resolution or healing. This term may be helpful to families when a loss is not easily visible to or recognized as significant by others, such as a prenatal loss or an adoption that falls through. In these examples, the ambiguity stems from experiencing the continued psychological presence while also feeling the physical absence of the hoped-for child. Families in similar circumstances may also feel that their grief is minimized by others at times because the grief is not straightforward.

The last concept to introduce is the idea of *continuing bonds*. This is a term that has specifically been applied in relation to parental loss and grief. It is an idea built on recent grief research that challenges the purpose of grieving as being able to let go or detach. Much of the work that uses a model of supporting continuing bonds comes out of work in children's hospitals, NICUs, and other child-centered medical practices. The idea is that parents can build narratives of their loss that continue to hold their child in their lives in meaningful and adaptive ways instead of working to detach from or diminish the loss.

Parents, siblings, extended social support, and medical support are important in being part of the wider community that acknowledges and validates the person who was lost and the meaning that person held for oneself and others. Organizations like The Compassionate Friends (TCF) provide opportunities to support continuing bonds for parents who have lost children; TCF holds an annual, worldwide memorial service at the start of the winter holiday season when family and friends can gather with others and remember and share their connections.

Losses and Other Experiences That Can Lead to Grief (and Growth)

Fertility and pregnancy-based losses are relatively common between ages 18 and 44; however, such losses can be difficult to share outside one's closest circle of friends and family. Every day and special occasions can become challenging for families who are navigating fertility challenges or pregnancy loss because their experiences do not reflect the happy story, and, sometimes, attempts at sympathy and support fall short.

Health Disparities in Prenatal Health, Pregnancy Outcomes, and Unexpected Infant Death

Note, families in the United States experience significant health disparities in the areas of fertility and pregnancy care and outcomes, and these disparities are comprised of individual (e.g., sex, age, risky behaviors) and social factors (e.g., income, discrimination, living conditions, access to healthcare and insurance). Disparities in these *social determinants of health* are reflected in national data for fertility, pregnancy outcomes, congenital abnormalities, and infant mortality. *Individuals and families who are affected by one or more of these factors may have particular experiences that intensify their perinatal and infant loss experiences and increase the likelihood of trauma.* Public health researchers and policy makers point to social factors, such as structural racism and implicit biases that create barriers to effective and timely care; community factors, such as rural locations and other communities where there is a shortage of local providers, language/cultural barriers, and inadequate transportation supports; and socioeconomic factors like lack of or inadequate health insurance and low socioeconomic status.

The United States' maternal mortality rate has held fairly steady since 2014, and infant mortality, attributed to birth defects (IMBD), declined by 10% overall between 2003 and 2017. Yet, black, non-Hispanic families bear the highest rates of both maternal mortality (three to four times higher than for any other race/ethnic group) and IMBD (13 per 10,000 births). In addition, Latinx infants are at higher risk of congenital abnormalities, particularly neural tube defects, than other race/ethnic populations (~7 per 10,000 births vs. 4 per 10,000 for Black, non-Hispanic and 5 per 10,000 for White, non-Hispanic populations). Gestational diabetes and hypertension occur in higher rates within the Latinx, Asian, and Native American/Alaska Native populations than for White, non-Hispanic women in the United States. These losses and rates of complications are significantly overrepresented in these race/ethnicity groups when compared to the overall U.S. population.

Sudden Unexpected Infant Death (SUID) is the leading cause of infant death before 12 months in the United States. SUID is any infant death that is not otherwise explained by an obvious cause prior to investigation. Ninety percent of SUID deaths in the United States occur between the infant's first and sixth months, and it affects about 3,500 infants annually in the United States. In the 1990s, the United States implemented the Back to Sleep® safety campaign, now called Safe to Sleep®, which has helped reduce the risk of SUID across all race/ethnicity groups. Yet, there are still significant group disparities such that American Indian/Alaska Native and Black, non-Hispanic families experience the highest SUID rates. In fact, these rates are twice the rate of White, non-Hispanic families and three and four times the rates of Hispanic and Asian/Pacific Islander families.

Fertility Challenges

Getting pregnant and being able to carry a pregnancy to term is a common goal in young families. However, these goals are not necessarily easily achieved or straightforward. Data from the National Survey of Family Growth (NSFG), an ongoing national survey administered through the Centers for Disease Control and Prevention (CDC), indicate that about 10% of individuals (~ 9% men, 11% women) and 12-15% of couples in the United States experience fertility problems, which is defined as being unable to conceive after 1 year of having unprotected sex. About 10% of couples continue to have impaired fertility after 2 years of actively trying to conceive. In contrast, otherwise healthy individuals and couples under age 30 have a 40-60% success rate of becoming pregnant within 3 months of trying to conceive. Approximately 13% of women (ages 15-49) have used fertility services to try to conceive.

The NSFG also estimates that approximately one quarter of women, ages 18 to 44 years, have considered adoption, and that number increases to 52% for women who have experienced fertility challenges. Consideration of adoption increases as women grow older; women in the 25-34 and 35-44 age groups consider parenthood through adoption more frequently than women in the 18-24 age group. Although the number of women who consider adoption increases with age and fertility problems, the number of women who actively seek adoption and then follow through is quite low, 1.2% and .7% respectively. (Comparative data are not available for men considering, seeking, or completing adoption.)

Because fertility problems are evaluated (medically) in years, these challenges can become a chronic stressor for individuals and families. Interventions often do not begin until after a year of being unsuccessful in getting and/or staying pregnant. Testing, for one or more partners,

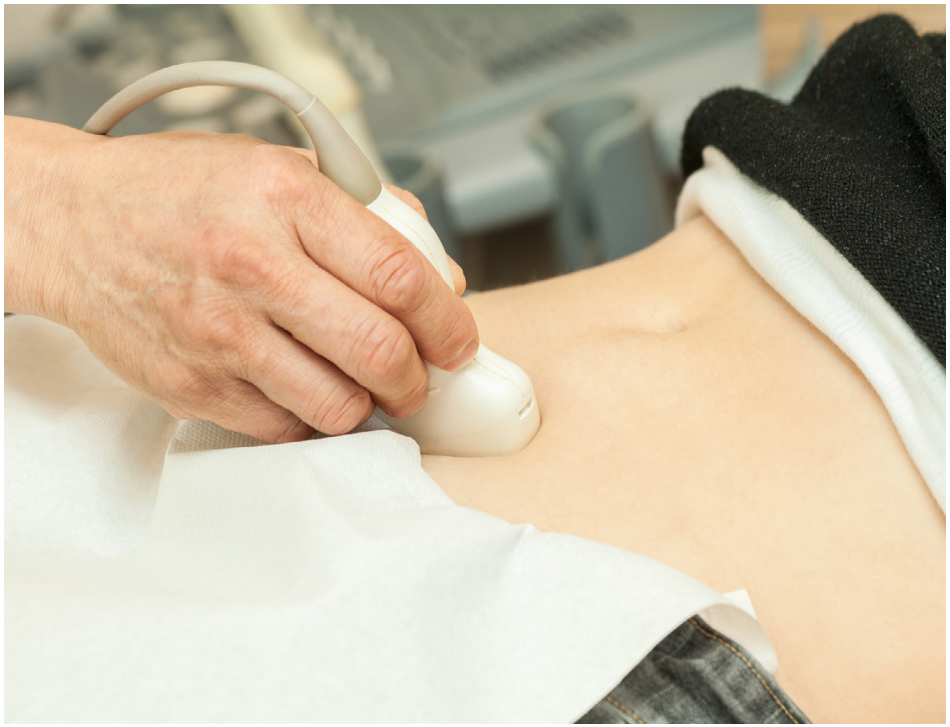
may take several months to eliminate different potential causes for infertility. For some families, the challenges do not end when medical assessments are concluded—testing may reveal that pregnancy is not possible. Other families may learn that their likelihood of carrying a pregnancy successfully to term is not possible or poses high risk to the pregnant person and/or fetus.

Perinatal Losses: Miscarriage, Fetal, and Neonatal Losses

In the United States, the term *miscarriage* typically refers to a spontaneous pregnancy loss before 20 weeks' gestation, whereas the terms *fetal loss* and *stillbirth* are used to describe those that occur after 20 weeks' gestation (i.e., 2nd trimester and later losses). The majority of pregnancy loss occurs within the first 12 weeks; of those individuals who confirm pregnancy, about 10-15% will experience miscarriage before 20 weeks. The most common reason for early loss is due to errors in chromosomes that prevent development from continuing. Fetal loss occurs in about 1 in 160 births and can occur due to a variety of reasons, including trauma (e.g., falls, exposure to disease or toxins),

maternal health conditions (e.g., diabetes, lupus), pregnancy conditions (e.g., preeclampsia, carrying multiples, growth restriction), fetal health conditions (e.g., congenital birth abnormalities, lethal fetal conditions), and labor trauma or injury (e.g., oxygen restriction, intracranial hemorrhages). *Neonatal loss* is defined as infant death in the first 28 days after birth. In 2019, the United States had a neonatal death rate of 3.7 per 1,000 live births.

Family members can experience miscarriage and fetal loss in different ways. It is common for adults to question whether or not they are parents if they have a perinatal loss. Siblings can also wonder if they are indeed an older brother or sister. The roles and labels can feel unfinished or invalidated. Additionally, it can be distressing to try to answer questions like "How many children (or brothers or sisters) do you have?" or "Don't you want to try again?". Some research has examined if loss is experienced differently when the conditions precipitating the loss are different, and, recently, fathers and men have been included to learn more about their experiences with loss, grief, and post-loss growth.



Research indicates that attachment is an important factor in understanding the grief response to perinatal loss. The experiences of having one's grief validated or invalidated (disenfranchised) contribute to individual and couple well-being after such loss. There is disagreement in the research that examines whether feelings of loss and grief increase as a pregnancy progresses. For example, early losses (less than 12 weeks' gestation) might not lead to intense mourning and grief, while losses that occur between 16 weeks and 40 weeks are more likely to be intensely experienced. The main assumption in this research states that the more time expectant parent(s) and family members have, to build their attachments to and hopes and expectations for the coming child, the more likely it is to feel those dreams and connections are ruptured when a pregnancy loss occurs. Yet, much of the research in this field is based on White women in the United States and other Western-based cultures and does not take into account experiences from non-Judeo-Christian or non-White populations. *Broadly, every pregnancy loss experience and subsequent feelings of grief and growth are deeply rooted in multiple layers of individual, family, and community circumstances.*

Difficult Diagnoses

Families who receive difficult diagnoses (e.g., life-threatening, terminal, chronic), either during pregnancy or in the first few months and years of their child's life, often experience a sense of loss. These feelings may be related to, among other things, the disruption of hopes and

dreams for their child, the uncertainty of what a diagnosis may mean for their child's and family's future, and stress about resources needed to support their child (e.g., financial, time, emotional, community). Yet, families may also experience feelings of relief as a diagnosis can also provide clarity for questions and concerns and direction for treatment, support, and connection. It is not unusual for families to have mixed feelings of loss and gain when there is new or additional information, treatment, or support. Families who have a child with a diagnosed condition may experience *recurrent grief* (also called *chronic sorrow*) throughout their child's life. Recurrent grief is not prolonged or unresolved grief. It is a dynamic experience of having alternating periods of well-being and positive coping and periods of grief and loss-focused emotions as family members process their own responses (positive and negative) to their child's condition and negotiate responses from the communities in which they live. In these cases, recurrent grief is tied to a specific set of circumstances and factors surrounding a child's diagnoses/conditions, but the triggers for feeling grief (and well-being) can vary over the child's lifetime. Parents may come to expect certain events as potentially triggering, like conversations about developmental milestones or a child's future as an independent citizen.

Foster Care and Adoption

Some families in home visitation programs may be actively engaged in the foster care system, whether as foster care families providing out-of-home and/or kinship care or as families who are at risk of having their child(ren) removed and/or having their parental rights terminated. Some foster families seek permanent placement of their fostered child(ren) through adoption, while others may not. It is also likely that some families entering into home visitation may pursue direct adoption through private services. Families who are active in fostering/adoption communities, families at risk of losing custody, and the children who are at the center of these actions can experience loss, grief, and growth as part of these family and legal decisions.

Families who foster can experience loss and grief when a placement ends, whether or not the fostered children are reunified with their birth families. Everyone in the family system can feel these losses—adults, other children, extended family—and those feelings can vary by person due to their unique relationship history. Loss can also be felt when a child is adopted into a family system as roles and relationships change in response to integrating the child into the family. For example, siblings can experience several changes in their relationships and roles, such as being the youngest, becoming a "middle" child, or being expected to take on new responsibilities.

6.3.3 Loss, Grief, and Growth in Young Families

Families at risk of having one or more children removed from their home are highly likely to be experiencing multiple stressors related to their current situation. The threat of or actual removal of children in their care brings every aspect of the parents' lives under examination. While the place and time of removal can vary, from just after childbirth to months (and even years) later, families going through temporary or permanent removal likely have several loss and grief experiences that may be related and generational.

By definition, children who enter into foster care and those who are adopted have experienced at least one early relationship disruption and potentially more than one. Trusting, stable caregiving relationships in early childhood are fundamental to healthy development, and children who experience multiple placements and/or extended separations can develop attachment issues that impact a range of developmental processes. Fostering/adoptive family members and the fostered/adopted child can experience ambiguous loss due to changes in belonging within a family system. For example, a young child placed into a foster home likely has parents he or she is attached to or may have other siblings who are not placed in the same home, yet these siblings' psychological presence is real for the child even though they are physically absent. Multiple separations and placements can be loss events that build up relational disruptions for children. This, then increases the likelihood of relational trauma and intensifies the risks for complicated grief and reactive attachment disorder. When these situations occur, clinical support and intervention are needed.

Children's Grief

As noted earlier, children also experience loss, grief, and growth. Children can experience loss and grief first-hand, like through the loss of a parent, sibling, friend, or beloved pet. Children can also experience loss and grief second-hand (vicariously), such as when someone or something important to their family or community is lost (e.g., a co-worker close to a parent, a natural or man-made disaster). Whether first- or second-hand, children are part of a family system that is also affected by the loss. As families are a primary source of attachment and connection, each relationship is part of a system where individuals are processing their own loss and dynamically responding or reacting to the expressions of loss that others in the family are feeling.

6.3.3 Loss, Grief, and Growth in Young Families

Children's experiences with loss and grief are both similar to and different from adult experiences. Similarities include the range of emotions they may have and the feeling that it is important to have a *Circle of Support* to help them as they process their grief and seek connection and safety. Children, particularly young children, also experience grief differently because, developmentally, their understanding of time (e.g., past, present, future) and permanence is limited, and they have limited language to link their emotions (e.g., sad, lonely) and body-based feelings (upset stomach, tiredness) to words. When children experience loss, it is common for them to seek out ways to feel safe and secure, to ask for assurances, and to have moments where it could appear that they are unaffected by a loss. For example, an infant, toddler, or 2-year-old may show distress and grief by becoming insistent on being with or next to his or her preferred person(s), refusing to let another parent or caregiver hold or soothe him or her, and crying inconsolably when separated from the preferred person. Other common changes in young children's behaviors include short-term regression in behaviors like toilet learning, sleeping, and word usage. It feels safer and less stressful for the child to return to what he or she knows than to push and explore limits by trying new or relatively new things.

Young children may ask if a loss is still true and want to have the loss story told multiple times and by multiple people as they try to make sense of what the loss means to themselves and others around them. Questions of why and how and when are common, expectable questions such as "What happened to Papa?," "Why did Sissy get sick?," "Where did Joey-dog go?," "Will this happen to you, too?," and "When will I see Oma again?" Young children may also incorporate loss into their play. As twos and threes start exploring imaginative play, they often pull scenarios from their current experiences. *Liquidating play* is play where children take an unpleasant experience, including

loss experiences, and put it into a narrative where they can investigate different aspects of the event, change outcomes, try out different feelings and thoughts, and explore what they think others are thinking and feeling about the event.

Questions and play episodes are ways of seeking understanding and assurances about specific loss experiences and, more generally, what loss feels and looks like across experiences and people. These are ways of coping for young children, and they give parents and others insight into how a child is trying to make sense of what happened and provide opportunities to share facts and beliefs about the loss. Adults can sometimes struggle to answer the questions or appreciate what may come out in liquidating play, but these interactions are an important part of helping children grieve and build their sense of what losses can mean for themselves and others. These interactions also provide opportunities for parents and caregivers to share and model

coping strategies, including being able to acknowledge and accept negative emotions and thoughts and access ways to reduce the stress through positive coping efforts.

Grief Support to Foster Growth After Loss

As described earlier in this *Moment*, about 60% of grieving individuals, in the United States, are able to integrate their loss experience into their lives and move forward and process their grief in ways that lead to post-loss growth. Of course, loss and grief rarely happen in isolation, so additional factors can impact one's grief experiences: previous mental and physical health conditions, previous loss or trauma, and whether one has supportive relationships and adequate resources to address a variety of consequences related to the loss. Another 10-15% of individuals experience levels of grief that may require clinical support (complicated grief), and the loss experience can contribute to trauma and post-traumatic responses.

Loss is almost always experienced as an adverse event, but it may or may not be a traumatic adverse event. Researchers and practitioners note this distinction because grieving experiences and potential for post-loss growth can differ. Individuals who experience a loss as non-traumatic are able to draw on their existing resilience reservoirs to help them return to a pre-loss state of normal daily life. They integrate their loss into their existing beliefs about themselves, their relationships, and the world around them. In other words, their fundamental worldview remains stable in the face of the loss. Individuals who have a traumatic loss are more likely to experience distress related to shifts in one or more areas of their beliefs. This tension between distress and change is what is thought to create *post-traumatic growth* (PTG). PTG is a potential outcome of actively managing the distress over the loss of one's beliefs about themselves, others, and their world to come to a

Through a Young Child's Eyes

Loss, Grief, and Growth

0-2 years

I am focused on what is happening in the present moment. Our connection right here and now is what I understand the best, and it is based on our relationship history.

I don't understand death, but I can feel significant distress if someone I have developed a relationship with dies or is no longer able to connect with me physically and emotionally. I can feel this because my relationships are full of connections and care that help me understand who I am and what my world is like.

I can pick up on the emotions and behaviors my important people show when they are grieving. By the time I'm 12 months old, I may try to show comfort and care to my important people when they are sad or find it hard to connect with me. I do this because I've seen you do this when I am upset, and I'm trying to be just like you.

What helps me when I feel the loss of an important person can also help you! I find comfort and security when we connect and share our feelings and try to help each other. You help me with big and tough emotions when we can talk about them and find ways to soothe ourselves and each other.

Routines are predictable ways I can connect with you and my loved ones, such as mealtimes, playing games like "patty-cake," snuggles at bedtime, and even diaper-changing times. Please help me feel those connections by keeping our daily routines as normal as possible.

Understand that I like predictability, so I may protest when things are changed or unusual. I'm letting you know that I notice these differences, and they can be challenging for me. I may want to repeat these routines again and again because they make me feel safe.

Through a Young Child's Eyes

Loss, Grief, and Growth

2-3 years	4-6 years
Even though I may say the word sometimes, I am not sure what it means when something or someone dies. My understanding of time and permanence is simple and changes as I gain new experiences with these concepts. I may ask the same questions over and over as I try to figure out what death means. There are a lot of things we are able to do again when they end, like a new day or rereading a book, but, if someone is gone when they die, I may not understand or know if I will see them again.	I understand a little more about death, but I can still be confused by it or think things that seem silly to older people. Like, I might wonder if I can catch death from someone, or I may develop a fear that other important people are going to die, too.
Clear words help me because I am learning to use my imagination, and, sometimes, I can scare myself with the new things I think about! I can scare myself thinking that I could die if I fall asleep or go away because I heard someone use those words to describe what death is like.	My imagination can create all sorts of connections to help fill in gaps for things I don't fully understand. For example, I might never want to play with a toy again because my sister played with it before she died.
When a person close to me dies, I feel that loss in many different ways. I feel a loss of security and safety, which may show up in my behaviors like being anxious, acting out, using "baby" talk, or wetting the bed. I feel the distress in my body, my emotions, and my relationships. It helps when we keep our daily routines because those are predictable and make me feel safe when many things feel uncertain.	I have more words to help describe my feelings and emotions, but I may not always be able to use them when I'm really distressed, and my feelings may come out in other ways. It is hard to use language when feelings are so big and raw, so I may show my distress in physical ways, like hitting someone or throwing toys. Help me identify ways to calm myself and understand my feelings, so I can learn to express them appropriately.
I may find comfort in the rituals our family uses to recognize death and loss. These rituals will be new to me, but I like learning new things, and, being part of them, helps me feel connected.	
You help me understand my grief when you recognize I'm feeling big or stressful emotions. Sometimes, I may act in ways that can appear naughty, but I'm looking for connection—maybe to the person I've lost or maybe to you. I am trying to increase my feelings of safety and security.	Work with me to build coping strategies that we can use when one or both of us feel overwhelmed. We might create our own "remember and feel box" that we can use to store emotions when they are too big to hold inside our bodies and minds. Our box can also hold items we might want to keep because they help us remember good and happy things about our lost person or thing. We can look at these items together and talk about our emotions and share the simple and complicated parts of our grief.
Sometimes, I need your help to sort out and move through big emotions. Help me by naming my feelings, like sharing that a tummy-ache could be part of feeling sad. Help me by running and jumping with me when my body feels like it just needs to *GO* to let off some energy! Show me that these feelings are normal, and I can trust you to help me figure out ways to handle them instead of ignoring them.	

new and modified understanding of their lives. Research with parents who experienced PTG indicates that there are at least five areas where a person may see changes in themselves from before the loss to afterwards: perception of themselves (self-identity), changes in relationships, attitude toward life, changed priorities, and existential change (e.g., beliefs about fairness in the world, the role of religious beliefs). Not all areas may change or change significantly due to a loss, but some change can be realized. Personal and post-loss growth are thought to be linked to several characteristics: personal (e.g., openness to experience), dispositional (e.g., seeking support, active vs. avoidant coping), empathic social supports (e.g., clergy, friends), other bereaved families (e.g., local groups, charities/organizations), and intense cognitive activity (e.g., making sense of the loss, continuing bonds).

The principles of *Trauma-Informed Care* are well-suited for working with grieving families in home visitation. Each of the principles contribute to a trusting relationship in which a parent and family can find safety, honesty, and non-judgmental support as they mourn. Families may see their home visitor as a skilled partner who is able to help make connections to social and instrumental support and who has a personal interest in their family's well-being. Home visitors may be able to identify barriers to grief support, including stigma around seeking formal support or lack of culturally responsive community connections (e.g., funeral and burial services) and work with a family to overcome or address these challenges.

Why Loss, Grief, and Growth Matters to Families

Families experience loss and grief throughout their life course, and there are some types of loss that are more likely to occur in families focused on having and caring for children. Yet families and individual members, from youngest to oldest, have the capacity to be and become resilient in the face of one or more losses and experience PTG when traumatic loss occurs. This *Everyday Moment* is being written in the era of COVID-19. Today there is heightened worry about family and community members, and safety protocols include varying levels of social distancing and isolation enforced by local, state, and federal regulations. This means that grief supports, including important rituals for remembrance, may be significantly altered, and this can compound the original loss.

Some parents may invite home visitors into conversations about a loss, while others do not, and some families may seek formal support while also participating in home visitation. Some families may ask for help in how to talk with children and others about the loss. The home visitor must be aware of his or her professional practice boundaries and offer help with compassion.

There are several ways to provide grief support and encourage finding meaningful social and instrumental supports, depending on whether a person is experiencing grief at a non-clinical or a clinical level. Many of these strategies can be tailored, so they are developmentally appropriate for families with grieving adults and children. In fact, many of these strategies are probably already in your home visitor toolkit! Here are some examples for using these skills when talking with parents and young children about losses they've experienced:

Active Listening and Active Watching

- Grieving adults and children sometimes just need someone to bear witness to their loss, to hear their stories, to sort through the variety of feelings their loss creates for them.
- People, particularly very young children, also communicate about their grief through their actions. Observation and curiosity-based questions and comments may be helpful to encourage a person, young or adult, to recognize the variety of ways in which grief can occur in the human body (e.g., lethargy; confusion; seeking comfort through routines/habits, including regression to earlier developmental levels).

Developmentally Appropriate Language and Reflective Responses

- Keep language about a death or other loss simple and clear. Realize that there may be limited understanding of what death means or other unknowns if death is not the loss.
- Keep the grieving person, child or adult, the focus of the conversation. Responses like, "It sounds like the loss of your Aunt has brought up a variety of emotions for you. Do you want to talk about her for a while?" can show the person you are listening and not judging his or her feelings.
- Avoid offering personal examples, such as "This happened to me, too." Personal examples may seem as though they are reflective, but they change the focus from the grieving person to the support person.

Honesty with Compassion

- Children of all ages can be confused by euphemisms about death. Very young children do not yet grasp the concepts of permanence and time. Thus, phrases like "Charlie had to go away" and "Tía Rosa went to sleep" are vague and impermanent. After all, Charlie could come back. Other people go away and come back. And, a child can wonder, "If I fall asleep, will I end up like Tía Rosa?"
- Older children, adolescents, and adults may ask questions like "Everything will be OK, right?". It can be tempting to offer solace and reassurance. But that response may not be honest, though offered with compassion. A compassionate and honest answer might be, "I don't know if everything will turn out OK, but I am here to support you through this."

Boots on the Ground: Everyday Moment Conversations with Families

This section highlights content and skill-building strategies you can use as you plan your home visits. For the *Everyday Moment* section of the visit, you will find a list of topics to choose from and to explore in conversations about loss, grief, and growth in young families. For each topic, you will find the associated *Protective Factors* and *Trauma-Informed Principles* addressed. *Family Pages* designed to support your conversations are listed next.

In addition, you will find suggestions of related one-on-one activities to choose from for the parent-child interaction portion of the visit.

There are several *Loss, Grief, and Growth* topics to choose from as you plan a visit to a family, and you should tailor the conversation to that family's specific needs and interests. You may find that you discuss one topic now and come back to discuss another in a month or two depending on certain circumstances.

Using the information you have about a family's *Protective Factors* can guide your curriculum choices to tailor the home visit discussion and activities. Ideas are presented in the next column with their associated icons to highlight how they correspond to meeting a family's needs and building each family member's resilience.

Parents' loss experience(s) and expectations

Parental Resilience may be covered when parents want to share about their loss and think about what the loss means to them and/or to their future expectations and plans.

Understanding big and uncomfortable feelings—for children and for parents

Knowledge of Parenting and Child Development and

Social and Emotional Competence of Children may be important to parents as they and their children try out ways to cope with a range of feelings and thoughts about a loss and find comfort.

Keeping relationships strong

Knowledge of Parenting and Child Development and

Social Connections and

Concrete Supports can help parents realize that they may benefit from expanding their *Circle of Support* so that they can connect with others who may have experience with or insight into their particular loss or grief experience. Having others to reach out to can help reduce stress on an intimate relationship when both are grieving and need support.

Family Pages

A series of *Family Pages* on *Loss, Grief, and Growth* have been created to support your conversations with families while you are visiting and to become a resource parents can refer to between visits. These include the following:

- Loss, Grief, and Growth from a Child's Point of View
- Big Feelings for You
- Big Feelings for Your Child
- Keeping Adult Relationships Strong When Grieving
- Difficult Diagnoses: Getting the Support You Need
- Growth After Loss: Finding Your Pathways with Grief and Growth
- Focus on You: Looking Back and Moving Ahead
- Practical Applications for Families: Figuring It Out Together

Related One-on-One Activities

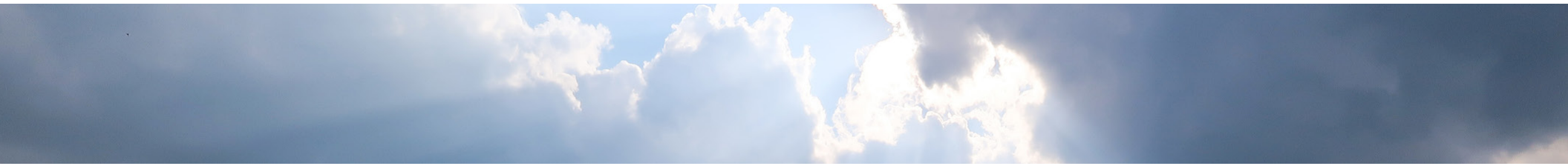
Book suggestions:

- *Mama's Waves*, by Chandra Gosh Ippen (foster care and parental mental health focus)
- *Papa's Waves*, by Chandra Gosh Ippen (foster care and parental mental health focus)
- *The Invisible String*, by Patrice Karst (general loss, separation anxiety)
- *Something Very Sad Happened: A Toddler's Guide to Understanding Death*, by Bonnie Zucker
- *My Father's Arms are a Boat*, by Stein Erik Lunde (parental loss focus)
- *Duck, Death and the Tulip*, by Wolf Erlbuch (children facing life-limiting illness)

Additional Resources

Community, Physical, and Mental Health connections may include:

- Local and National Hospice and Palliative Care support organizations
- Local and State chapters of condition-specific parent support organizations (e.g., Down's Syndrome Association of Oklahoma)
- Sesame Street: https://www.sesamestreet.org/
- Fred Rodgers Center: https://www.fredrogerscenter.org/
- The Compassionate Friends: https://www.compassionatefriends.org/
- March of Dimes: https://www.marchofdimes.org/
- Star Legacy Foundation: https://starlegacyfoundation.org/



Special Focus Moments 6.4 Military Family Life

Military families have a lot in common with civilian families. There are common family development experiences, such as the birth of a child, a teenager earning his or her driver's license, and caring for an adult relative. Military and civilian families often live side-by-side in communities and share schools, religious affiliations, and social connections.

Yet, there are some hallmark features of military family life that do not have a clear counterpart in the civilian population. These include being part of a community that places service to others before self, operates within a clear chain of command, and expects multiple family relocations during time of service. While all families experience separations and injuries, these challenges are accepted as a *typical* risk of duty.

Home visitors may work with families during separations or after an injury as trusted allies who can make the family's resilience visible to them as they adapt and grow, foster the maintenance of strong connections, and highlight families' strengths in *Everyday Moments* and decisions.

In this section, you will find chapters and *Family Pages* that will support you in conversations with military families as you provide support and a sense of steadiness as parents and their young children cope with parental absence and injury.

6.4.1 Parental Absence in Military Family Life

Sharing care and parent engagement during a time of military parent absence can be challenging to expectant families and families who have very young children. A military parental absence can become even more challenging when other stressors, such as health or employment needs of the at-home parent, rocky spousal relationships, or children's health crises, are also present. Additional family-based stressors might include separations and reunions. Separations and reunions naturally stir up deep feelings in everyone. This can be true even for everyday goodbyes. What can be tricky about these feelings is that they are deep, and they may not seem to go together. This is natural and to be expected—even if it can feel confusing. In this chapter, parents are offered insights and strategies for working together to keep family connections strong as they work to support themselves and their young child(ren).

6.4.2 Parenting After Injury

Injuries are a part of everyday life. A pinched finger, a bloody knee, even a broken leg or arm are examples. In addition, military families may experience service-related injuries. These can be physical and/or psychological, visible and/or invisible, mild or severe, short-term or long-term, and accidental or intentional. Injuries impact every family member—from the youngest to the oldest. Dealing with an injury may cause a temporary wobble until family members regain their balance, or an injury may mean lifelong changes. In this chapter, parents are invited to consider that their relationships, strengths, and resiliency are still present and can be drawn upon as they meet challenges and discover new strengths and possibilities as their family returns to everyday life or moves forward in their *new normal*.

Special Focus Moments 6.4 Chapter 1: Parental Absence in Military Family Life

Main Elements

Content Areas

- Teaching About Military Parental Absence: *Protective Factors* and *Trauma-Informed Principles*
- The Science: Trusting Relationships and Parental Absence; Ambiguous Loss and Parental Absence
- Why it Matters to Families: Building a Resilient, Long-Distance, Co-Parenting Plan; Addressing Challenges of Separation, Reunion, and Reintegration; Parent Engagement During Military Parental Absence
- Home Visit Activities and *Family Pages*
- Important Safety Supports and Knowledge: Military Family Plans

Teaching About Military Parental Absence: Protective Factors and Trauma-Informed Principles

Military family life is, in many ways, similar to civilian family life. There are common family development experiences, such as the birth of a child, teenagers earning their drivers' licenses, and caring for an adult relative. Both military and civilian families also share experiences related to parents' occupations and professional training or advancement. Yet, there are some hallmark features of military family life that do not have a clear counterpart in the civilian population. These include being part of a community that places service to others before self, operates within a clear chain of command, and expects multiple family relocations during time of service. *Military Parental Absence* is shaped by these characteristics and other challenges that are *typical* in the military family life, such as separation, relocation, and risk of injury or death. This grouping of challenges is not easily found in any other occupational or family group in the U.S. Military-connected spouses often refer to themselves as being *geographically single* parents during an occupational absence.

Exactly what is parental absence and how might it be experienced in a military family? Sometimes, it is easier to define what something is NOT and then build a picture of what it is and can be. So, what is it NOT?

6.4.1 Parental Absence in Military Family Life

Parental absence IS NOT the same as an absent parent.

Parental absence is defined as temporary in nature, resulting in a parent returning and reengaging with a child. The absence is almost always described as a physical absence, although there can be and are situations where a parent may be psychologically absent in a child's life. A psychological absence occurs when a parent cannot maintain a meaningful emotional connection and may also involve a physical absence (e.g., different types of mental illness, life/work situations that severely restrict contact between parent and child). In contrast, an absent parent is one who has abandoned and fails to maintain contact with his or her child. In legal situations, the term absent parent may also describe a parent who has no custodial duties or rights but still has a financial obligation for the children.

Some examples of parental absence include those due to divorce, separation, and/or custody arrangements; incarceration; civilian occupational absence where a parent must travel or be away for work obligations (e.g., oil and gas industry workers and long-distance freight haulers); and military occupational absence, which includes temporary duty (e.g., training or as a specialist assigned to a unit), unaccompanied tours (i.e., a duty station where dependents are not allowed to live, such as the Demilitarized Zone in South Korea), and deployment for combat, peacekeeping, or humanitarian needs. Families can experience one or more types of parental absence, whether military or civilian.

Yet, through many of these types of parental absence, the majority of parents who take on the primary caregiving roles actively try to maintain or achieve some level of co-parenting and sharing care with important others, like child care providers and grandparents. Most parents who are away also hope and work to maintain meaningful connections with their children.

Sharing care and encouraging parent engagement during a time of military parental absence can be particularly challenging for expectant families or families who have very young children. This population tends to be younger (early 20s), with the Service member lower in rank (E1-E4, enlisted), and may not have well-developed social and concrete supports. Service members may also become parents while they are away from their spouses or partners, meeting their child for the first time through a video screen and holding them for the first time at a unit's reunion ceremony. A military parental absence can become more challenging when other stressors are also present. These family-based stressors might include health or employment needs of the at-home parent, unstable spousal relationships, or children's health crises. Occupational stressors can also increase a family's challenges, such as those that can pose risk of injury or death to the Service member or an extension of a current absence.

6.4.1 Parental Absence in Military Family Life

As a home visitor, you may find that information from the other chapters of this curriculum may be relevant for families who will be or who are experiencing a military occupational absence. That is because family life continues. Routines, relationships, and individual development carry on, so no one person and no family is in the exact same place as when the absence began. Because this chapter is about a specific military family circumstance and experience, other TRHV topics about *Everyday Moments* may be useful in showing families how life for both parents and children continues through military parental absence and that the away parent can build and maintain meaningful family connections in spite of separation.

For example, there may be content or *Family Pages* from *Building Trusting Relationships* that could be useful and appreciated for the sailor who is away and worried about his toddler remembering him after 6 months at sea. Content and *Family Pages* from *Co-parenting and Sharing Care* could spark an a-ha! moment for a couple who is reintegrating after an absence by helping them recognize ways each communicates support and encouragement for their partner as family roles are adjusted. A family who is in the early months of a 1-year unaccompanied tour may find that sharing information and *Family Pages* describing current milestones or challenges faced by their child is an effective way to support parent engagement and connection for one or both parents. As you become more familiar with TRHV, you will start to make these connections that, in turn, can strengthen the families in your program.

This chapter provides information that supports the following *Protective Factors*:

- ***Social Connections***
- ***Concrete Supports of Families***
- ***Parental Resilience***
- ***Knowledge of Parenting and Child Development***
- ***Social and Emotional Competence of Children***

Teaching about *Military Parental Absence* offers opportunities to model the following *Trauma-Informed Principles* in the parent-child and parent-home visitor relationships:

Safety – Safety is a key characteristic of healthy relationships, psychologically and physically. Parental absence can challenge feelings of safety for young children and their parents. The at-home parent or caregiver who assumes primary family responsibilities may wonder if he or she can handle all the additional work and management of family life. The away parent may have those same worries for his or her partner. In addition, parents at home and away may both worry about the health and safety of the away parent. The very young children in these families also feel the changes in who is present and who cares for them. It is difficult for children younger than age 4 to grasp time and being emotionally connected to people who are not physically present. When parents are able to find and build their own sense of safety, their children benefit from reduced family stress.

Home visitors may be in a position to help the at-home parent build and maintain connections that reduce worry for his or her Service member and strengthen social and concrete supports for one or both parents. For example, a home visitor may focus part of a visit on resource sharing and may explain how the Army's rear detachment system (each Service has a system, but they are not all alike) works for families of deployed Soldiers. Concrete resources are available from this system and include information, such as where to take the car for service or who to contact for help with the yearly tax return. Social connections, personal and community-based, can also go a long way to decreasing uncertainty and pressure for the at-home partner who may feel she or he is *handling it all*. Spouses who become active in the family readiness systems of their Service member's unit can build social and formal support connections related to keeping themselves informed about their Service member and his or her working conditions.

Trustworthiness and Transparency – Healthy co-parenting and extended caregiving relationships are honest, stable, and supportive, whether both parents are physically present or one (or both) is away. In healthy co-parenting and extended family relationships, discussions about care, nurturing guidance, and concerns are open, and decisions are shared and then supported. What these processes and conversations look like during a military parental absence can vary, but the principles are the foundation for finding a way forward together. The away parent may need to have reassurance or more explicit support to feel meaningfully connected, but it is possible. For example, the at-home parent may record a video of a toddler singing the *Barney* "I Love You" song for the away parent, and that video can be played any time by the away parent. Or, an at-home parent may ask the away parent to give input about places to take the car for maintenance because that is usually his responsibility.

Military families can face challenges to trust and transparency when the parenting relationship is unstable, and a parent is away. The conditions of the away parent's duty can also shape a couple's trust and ability to be transparent.

Home visitors can work with parents to help them define how and what family life information they share during an occupational absence. This might mean raising hypothetical questions like "Would you want to know if your partner or child had a mild illness or accident?" and "What do you worry about and how do you regroup when a scheduled call falls through and you are not able to connect?". There are times when one or both parents may buffer information so as not to worry their partner. Discovering what events would lead to buffering information can help keep trust and transparency healthy in the family system.

Home visitors may work with military parents who are not in 2-parent families and for whom the shift in parenting responsibilities is to an ex-partner, close relative, or trusted friend. It may be important to help away parents build a sense of trust that these partners share similar goals in caring for their children. The *Family Care Plan*, which each Service member completes before a deployment or other absence, addresses important legal aspects of dependent care and can serve as a conversation opener about important caregiving values that the away parent wants to support and trusts will happen in his or her absence. Home visitors may be able to help the away parent establish a communication plan with the at-home caregiver and have him or her try it out before separation occurs.

Peer Support and Mutual Self-Help – Healthy co-parent and care partnerships offer support to each person in the relationship. This support is built and strengthened through connection and a mutual focus on the well-being of the child. Parenting partners can provide support even when long distance. Such parents can benefit from recognizing how giving and receiving support can change when one parent is physically away and identifying what kinds of frustrations can develop. The at-home parent may be able to facilitate the away parent's continued engagement by sharing about their child's daily life and setting up opportunities to connect the away parent directly with the child. An away parent might regularly include questions about the at-home parent's well-being, so there are conversation openers to share emotional and physical needs and strengths.

Home visitors and parents can build a relationship that accommodates an away parent's involvement in parent education through sharing visit information. When home visitors learn which strategies of sharing and, potentially, connecting in real-time work, that information can improve the practice of home visitation while supporting the family's resilience to survive and thrive in military life.

Collaboration and Mutuality – Parents who are able to discuss the unique challenges of military parental absence may be better able to anticipate and address how power and decision-making as a parent may change before, during, and after an occupational absence. The dynamic nature of the cycle—preparing for absence, being absent/experiencing absence, and reintegrating into relationships—can mean multiple shifts in parenting responsibilities and how much weight a parent's input may have in different decisions. When parents prepare for a military occupational absence, there will be tasks that are shifted from one parent to another. Those tasks may be addressed differently by the parent taking on these additional tasks. It may feel bumpy to release tasks to a co-parent because there is likely an established division of chores and family management needs, like who does laundry, maintains the monthly budget, takes care of the lawn, or contacts a building supervisor when the stove goes out. The at-home parent may find that some routines and tasks that were already part of his or her load need to be adjusted. For example, a parent who did daily child care drop-off and pick-up for her toddler may seek out a carpool buddy, so she can have 1 or 2 days free to stay at work longer or complete life tasks, like banking, that often need to occur during *normal* work hours.

Home visitors and parents each have goals in building their partnership. When occupational absence is relevant for a family, information about healthy caregiving partnerships and a family's specific parenting and caregiving arrangements can be discussed in this context, and strategies can be shared that help keep the child and the family at the center of their work together.

Empowerment, Voice, and Choice – Military parental absence can feel overwhelming to families with very young children, but this experience can also provide opportunities to gain confidence and skills in the areas of family and life management for the geographically single parent. Parents who are able to adjust with attitudes that empower their partner can communicate respect where both partners feel heard and supported for making choices about how to accomplish the changed roles.

Home visitors who work with families experiencing military parental absence may find that there are occasions when one or both parents feel uncomfortable with the role change or worry that they may not be up for the task(s). Home visitors may be able to help parents reframe their experiences in ways that highlight their strengths, which illustrates a belief in a family's ability to be resilient and resourceful in the face of challenges. Sometimes, changing the perspective of the conversation provides a sense of psychological relief and frees parents to explore options or come to terms with circumstances that may not be changeable while one or both parents are away.

Cultural, Historical, and Gender Factors – Military families belong to a community that has a shared culture, a long history, and many unique gender characteristics as compared to the civilian population. Each of these aspects shapes a family's experiences with military parental absence. To better understand the military family population, the following bullets describe some demographic characteristics of active duty families that are important for home visitation and parent education programming that serves military families with very young children.

The 2016 Demographics Profile of the Military Community (DASD, 2017) offers the following information about active duty members and their families:

- Over half of active duty members have spouses and/or dependents, with Army having the highest percentage and Marine Corp having the lowest percentage (61% and 42%, respectively).
- Service members who have children are more likely to be married to a civilian (32%), followed by being a single parent (4%), with a small percentage being in a dual-military marriage (2.5%).
- Spouses of Service members are overwhelmingly female across all branches (Army, 93%; Navy, 91%; Marine Corps, 97%; and Air Force, 87%).
- 25% of spouses are 25 years or younger with another 25% being between ages 26 and 30 years.
- Approximately 40% of active duty members have children (N= 514,021 children), 42% of whom are 5 years and younger.

- The vast majority of military children who are 2 years and younger (82%) reside in families where the Service member's rank ranges from E1-E6 and O1-O3, which are the entry and mid-level ranks of both enlisted and officer positions.
- Race of active duty members, but not of their spouses or children, is tracked. Active duty members self-report their race in the following groupings:
    - White (68%),
    - Black or African American (17%),
    - Asian (4%), other/unknown (4.2%),
    - Multi-racial (3%),
    - American Indian/Alaska Native (1%) and
    - Native Hawaiian/Other Pacific Islander (1%)
- Across all race categories, approximately 15% of active duty members also identify as Hispanic or Latinx, with the Other/Unknown group reporting the highest percentage at 56%.

These statistics indicate that a significant proportion of the active duty population is a diverse, young workforce with young spouses and young children, and the majority of spouses are women. Many of these families may be learning what it means to be part of a military community and how their own expectations for family life may or may not work well in the military context. Families who experience military parental absence can face challenges to cultural and gender expectations for family roles and responsibilities. Yet, the majority of families can find a pathway forward that works for them.

A home visitor may be able to provide an outside perspective when strengths and challenges are linked to a family's cultural and/or gendered experiences. For example, a young family with strong Puerto Rican heritage may find strength in connecting with extended family members during an occupational absence. Some family members might come to help the at-home parent with daily living support, and other family members might provide social and emotional connection to both the at-home and away parents. If these kinds of connections and support are not feasible with extended family, a home visitor might be able to help the parents explore how underlying values of sharing care could work within their immediate military family community with other families. If a father is the at-home parent, a home visitor may be in a position to learn about and share social and concrete support connections that appeal to dads and how support may look different from or similar to experiences for moms within a community.

The Science: What Do We Know About Military Parental Absence?

Parental Absence is an area of military family research that has received significant attention in the post 9-11 era. However, this research area is still developing and does not yet show a full picture of military life for children, parents, or spouses. Recent studies build our understanding of how absence, mostly deployment focused, relates to several outcomes of interest for Service members and their families, such as overall readiness, resilience, and retention; psychological and physical well-being; family functioning; child maltreatment and interpersonal violence; and academic outcomes for school-age children and youth.

Currently, there is more information on military-connected school-age children and adolescents than for children birth to 5 years. There is also more research on the well-being of the at-home parent than of the away parent, whether before, during, or after (combat) deployment. Even though research on military parental absence is limited for families with children under 5 years, two areas of research provide important insights in helping parents and home visitors understand how young children and their parents experience parental absence in the military context. The first line of research concentrates on building trusting relationships in the parent-child relationship and the second line focuses on a concept called *ambiguous loss*, which describes how family members can experience the physical and/or psychological absence of a loved one. Insights from these areas can lead to effective family and community-based practices that support healthy relationship development in spite of the challenges of a parent's military occupational absence.

Building Trusting Relationships and Military Parental Absence

Parents and other important caregivers can foster young children's resilience during a parental absence by building and maintaining trusting parent-child relationships. Parents who can acknowledge their feelings of distress or sadness about a parenting partner's absence can help their young children learn about and begin to cope with their own feelings and needs related to these budding relationships. Infants, toddlers, and twos are continually building their understandings of who their important people are and what their relationships look and feel like in terms of shared or recognized behaviors, routines, language, and emotions. However, very young children are still limited in what they can understand and communicate about a caregiver's absence and have limited coping skills to lower their distress about an absence. Healthy attachment can develop and be maintained with an away parent during parental absence, but it is important to realize that young children rely on having at least one trusting relationship with a primary caregiver to help them learn ways to process big feelings related to this absence experience and to facilitate the connections with the away parent.

So, what child development knowledge is helpful to parents and other important caregivers as they think about ways to support young children and their family's caregiving system during military parental absence? The next few paragraphs highlight information about how infants, toddlers, and twos understand relationships and absence and give examples of some expectable interactions linked to different developmental abilities. For more details on attachment relationships, please see the chapter on *Building Trusting Relationships*.

Infants – Infants younger than 6 months appreciate almost every caregiver who attends to their daily needs, physical and emotional. Infants younger than 4 months lack *object permanence*. This means that young infants do not yet realize people (and things) that they cannot see still exist. It is this limit in their development that can make it easier for them to willingly go to a person with whom they are not familiar. All people are there and then gone when not visible! Yet, with each interaction young infants have with their consistent caregivers, memories are building and creating a foundation for expectations of who should be available and when things should happen. They are learning the very basics of routines and associating characteristics of their important people, such as voices, smells, and the ways their people hold and interact with them.

Families who experience military parental absence during the first few months of a child's life can use this knowledge to help each parent connect to and build his or her relationship with the infant. Parents meeting their infant for the first time after an absence may wonder if their infant will *know* them or may worry that they might be scared of them. Connection strategies used while separated can be the part of a reunion routine. For example, a song or book that the away parent recorded for his infant to hear can be used to talk to the infant as the away parent and infant meet in person for the first time.

A returning parent may use similar phrases as the at-home parent to talk with his infant, remarking on the child's smile or something the child does (e.g., "Look at you reaching for your blankie!"). Very young infants are likely to be curious and, depending on their emerging temperaments (and whether it is close to nap or food time!), willing to stay engaged as they check out this parent. Engaging might look like bouts of staring and taking in information, like the voice and expressions of the *new* parent and watching how the at-home parent is responding to his or her returning partner.

Between 4 and 7 months, infants do develop a sense of object permanence, and this impacts their caregiving relationships. During this period, infants identify who their consistent caregivers are and what they do. Routines and personal styles of interaction have developed that are unique, and infants develop preferences for who they want to spend time with. They often invent behaviors to encourage their important people to connect with them, such as doing a squealing laugh or tapping on a parent's cheek. Older infants recognize changes in their environment (e.g., home, day care, grocery store), routines that will separate or reunite them with their preferred caregivers, and may become reserved when meeting someone who is new or unfamiliar–including a family member they may not have seen in person (e.g., video or photograph only) or since they were in early infancy.

Developing preferences and an understanding that people still exist even when not seen can trigger distress for older infants (and toddlers and twos!). Older infants have the ability to share how they feel about changes in routines, including hellos and goodbyes. By this point, many infants will have experiences with external child care where these routines occur daily, but a military parental absence is not on that same rhythm. Their understanding of time is linked to these rhythms and routines of daily care, which helps them to develop expectations for what is likely to happen next and who they can depend on. Time, like days, weeks, and months, doesn't mean anything to them yet. That can make an extended absence tough even when infants get to see or hear their away parent in real time and in pre-recorded/static ways, like videos and photos. Seeing, hearing, and otherwise being reminded of their away parent elicits their desires to see and connect with that parent. An infant might give a big smile and reach out toward the screen and then quickly experience frustration that she cannot touch or be touched by that parent.

The at-home parent may feel torn between making sure that the infant has connection opportunities yet also feel the struggle of helping her child feel and manage a range of big feelings. Military parents can support their infants through parental absence by better understanding how caregiver connections and preferences develop and learning how temperament can influence infants' expressions of distress and comfort.

Toddlers and Twos – By 12 months, infants will seek information from their important people to help them figure out how to feel about an unfamiliar situation, such as going to a new play group. As infants progress into toddlerhood, their mobility, language, emotional expression, and understanding of the world grow by leaps and bounds. This developmental progress affects how toddlers and twos can connect with their parents. Each early relationship develops unique rhythms of give and take and styles of interaction. Both persons in the dyad, child and partner, build what their relationship looks and feels like through their collaborative actions. These actions, repeated, adjusted, and emphasized over time, give feedback to each participant. Toddlers and twos also often develop attachments to security objects like stuffed toys or blankets, and these can help young children find comfort when they may not be able to reach their parents or caregivers.

Another aspect of development in the second and third years is discovering that one can expect and rely on routines because they are constant or consistent. Routines allow toddlers and twos to devote their energies to learn and explore because they can anticipate what will happen next and feel confident in their place in the world. This reliance on patterns and routines is not unique to young children but part of a lifelong pattern that helps people make choices for allocating resources to things that need more energy, concentration, or time. When there are changes in daily or care routines, a child's sense of a safe base for exploring and moving forward can feel threatened. This uncertainty can lead to developmental regression, which is when a child who has gained a skill, like walking or staying dry through the day, steps back to a lower level of skill. It may be that the skill is new, like toilet learning, so it is still tough and takes a lot of concentration to maintain on a good day, let alone during a time of uncertainty. It could be that stepping back to an earlier mastery level meets other needs, such as a 2-year-old who had moved to his own big boy bed wants to sleep with a big brother or at the foot of his parent's bed to be closer to people important to him.

Military parents can support their toddlers and twos through a parental absence in several ways. Routines that show care and connection may be a little different with parenting roles shifting between the at-home and away parents, yet each parent can still convey care, love, and safety. Time is still a puzzling concept at this age, but parents can talk about how many *sleeps* it might be before a parent goes away or returns or use other methods of counting things that show the passing of time. The away parent may give her 2-and-a half year old a cloth doll that has mom screen-printed on it or set up a system of small *love* gifts (e.g., books, hair ties, hot wheels) that arrive once a week or month. An at-home parent might spend time with his 3-year-old talking about what each of them wants to say and share when they video chat the away parent.

Through a Young Child's Eyes

Parental Absence

How I might feel during this time of big feelings...	How you can support me during this time of big feelings...	
	If you are the parent at home with me...	If you are the parent that is away...
At times I might be clingy. If one of you is away, how do I know the other isn't going away too?	Keep our daily routines—eating, sleeping, bathing, dressing, diapering, and toileting—consistent. This helps me feel safe as I learn that our daily lives continue even during a challenging time.	Make a tape and/or video of you reading a story or doing daily tasks around the home so I can hear and see you any time I want.
I might feel many feelings: sadness, longing, anger, frustration, deep love, and confusion. Or, at times, I might be having so much fun playing that you would never know one of my parents is away.	Keep reminders of my away-parent around so we can see and talk about him or her. For example, put photos of us all at child-level so I can see them, hang his or her jacket on our coat rack just like always, play the songs we sing together, or read the books we read. Offer me a tee-shirt that gives me the security of softness and smell of my parent who isn't here so I can carry it around and sleep with it. You might want one too.	Send photos of you doing the same routines I do at home: brushing your teeth, eating breakfast, going to bed. This helps me keep a picture of you in my head and helps me feel connected because we are doing the same activities.
I might go back to behaviors I used to do like wetting my pants, sucking my thumb, or wanting you to carry me or feed me. When these things happen, I am telling you that this is a hard time for me.	Tell me family stories of times we are all together. We sure do lots of neat things, like walk in the park, read books, and sing silly songs at bath time.	Give me some simple descriptions of what you do at work. For example, "I work on the computer." "I drive a jeep." "I help my friends fix their airplane." Avoid topics that may worry or frighten me.
I might get angry more often—at you or at a friend. Sometimes my feelings are so big they overwhelm me. Sometimes, it is hard for me to *hold it all together*. Sometimes, it can be easier to be angry than to be sad.	Share stories of things I say and do—of how I am growing and changing so my away-parent feels part of my life and will have a clearer picture of who I am when we are together again.	Keep our connection strong. Send me letters or video messages. Talk with me on the phone or during video calls. Keep a photo of me nearby and/or pictures of us together in your head—when it is a safe time for you to think of home.
I might show my love for the parent who is away by laughing and singing and reaching for a hug when we are together on a video call or when they come home. Or, I might break into tears or hide my face. These are all ways that I say, "I love you." Some are harder to understand and accept than others.	Give me words for what I might be feeling, "I think maybe you are feeling sad that Mommy is away working. How about we draw her a picture that we can send to her?"	

Together you can...

Keep lines of communication open—phone calls, letters, email, and video calls. At the same time, be aware that sometimes planned calls may not work out due to technical issues, work demands, or me!	Talk about *big feelings* with each other and at times with me. Putting feelings into words can help us feel more in control and know we are not alone.	Give all of us time to reconnect and find our rhythm when we are back together again. We've all changed, and, even though we love each other, we may have some bumps along the way.

Ambiguous Loss and Military Parental Absence

The previous section highlighted how young children's developmental stages contribute to their ability to process and understand how, why, and how long a parent may not be meaningfully present in their lives. Ambiguous loss is a concept that helps explain physical and psychological characteristics of relationship disruptions, such as military parental absence, for which there may not be a clear path to closure or healing. These transitions of absence and presence create a potential for boundary ambiguity—uncertainty about who is in and who is out of the family caregiving system. Young children's trusting relationships are rooted in physical and psychological connections, and, when a parent is away, feelings of loss can be tied to both types of connection. It can also be challenging when a parent returns because both parent and child are in different places in life than when the absence started; family roles have changed; and there may have been difficulties in maintaining connection during the absence, whether due to logistics like stable internet or due to high stress conditions for the away parent.

At-home and away parents also experience ambiguous loss, which can contribute to the overall family system functioning. As a parent prepares for an extended time away, he or she may spend more time at work as part of preparations, so the parent is still present but also partially absent. As parents shift family roles, the at-home parent may take on additional caregiving tasks that have an effect of decreasing the frequency of routine parenting interactions of the away parent before the absence officially begins. Military families also face ambiguity in terms of how long an absence may be. Military priorities and needs can shift, which can result in extended tours and changed locations and expectations for deployment.

Ambiguous loss often evokes distress and uncertainty, and each person in a family may experience it differently. Sometimes, the distress can show up as anger—more conflicts, more angry words between adults, more tantrums, or more inconsolable crying by young children. This is because anger is an *easier* negative feeling to express than sadness or extended uncertainty. Anger often has a flash point and then dissipates, but other negative emotions may linger and be more difficult for a person—big or small—to find effective ways to lessen those feelings. Because anger may be misplaced or override other emotions related to a parental absence, it can be helpful for parents to recognize their own emotional reactions, so they can manage their reactions more effectively for themselves, their partners, and their children. Acknowledging negative feelings also helps young children learn more about themselves and their own ways of responding to stress, which increases their emotional competence.

Why Military Parental Absence Matters to Families

Military parents face some significant work-related challenges to their daily family life. Adding in factors of being younger adults who are caring for very young children and learning to partner with one another, an occupational absence can spur a significant disruption in family relationships. Yet, there is a rich history of community and support that military families sustain across generations to guide young Service members, their partners, and children through *expectable military* events like absence.

Military parents who are just beginning to establish their collective rhythm have to learn about each other's needs to thrive in military life, through multiple separations, reunions, and reintegrations. Flexibility is one aspect that is important to family resilience as roles will shift over the deployment cycles. Communication skills and styles, and mutual support, are other vital relationship characteristics that parents can focus on to survive and thrive as at-home and away parenting partners. There are shared and unique worries for at-home and away parents regarding their children and their family's well-being. Home visitors can support parents and other at-home caregivers during an absence and do so in ways that foster healthy communication about and with their children. They can be helpful in keeping the away parent feeling more connected and the at-home parent feeling more supported.

As noted at the beginning of this chapter, the topic of *Military Parental Absence* is really focused on understanding a common military family experience. Daily family life continues throughout all phases of an absence. This means that other topics may be relevant to help parents practice communicating about their own lives and their children's lives. For example, maybe a 2-year-old has announced she is a big girl and

will not be wearing pull-ups anymore. Share information on *Toilet Learning* that both parents may be able to use as they talk about this exciting moment! Perhaps, an at-home parent discloses that he needs to change child care arrangements but is not sure how to let his wife know because she really likes the current provider. Strategies in *Co-Parenting and Sharing Care* may be a timely topic that helps this father plan a positive conversation with his wife about upcoming changes.

Military families can be and are resilient families. Parental absence is an expectable event in military family life, and home visitors can be instrumental in assisting young parents with young children build their capacities to thrive.

Boots on the Ground: Everyday Moment Conversations with Families

This section highlights content and skill building strategies you can use as you plan your home visits. For the *Everyday Moment* section of the visit, you will find a list of topics to choose from and to explore in conversations about nurturing guidance. For each topic, you will find the associated *Protective Factors* and *Trauma-Informed Principles* addressed. *Family Pages* designed to support your conversations are listed next.

In addition, you will find suggestions of related one-on-one activities to choose from for the parent-child interaction portion of the visit.

There are several *Parental Absence* topics to choose from as you plan a visit to a family. You should tailor the conversation to that family's specific needs and interests. You may find that you discuss one topic now and come back to discuss another in a month or two depending on certain circumstances.

Using the information you have about a family's *Protective Factors*, you can guide your curriculum choices to tailor the home visit discussion and activities. Ideas are presented below with their associated icons to highlight how they correspond to meeting a family's needs and building each family member's resilience. These include the following:

Parent's experiences with and expectations about parental absence

Parental Resilience may be fostered when parents reflect on their own experiences of separating and reuniting with those who cared for them in childhood and when co-parents are able to establish routines that help an away parent remain engaged and active in their young child's life.

Children's experiences with and expectations about parental absence

Knowledge of Parenting and Child Development and

Social and Emotional Competence of Children are supported when parents recognize how their child understands relationships with his important people and work to help their child feel connected to the away parent.

Family Pages

A series of *Family Pages* on *Parental Absence in Military Family Life* have been created to support your conversations with families while you are visiting and to become a resource parents can refer to between visits. These include the following:

- Parental Absence from a Child's Point of View
- Big Feelings for You
- Big Feelings for Your Child
- Saying Goodbye
- Keeping Relationships Strong
- Reuniting
- Focus on You: Looking Back and Moving Ahead with Your Child
- Practical Applications for Families: Figuring It Out Together

Related One-on-One Activities

These are suggested activities for *Parental Absence*. There is a broad selection of one-on-one activities available in the Activity Card deck.

- Notice and Wonder: How does your child like to connect with his or her away parent? What do you want to share with your partner during an absence?
- Peekaboo
- Counting games with days or sleeps until a parent returns
- Making "Welcome Home" art together

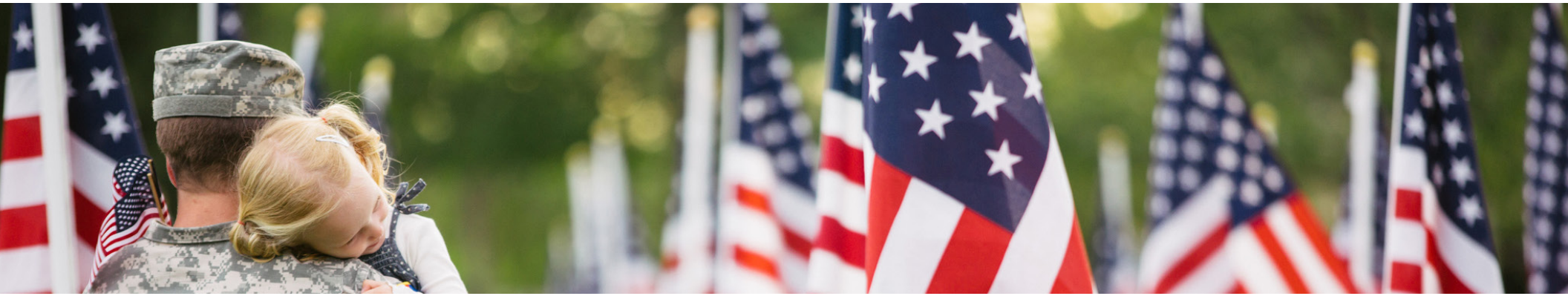
Book suggestions:

- *You Weren't With Me* by Chandra Ghosh Ippen
- *Nonni's Moon* by Julia Inserro

Additional Resources

Community connections include:

- Military OneSource
- Zerotothree.org
- Sesamestreet.org
- Child Care Settings
- Healthcare Providers



Special Focus Moments 6.4 Chapter 2: Parenting After Injury

Main Elements

Content Areas

- Teaching About Parenting After Injury: *Protective Factors* and *Trauma-Informed Principles*
- The Science: Visible and Invisible Wounds; Injury and Trauma; Parenting After Injury and Ambiguous Loss; Children's Curiosity and Concern about Injuries and Injury Communication
- Why It Matters to Families: Building a Resilient Family System; Compassion Stress and Fatigue; Addressing Challenges of Short-Term and Long-Term Recovery; Parenting in a *New Normal*
- Home Visit Activities and *Family Pages*
- Important Safety Supports and Knowledge: Military Family Plans, Family Safety Plans

Teaching About Parenting After Injury: Protective Factors and Trauma-Informed Principles

This chapter focuses on military families who experience injury, yet much of the content may be relevant for civilian families who are also affected by injury. Military families have a lot in common with civilian families. They often live side-by-side in communities and share schools, religious affiliations, and social connections. Yet, there are some hallmark features of military family life that do not have a clear counterpart in the civilian population. For instance, military families belong to a community that places service to country before self; operates within a clear, yet complex, chain of command; and expects multiple family relocations during time of service.

Risk to personal well-being, due to duty, is another potential area of difference between most Service members and civilians. However, there are civilian occupations with higher than average physical and psychological risk too, such as policework, firefighting, child protective services, construction, and energy production. The type of job a Service member is trained to do has important implications for that person's physical and psychological safety. Some military occupations can be relatively low risk when the Service member is not deployed, such as administrative and supply chain positions. Some positions become higher risk due to the location of a

deployment or to changes in one's daily job function. For example, a chaplain may be stationed at a military treatment facility (e.g., a hospital) but could be called to deploy with a unit to help meet humanitarian crisis needs after a natural disaster. In another case, a driver, who usually transports supplies from warehouses to installations stateside, may be deployed to support a materiel command unit that requires driving through hostile territory to deliver goods to multiple forward operating bases (FOBs). Other military occupations can be higher risk, whether at home or deployed, because the positions themselves focus on work that is dangerous, such as combat and rescue positions.

The term **injury** is used broadly in this chapter to describe *harm and hurt caused by a variety of events that results in at least short-term disruption to family or work life*. Injuries can be physical and/or psychological, visible and/or invisible, mild or severe, short-term or long-term, and accidental or intentional. In this broad definition, significant and/or chronic illnesses, such as cancer or an autoimmune disease, can also be included. While this chapter concentrates on Service members parenting after injury, it is important to keep in mind that a Service member's spouse or co-parenting partner(s) could be the injured person (e.g., car wreck, health crisis). Whether the Service member or spouse/co-parent is injured, the family system and parent-child relationships can be affected.

Home visitors can play a vital role in a family's life after a parental injury. A home visitor may be one of a few people involved with the family who are able to consistently use strengths-based language in their work, which can foster the family's resilience through a challenging time. Home visitors may serve in a role to help connect families with appropriate resources. For example, there may be on-going clinical needs for the injured parent, which can cause family life to be so stressful that home visits are often canceled, and visits that do occur may focus on

atypical topics or crisis management. Yet, home visitors can provide information to help a family realize they are not alone and that, while the injury-to-recovery path is unique to each person and their family system, some things can be expected, and everyone in the family system is going to feel effects of the injury in some unique and shared ways.

This chapter provides information that supports the following *Protective Factors*:

- ***Social Connections***
- ***Concrete Supports of Families***
- ***Parental Resilience***
- ***Knowledge of Parenting and Child Development***
- ***Social and Emotional Competence of Children***

6.4.2 Parenting After Injury

Teaching about *Parenting After Injury* offers opportunities to model the following *Trauma-Informed Principles* in the parent-child and parent-home visitor relationships:

Safety – Safety is a key characteristic of healthy relationships, psychologically and physically. Parental injury can introduce uncertainty into the family system that was not present before the event, and both parents and children can be affected. One or more factors regarding the injury can threaten a sense of safety, such as the injury type and severity, the location where it occurs (e.g., local/at-home or far away), and if young children are present when the injury happens. Trusting parent-child relationships may be affected temporarily due to medical treatments and hospitalizations, or relationships may be affected long-term due to traumatic brain or combat stress-type injuries that impact how a parent can relate to his or her child.

Home visitors may provide support by helping the non-injured parent identify resources for the injured parent, being a thought partner with the non-injured parent as difficult choices are addressed, and sharing ways to talk to young children about a parent's injury or illness. There may be conversations about what makes a family system feel secure and how an injury can affect those feelings. Home visitors may also work with an injured parent in identifying and understanding changes that may require adapting parenting interactions and opportunities.

Trustworthiness and Transparency – An injury may be a trauma to a family system that provokes protective behaviors, such as fear, isolation, and distrust. If an injury is serious and/or prolonged, family members will be continually assessing their senses of trust in healthcare providers and others who may be in their *Circle of Support* or with whom they need to communicate about work or family needs, like a supervisor or child care provider. Parents may also struggle to be transparent about needs after an injury, balancing them against a need for privacy.

Parents who feel secure in the parent-home visitor relationship may be able to use this relationship to safely explore and question changes surrounding an injury and recovery. A trusted home visitor can represent a safe relationship where parents can express worries, fears, and thoughts about what the future might hold. This relationship may also present some opportunities to turn parents' attention back toward their children and away from the injury. Sometimes, being able to focus for a short time on a daily or mundane event can offer parents a moment where they find a bit of steadiness even when things feel out of control.

Peer Support and Mutual Self-Help – Healthy co-parent and care partnerships offer support to each person in the relationship. This support is built and strengthened through connection and mutual focus on the well-being of the child(ren). When a parent is injured, his or her ability to maintain usual parenting roles and co-parent support may be impacted. For example, picking up and soothing a tired toddler or bath time duties might need to shift to the other parent or caregiver. These shifts could be temporary because an injury requires crutches or other mobility supports for a few weeks. Or, these shifts could be longer term because an injury permanently affects mobility or dexterity (e.g., a stroke or amputation) or lowers a parent's tolerance for noise and light (e.g., traumatic brain injury, combat stress reaction). Co-parents and care partners can still work together to support each other, recognize changes, and find ways to move forward together.

Home visitors may work with families after an injury to help co-parents build and rebuild parenting skills and confidence. Families who are in the middle of the injury-recovery continuum may find it difficult to see anything positive, good, or within their control. Everything is affected and maybe nothing will be OK again. Home visitors can be trusted allies who can make the family's resilience visible to them as the family adapts and grows and can highlight the strengths they see in *Everyday Moments* and decisions.

Collaboration and Mutuality – Parents who are able to discuss the challenges of parental injury may be better able to anticipate and address how they work together as parents and partners after an injury. Yet, this may not be possible for all parents living through an injury. The dynamic nature of the injury-recovery process may mean that collaboration and mutual decision-making look different from before the injury. Finding a *new normal* that provides ways for both parents to collaborate and learn together can feel bumpy. But, it can also be very satisfying to find new ways of being a family, partners, and co-parents.

Home visitors can provide support to families after an injury by listening to family's concerns and understanding how the family's needs may have changed (or remained stable!) and, then, tailoring information and resource connections to meet a family's unique blend of circumstances, challenges, and strengths. Meeting a family at their current levels of need and resilience and helping them find their way forward are the actions of collaboration for the benefit of the family.

Empowerment, Voice, and Choice – A parental injury can alter how both an injured and non-injured parent see themselves, see each other, and how they connect. Parenting after an injury can be overwhelming or uncomfortable—roles and expectations may have shifted from one parent to the other, and some parents may feel a loss of their parenting identity because they no longer do what they used to with their children. When parents are able to view changes without judgment, they are more likely to be able to find their way forward and work toward building their own resilience and recovery.

When home visitors view the families they work with as resilient and resourceful, it communicates belief in their ability to thrive even in challenging times. This stance encourages problem-solving and being willing to learn or relearn information and skills.

Cultural, Historical, and Gender Factors – An injury can affect more than one's perception of self or partner as a parent. Each parent has built an identity that includes their culture, experiences of gender, and personal history. Parents have expectations for being a partner, parent, and building their family life based on these different aspects of their identity. After an injury, these expectations may be challenged. Some parents may have to work to re-construct their identity and expectations of themselves or their partners and address stereotypes that they hold. For example, a parent who planned to be involved as his or her child's t-ball coach may have to adjust that sense of what that looks like or if it is possible after a serious back injury. A parent who planned to stay at home until the youngest child started school may need to become a primary income earner to carry the family finances after his or her partner's injury. This is not how either parent envisioned being a good parent before the injury, but it becomes part of each one's identity after the injury.

Home visitors may be some of the closest people outside the family system to hear a parent's struggles with identity and changes in life due to a parental injury. Keeping an open mind can help parents reflect on their expectations and see insights into how they can build and adapt, instead of feeling stuck or lost.

The Science: What Do We Know About Parenting After Injury?

This chapter purposefully uses a broad definition of injury to show the wide ranges of what can harm or hurt a person and how harm or hurt can manifest in an individual's and his or her family's life. Including the very mild and very severe experiences of hurt and harm in the definition can be helpful when working with families who are feeling like their experience of an injury is unlike anyone else's. Families who are feeling isolated as part of their injury experience can often also feel stuck, like there is no path forward toward recovery or there are no resources that can help their situation. It can be disorienting and debilitating to live with a significant amount of uncertainty about a current situation and what the future may hold. Prolonged uncertainty can have negative effects on a person's sense of control, mastery, and confidence to shape his or her own life. Connections to a *Circle of Support*, including a home visitor, and being able to build trust with healthcare providers can provide a stable foundation when a parental injury rocks a family's world. These connections can help families find a way forward even though there are circumstances beyond the family's control. You may work with families who do not have stable and supportive social connections or who struggle to trust healthcare professionals. For families who have scarce social and concrete supports, a parental injury can be an event that makes it harder to reach out.

Visible and Invisible Wounds

Most people, if asked, could give a few examples of a visible wound. Cuts, sprains, bruises, and fractured bones are some of the most common ones. There are also invisible wounds, such as injuries that affect mood, thoughts, and behaviors. These wounds may result from a physical injury, like a head injury, but many invisible wounds result from psychological injury (e.g., witnessing or being part of a traumatic event) or a combination of physical and psychological injuries.

Individuals with an invisible wound often seem to be perfectly fine and healthy—no characteristic of hurt is visible to family members, colleagues, and even healthcare professionals. Yet, individuals feel and experience the injury in very real ways—maybe in their thought processes and emotions, such as feeling highly anxious in crowded public spaces when they used to enjoy events, like baseball games. On the other hand, there may be a change in behaviors and mood when a person tries to avoid remembering a traumatic event or when he or she dreams

about it while asleep. Changes could include playing online games for extended hours and having several energy drinks each day as coping strategies to stay awake and *in a zone*. Maybe a person who sustained a concussion a few months ago now seems to have trouble with impulse control and buys items without regard for costs or takes risks that he or she would not have thought about doing before the injury.

The main types of invisible wounds that military and veteran healthcare providers identify include post-traumatic stress, depression, traumatic brain injury, military sexual trauma, anxiety, and complicated grief. Any of these may also have a substance misuse element. It can be more difficult for persons feeling the effects of an invisible injury to reach out for support, partially because they appear to be fine to others and partially because there is stigma attached to mental and behavioral health needs. Many individuals feel this type of injury is a personal weakness rather than a trauma or a need for certain kinds of support and care. This stigma is present across civilian and military communities, but Service members may feel a potential threat to continued service if they disclose or seek help for an invisible injury. Home visitors may be able to support parents to seek care by showing them that wellness is physical and psychological.

Injury and Trauma

Professionals who work in the medical fields that focus on injury and recovery often describe injuries as occurring on a continuum from medically mild to severe. They also describe recovery as a pathway that is not completely pre-determined and often is not quite linear or straightforward. All injuries cause harm or hurt, but not all injuries are traumatic in a psychological sense. In medical terms, every injury is a physical trauma or shock to the body. The focus in this chapter includes the psychological responses to an injury. Those can be more difficult to see and assess, yet they are no less real for the person experiencing them. Moving forward in this chapter, when injuries are **traumatic**, *the trauma includes the level of medical severity, the level of and time needed for recovery*, ***and the perceptions the injured person and his or her important others have about the injury***. The next few paragraphs explain the injury continuum and how trauma can become part of an injury experience.

Some injuries are part of everyday life, and, although inconvenient, they are not totally surprising. These kinds of injuries can range from simple hurts like a paper cut to knocking one's shin on a truck's trailer hitch. Parents of very young children learn quickly that injuries are going to happen as toddlers and twos explore their world and try things that they do not realize are risky or that take more skill than they currently have, like running on a slick floor or smashing fingers when opening and closing cabinet drawers. Injuries like these typically are not thought of as traumatic. The toddler with the smashed fingers may react intensely and need the help of a parent to assess his or her hurt and be soothed, but, if mild, the disruption it causes will not have a long-term impact on the toddler's or her family's life.

At the severe end of the continuum are injuries that are almost always unexpected, and extensive harm and hurt occur. These kinds of injuries need immediate medical attention. They are often medically severe and complex, like those from car wrecks or blast injuries from improvised explosive devices (IEDs). These injuries can create outwardly visible injuries and internal injuries that can be more difficult to assess; this is called *polytrauma* (multiple injuries).

Medically severe injuries often have long-lasting effects for the injured person and his or her family. The disruption caused by parental injury can be extensive in terms of how many aspects of family life are

affected (e.g., ability to return to work in current job, stepping back into the same family roles and expectations as before the injury), how long recovery is expected to take (e.g., a few months to mend wounds or broken bones, months of hospitalization followed by in-patient rehabilitation to remaster skills of daily living), and what level of recovery is expected (e.g., full recovery that meets or exceeds preinjury abilities; limited recovery in physical, cognitive, and/or psychological areas of wellness). Within military treatment programs, medical and human service professionals may refer to the *injury-recovery process* when talking with families.

This process has four phases:

- *Acute care* – the first phase that begins at the point of the injury. The focus is to save and sustain the injured person's life.
- *Medical stabilization* – this phase begins when the injured person arrives at a major medical facility to receive medical and/or surgical care. Depending on the severity of the injury(ies), a stay might be a few days or might extend to several months. In-patient rehabilitation is part of this phase, if needed.
- *Transition to outpatient care* – this phase focuses on the planning needs to discharge the injured person from the medical facility. There is often a medical social worker who helps identify outpatient needs; facilitates transfer of care to local doctors/specialists; and assesses if there are financial, transportation, and community resource needs.
- *Rehabilitation and recovery* – this phase begins when the injured person returns home or to a new community and continues as long as there is active recovery or health maintenance and care for a person who may have a permanent change in abilities or quality of life.

Perceptions of a parental injury often begin to include elements of trauma when injuries are in the middle of the continuum from mild to severe. Moderate injuries, where full recovery is expected, can still create significant disruption in family and work life. Each person in the family system has coping abilities and limits as to how much uncertainty and disruption they can effectively handle when stressful events occur.

Mental health professionals may use the term *Window of Tolerance* (see Resources/*Family Pages* for this chapter) to help their clients learn more about their own comfort levels and how they respond to stress and trauma. Basically, when something unexpected happens, like an injury, that event pulls on a person's resources—mental, emotional, and physical energy; social and concrete supports; and financial means. The resource pull can come from a person's *reserves*, but reserves can be depleted, and the event can start pulling from the resources that are devoted to everyday tasks and needs. Feelings of "I'm not enough. I can't do enough. I can't handle this" may become part of a person's inner voice. A person might respond by becoming more anxious or angry and using harsh words toward a child or partner that would normally not be used. A person might respond to the increase in stress by trying to find distance from distress, sleeping more, feeling sluggish, and/or pushing away from a partner or child emotionally and maybe even physically.

Examples of Perceptions and Trauma

These abilities and limits become part of each person's perceptions about what a parental injury means for him or herself and his or her family system. For example, an injured parent who needs several months for recovery, including multiple medical and therapy visits, could view the injury as putting his family's well-being at risk because of high costs due to medical needs, financial and time costs for travel to specialists, time off work for his spouse, and additional paid child care needs. This same parent might view his injury and recovery from a place of thankfulness that it wasn't worse and that he will soon be able to get back to work and to life with his spouse and young children.

The non-injured spouse might view his husband's injury as a significant but manageable event and cope by stepping into a problem-solving mode to organize the extra medical needs, adjust the family's monthly budget, talk with his employer to learn about options for time off, and ask the child care provider if they could offer extended hours or recommend someone who could. It is also possible that the non-injured spouse might feel overwhelmed at times and wonder if the family will get through this challenge and be OK. Maybe there are recovery set-backs, additional financial concerns due to car repairs, the injured spouse happens to be a terrible patient, or the family passes around the stomach flu that their toddler brought home from day care.

Young children also feel the stress of a parental injury. The injured parent might be suddenly absent, sound different on the phone, or have injuries that affect what they can do together. Their non-injured parent may be more emotional than typical and may change daily routines or respond differently to them or be more anxious, distant, or tired. Young children may not have the words to describe what they feel, but their behaviors are good indicators of how they are coping with and experiencing the distress linked to the parent's injury.

Developmental regression describes how stress and trauma can cause young children's behaviors and skills to go back to an earlier stage of mastery. This might look like a 20-month-old who wants to be held more and stays physically close to parents and her child care provider when she would normally be an active explorer. Another example may be a 3-year-old who starts using baby talk when he had been using bigger words and sentences in conversation. These types of behaviors indicate where a young child's *Window of Tolerance* is—what is comfortable and what is uncomfortable. Developmental growth takes energy and concentration, both of which are being diverted to help handle the increased stress he or she feels.

Through a Young Child's Eyes

Parenting After Injury

How I might feel during this time of big feelings...

I might feel many feelings: sadness, longing, anger, frustration, deep love, confusion. At other times, I might be having so much fun playing that you would never know there have been big changes at home because one of my parents is injured.

I might go back to behaviors I used to do like clinging to you, wetting my pants, sucking my thumb, or wanting you to carry me or feed me. This is a way I tell you that this is a hard time for me.

It is stressful for me when our daily routines change, and you are hurting. I feel unsure about what is happening.

I might get angry more often—at you, at a friend.

Sometimes, my feelings are so big they overwhelm me.

Sometimes, it is hard for me to *hold it all together*.

I might need you to gently help me calm down. Sometimes, it can be easier to be angry than to be sad or confused.

I may be curious and ask questions and want to touch your boo-boo. I may shy away and seem extra sensitive about small boo-boos on my own body. Some of these boo-boos may be so small you are not able to see them. I am learning about bodies and boo-boos in my own way.

How you can support me during this time of big feelings...

If you are the parent at home with me...

Keep our daily routines—eating, sleeping, bathing, dressing, diapering, and toileting—consistent. This helps me feel safe as I learn that our daily lives continue even during a challenging time.

Tell me family stories of times we are all together. We sure do lots of neat things, like walk in the park, read books, and sing silly songs at bath time.

Offer me words for what I might be feeling: "I think maybe you are feeling angry that I have been away at the hospital taking care of Daddy. How about we draw Daddy a picture together to help him feel better?"

Do an attitude-check. If you believe everything will be OK, I will feel that way too.

If you are the parent that is injured...

Give me some simple descriptions of what is happening to you and to us. For example,

"I hurt my leg and for now I will use this wheelchair to move around."

"Will you please play quietly or go outside to play with Daddy?"

"When we are quieter, it helps Mommy feel better."

"My face looks different, doesn't it? But I am here with you. Would you like to sing or read a book together?"

Keep our connection strong if you are away at a medical facility for a long time. Send me letters or video messages or talk with me on the phone or during video calls if and when you can. Keep a photo of me nearby and a picture of us together in your head.

Together you can...

Keep lines of communication open. When you keep talking with each other and to me, you show me that you can work together even when times are challenging. I feel safe knowing you are a team.

Give all of us time to reconnect and find our rhythm when we are back together and finding our *new normal*. We've all had big changes. Even though we love each other, we may have some bumps along the way. This is to be expected. We'll be OK.

Talk about *big feelings* with each other and at times with me. Putting feelings into words can help us feel more in control and to know we are not alone.

Young Children's Curiosity and Injury Communication

Young children are often curious about differences they notice in people, including those related to an injury. They will point at, touch, ask about, and even mimic changes they see. These are all ways of trying to make sense of what is new and different. A 2-year-old may repeatedly ask questions about "Mama's ouchy," or ask "It hurt? Why you still have that [cast or bandage]? How happen?". Young children may show their care for an injured parent by patting that parent's arm, giving hugs and kisses to make it better, and saying things like "It be OK. It be OK." Some young children may want to play with items related to injury care, like bandages, or sit in a wheelchair and be pushed down hallways.

Caregivers, injured or non-injured, may be able to support children's curiosity and feelings about an injury through medical play. A doll or stuffed animal may be the patient, and a variety of pretend props can be created, like a hospital bed or an ambulance. A big box of bandages might also come in handy. Medical play offers caregivers opportunities to help young children learn what is happening in ways that the child can understand. This is part of injury communication. Each family member benefits from injury communication, which starts as soon as a family is notified about an injury and continues through the injury-recovery process. Effective injury communication helps a family create a shared understanding of the injury and its consequences in age-appropriate ways.

Parenting After Injury and Ambiguous Loss

Parenting roles and expectations in a family system may shift temporarily or permanently after parental injury. During the early phases of injury recovery, young children may experience a disruption in who cares for them and where and how they are cared for. A non-injured parent may need to be with the injured parent making medical and support decisions. Some families may stay in short-term support housing next to a medical treatment facility, like a Fisher House or an extended stay hotel. Sometimes children are split up between or among multiple extended caregivers, trying to address competing needs of both children and available caregivers.

During the later phases of injury recovery, families may more clearly understand if and how a parent's injury affects parenting roles, expectations, and abilities. Young children's developmental stages contribute to their ability to process and understand how, why, and how long a parent may not be meaningfully present in their lives across all phases of the injury recovery process.

Ambiguous loss is a concept that helps explain physical and psychological characteristics of relationship disruptions, such as parental injury, for which there may not be a clear path to closure or healing. These transitions of absence and presence create potential for boundary ambiguity—uncertainty about who is in and who is out of the family caregiving system. Young children's trusting relationships are rooted in physical and psychological connection, and, when a parent is away, feelings of loss can be tied to both types of connection. A young child may want to stay close to an injured parent but be worried about that parent going away. Wanting to connect but also showing hesitance in connecting are pretty common. It can also be challenging when a parent returns into daily family life because both parent and child are in different places in life than when the absence started, family roles have changed, and there may have been difficulties in maintaining connection during the absence. Non-injured parents and partners may also experience ambiguous loss or even grief if there are significant changes in family life due to injury. For example, non-injured partners may take on caregiving roles for their injured partner while still identifying as a co-parent and romantic partner. It can be difficult to integrate the addition of caregiving alongside the possible uncertainties of how to maintain co-parent and romantic aspects of the relationship.

Why Parenting After Injury Matters to Families

Military families can be and are resilient families. Parental injury can be disruptive in family life and can create confusion and uncertainty. Family routines are often affected, and young children can feel the stress when daily life is uncertain and the people they love are hurting. When injury is extensive and/or long-lasting, a non-injured parent (and other adults, such as in-laws) may be taking on extended caregiving roles for the injured parent in addition to shouldering more of the parenting and daily family life management roles. For many families, the disruption due to parental injury will be short-term, the parent will recover, and the family will find their rhythm again. For other families, the injury may have lifelong impacts on relationships, roles, and overall well-being. For these families, a new normal that accommodates changes in a parent's health may be a goal to move toward.

Home visitors may find that the content in the *Parental Self-Care* chapter is relevant for families experiencing a parental injury. It can be more difficult for the non-injured parent to find time and energy for self-care. Non-injured parents and relatives can develop compassion stress and fatigue when there is little to no relief from experiencing their loved one's suffering.

Boots on the Ground: Everyday Moment Conversations with Families

This section highlights content and skill-building strategies you can use as you plan your home visits. For the *Everyday Moment* section of the visit, you will find a list of topics to choose from and to explore in conversations about nurturing guidance. For each topic, you will find the associated *Protective Factors* and *Trauma-Informed Principles* addressed. *Family Pages* designed to support your conversations are listed next.

In addition, you will find suggestions of related one-on-one activities to choose from for the parent-child interaction portion of the visit.

There are several *Parenting After Injury* topics to choose from as you plan a visit to a family, and you should tailor the conversation to that family's specific needs and interests. You may find that you discuss one topic now and come back to discuss another in a month or two depending on certain circumstances.

Using the information you have about a family's *Protective Factors* can guide your curriculum choices to tailor the home visit discussion and activities. Ideas are presented below with their associated icons to highlight how they correspond to meeting a family's needs and building each family member's resilience. These include the following:

Parent's experiences with and expectations for parental injury

- *Parental Resilience* may be supported when parents can reflect on past experiences in meeting unexpected challenges and use those experiences to think about how they can meet this new challenge.

Understanding big feelings—for children and parents

- *Parental Resilience* and
- *Knowledge of Parenting and Child Development* and
- *Social and Emotional Competence of Children* are evident when parents are able to appreciate how a parental injury can affect the sense of safety for everyone in the family system and how the feelings associated with this can impact how family members, big and small, respond to this and other stressors in daily life.

Keeping relationships strong

- *Social Connections* and
- *Concrete Supports of Families* and
- *Knowledge of Parenting and Child Development* can reduce relationship stress between parent and child and parent and co-parent by highlighting ways that parents can access support for themselves and their children after a parent is injured and find ways to help everyone cope with the distress associated with the injury.

Family Pages

A series of *Family Pages* on *Parenting After Injury* have been created to support your conversations with families while you are visiting and to become a resource parents can refer to between visits. These include:

- When a Parent is Injured from a Child's Point of View
- Big Feelings for You
- Big Feelings for Your Child
- Keeping Adult Relationships Strong
- Getting the Support You Need
- Focus on You: Looking Back and Moving Ahead with Your Child
- Practical Applications for Families: Figuring It Out Together

Related One-on-One Activities

These are suggested activities for sharing care. There is a broad selection of one-on-one activities available in the Activity Card deck.

- Notice and Wonder: How does a care partner(s) interact and talk with your child about the injury?
- Co-create a story with your child about helping an injured doll or stuffed animal friend feel better.

Book suggestions:

- *When Daddy Comes Home* by Maggie Hundshame
- *Why is Mom So Mad?* by Seth and Julia Kastle (Also in Dad version)
- *Is Your Dad a Pirate?* by Tara McClary Reeves and Daniel Fernández
- *Sparrow* – Mama version and *Sparrow* – Dad version from Zerotothree.org

Additional Resources

Community connections include:

- Child Care Settings
- Healthcare Providers
- Zerotothree.org
- Sesamestreet.org
- The National Institute for the Clinical Application of Behavioral Medicine (*Window of Tolerance* graphic)
- National Child Traumatic Stress Network

A

Afifi, T. O., Mota, N. Sareen, J., & MacMillan, H. L (2017). The relationships between harsh physical punishment and child maltreatment in childhood and intimate partner violence in adulthood. *British Medical Journal of Clinical Public Health*, 17, 493-503.

Amin, N. A. L., Tam, W. W. S., & Shorey, S. (2018). Enhancing first-time parents' self-efficacy: A systematic review and meta-analysis of universal parent education interventions' efficacy. *International Journal of Nursing Studies*, 82, 149-162.

Ammerman R. T., Putnam, F. W., Chard, K. M., Stevens, J., & Van Ginkel, J. B. (2011). PTSD in depressed mothers in home visitation. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. doi: 10.1037/a0023062

Anderson, A. T., Jackson, A., Jones, L., Kennedy, D. P., Wells, K., & Chung, P. J. (2014). Minority parents' perspectives on racial socialization and school readiness in the early childhood period. *Academic Pediatrics, 15*, 405-411.

Appleyard, K., Egeland, B., van Dulmen, M. H. M., & Sroufe, L. A. (2005). When more is not better: The role of cumulative risk in child behavior outcomes. *Journal of Child Psychology and Psychiatry, 46*, 235-245.

B

Badr, H., Barker, T. M., & Milbury, K. (2011). Couples' psychosocial adaptation to combat wounds and injuries. In S. MacDermid Wadsworth & D. Riggs (Eds.), *Risk and resilience in U.S. military families* (pp. 213-233). New York, NY: Springer Science.

Bartlett, J. D., & Easterbrooks, M. A. (2015). The moderating effect of relationships on intergenerational risk for infant neglect by young mothers. *Child Abuse & Neglect, 45*, 21-34.

Beardslee, W. R., Avery, M. W., Ayoub, C. C., Watts, C. L., & Lester, P. (2010, September). *Building resilience: The power to cope with adversity*. Washington DC: Zero to Three.

Bentovim, A., & Elliott, I. (2014). Hope for children and families: Targeting abusive parenting and the associated impairment of children. J*ournal of Clinical Child & Adolescent Psychology, 43*, 270-285.

Blaisure, K., Saathoff-Wells, T., Pereira, A., MacDermid Wadsworth, S., & Dombro, A. (2016). *Serving military families: Theories, research, and application* (2nd ed.). New York, NY: Taylor & Francis.

Boller, K., Daro, D., Del Grosso, P., Paulsell, D., Hart, B., Coffee-Borden, B., … Hargreaves, M. (2014, January). *Making replication work: Building infrastructure to implement, scale-up, and sustain evidence-based early childhood home visiting programs with fidelity*. Princeton, NJ: Mathematica Policy Research.

Boss, P., Bryant, C., & Mancini, J. A. (Eds.) *Family stress management* (3rd ed.).Thousand Oaks, CA: Russel Sage Foundation.

Boyle, P. E., & Delos Reyes, C. M. (2015). *Trauma-informed care– core principles, professional development, and state update (RPH Videoconference series)*. [PowerPoint slides]. Retrieved from https://www.centerforebp.case.edu/client-files/events-supportmaterials/2015-0115_RPHVideoConference.pdf

Part 7 References

Brown, B. (2012). *Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead*. New York, NY: Penguin Random House.

Browne, C. H. (2014, September). *Strengthening Families Approach and Protective Factors Framework: Branching out and reaching deeper*. Washington DC: Center for the Study of Social Policy.

C

Cairone, K., Rudick, S., & McAuley, E. (2017, January). *Issue brief: Home visiting issues and insights: Creating a trauma-informed home visiting program*. Home Visiting Improvement Action Center Team (HV-Impact). Retrieved from https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/Creating_a_Trauma_Informed_Home_Visiting_Program_Issue_Brief_January_2017.pdf

Canadian Paediatric Society. (2004). Position statement (PP-2004-01): Effective discipline for children. *Paediatric Child Health, 9*(1), 37-41.

Cassidy, J., & Shaver. P. R. (Eds.). (2016). *Handbook of attachment: Theory, research, and clinical applications* (2nd ed.). New York, NY: Guilford Press.

Center for the Study of Social Policy (2012). *The Protective Factors Framework*. Retrieved from https://cssp.org/resource/about-strengthening-families-and-the-protective-factors-framework/

Cheng, T. C., & Lo, C. C. (2016). Linking worker-parent alliance to parent progress in child welfare: A longitudinal analysis. *Children and Youth Services Review, 71*, 10-16.

Chesmore, A. A., Piehler, T. F., & Gewirtz, A. H. (2018). PTSD as a moderator of a parenting intervention for military families. *Journal of Family Psychology, 32*, 123-133.

Child Welfare Information Gateway. (2014). *Parent education to strengthen families and reduce the risk of maltreatment*. Washington, DC: U. S. Department of Health and Human Services, Children's Bureau.

Child Welfare Information Gateway. (2017). *Child maltreatment prevention: Past, present, and future*. Washington, DC: U. S. Department of Health and Human Services, Children's Bureau.

Counts, J. M., Buffington, E. S., Chang-Rios, K., Rasmussen, H. N., & Preacher, K. J. (2010). The development and validation of the protective factors survey: A self-report measure of protective factors against child maltreatment. *Child Abuse & Neglect, 34*, 762-772.

Cozza, S. J., & Guimond, J. M. (2011). Working with combat-injured families through the recovery trajectory. In S. MacDermid Wadsworth & D. Riggs (Eds.), *Risk and resilience in U. S. military families* (pp. 259-277). New York, NY: Springer Science.

Cozza, S. J., Guimond, J. M., McKibben, J. B. A., Chun, R. S., Arata-Maiers, T. L., Schneider, B., … Ursano, R. J. (2010). Combat-injured service members and their families: The relationship of child distress and spouse-perceived family distress and disruption. *Journal of Traumatic Stress, 23*, 112-115.

Cozza, S. J., Holmes, A. K., & Van Ost, S. L. (2013). Family-centered care for military and veteran families affected by combat injury. *Clinical Child and Family Psychological Review, 16*, 311-321.

Culler, E., & Saathoff-Wells, T. (2017). Young children in military families. In J. Szente (Ed.), *Assisting children caught in disasters: A resource book for educators* (pp. 37-46). New York, NY: Springer.

Culp, A. M., Culp, R. E., Howell, C. S., Hechtner-Galvin, T., Saathoff-Wells, T., & Marr, P. (2004). First-time mothers in home visitation services utilizing child development specialists. *Infant Mental Health Journal, 25*, 1-15.

Curry, J. F., Kiser, L. J., Fernandez, P. E., Elliot, A. V., & Dowling, L. M. (2018). Development and initial piloting of a measure of post-deployment parenting reintegration experiences. *Professional Psychology: Research and Practice, 49*, 159-166.

D

Dekel, R., & Solomon, Z. (2007). Secondary traumatization among wives of war veterans with PTSD. In C. R. Figley & W. P. Nash (Eds.), *Combat stress and injury: Theory, research, and management* (pp. 137-157). New York, NY: Routledge.

Department of Defense, Office of the Assistant Secretary of Defense for Military Community & Family Policy. (2017). *2016 demographics: Profile of the military community*. Washington, DC: Author.

Department of Defense, Office of the Assistant Secretary of Defense for Military Community & Family Policy. (2018). *2017 demographics: Profile of the military community*. Washington, DC: Author.

Dodge, J., Gonzalez, M., Muzik, M., & Rosenblum, K. (2018). Fathers' perspectives on strengthening military families: A mixed method evaluation of a 10-week resiliency building program. *Clinical Social Work Journal, 46*, 145-155.

Domoney, J., Iles, J., & Ramchandani, P. (2018). Fathers in the perinatal period: Taking their mental health into account. In J. Domoney (Ed.), *Transforming infant wellbeing: Research policy and practice for the 1001 critical days* (pp. 205-214). New York, NY: Routledge.

Don, B. P., Biehle, S. N., & Mickelson, K. D. (2013). Feeling like part of a team: Perceived parenting agreement among first-time parents. *Journal of Social and Personal Relationships, 30*, 1121-1137.

Dunsmore, J. C., Booker, J. A., & Ollendick, T. H. (2013). Parental emotion coaching and child emotion regulation as protective factors for children with oppositional defiant disorder. *Social Development, 22*, 444-466.

E

Edmondson, A. C. (2004). Psychological safety, trust, and learning in organizations: A group-level lens. In R. M. Kramer & K. S. Cook (Eds.), *Trust and distrust in organizations: Dilemmas and approaches* (pp. 239-272). New York, NY: Russell Sage Foundation.

Ellis, W. R., & Dietz, W. H. (2017). A new framework for addressing adverse child and community experiences: The building community resilience model. *Academic Pediatrics, 17*, S86-S93.

Evans, G. W., Li, D., & Whipple, S. S. (2013). Cumulative risk and child development. *Psychological Bulletin, 139*(6), 1342-1396.

F

Faber, A. J., Willerton, E., Clymer, S. R., MacDermid, S. M., & Weiss, H. M. (2008). Ambiguous absence, ambiguous presence: A qualitative study of military reserve families in wartime. *Journal of Family Psychology, 22,* 222-230.

Fairbrother, N., Thordason, D. S., Challacombe, F. L., & Sakaluk, J. K. (2018). Correlates and predictors of new mothers' responses to postpartum thoughts of accidental and intentional harm and obsessive-compulsive symptoms. *Behavioural and Cognitive Psychotherapy, 46*, 437-453.

Feinberg, M. E., Jones, D. E., Hostetler, M. L., Roetger, M. E., Paul, I. M., & Ehrenthal, D. B. (2016). Couple-focused prevention at the transition to parenthood, a randomized trial: Effects of coparenting, parenting, family violence, and parent and child adjustment. Prevent*ion Science, 17,* 751-764.

Fogel, A. (2009). *Infancy: Infant, family and society* (2nd ed.). Cornwall-on-Hudson, NY: Sloan Publishing.

Folger, S. F., & Wright, M. O. (2013) Altering risk following child maltreatment: Family and friend support as protective factors. *Journal of Family Violence, 28*, 325-337.

Font, S. A., & Cage, J. (2018). Dimensions of physical punishment and their associations with children's cognitive performance and school adjustment. *Child Abuse & Neglect, 75*, 29-40.

Frank, T. J., Keown, L. J., Dittman, C. K., & Sanders, M. R. (2015). Using father preference data to increase father engagement in evidence-based parenting programs. *Journal of Child and Family Studies, 24*, 937-947.

Frank, T. J., Keown, L. J., & Sanders, M. R. (2015). Enhancing father engagement and interparental teamwork in an evidence-based parenting intervention: A randomized-controlled trial of outcomes and processes. *Behavior Therapy, 46*, 749-763.

FRIENDS National Resource Center for Community Based Child Abuse Prevention (2011). *The Protective Factors Survey user's manual*. Chapel Hill, NC: Chapel Hill Training Outreach Project.

G

Geller, P. A., Posmontier, B., Andrews Horowitz, J., Bonacquisti, A., & Chiarello, L. A. (2018). Introducing Mother Baby Connections: A model of intensive perinatal mental health outpatient programming. J*ournal of Behavioral Medicine, 41*, 600-613.

Gewirtz, A. H., Erbes, C. R., Polusny, M. A., Forgatch, M. A., & DeGarmo, D. S. (2011). Helping military families through the deployment process: Strategies to support parenting. *Professional Psychology: Research and Practice, 42*, 56-62.

Gewirtz, A. H., Polusny, M. A., DeGarmo, D. S., Khaylis, A., & Erbes, C. R. (2010). Posttraumatic stress symptoms among National Guard soldiers deployed to Iraq: Associations with parenting behaviors and couple adjustment. *Journal of Counseling and Clinical Psychology, 78*, 599-610.

Giallo, R., Dunning, M., & Gent, A. (2017). Attitudinal barriers to help-seeking and preferences for mental health support among Australian fathers. *Journal of Reproductive and Infant Psychology, 35*, 236-247.

Giallo, R., Evans, K., & Williams, L. (2018). A pilot evaluation of "Working Out Dads": Promoting father mental health and parental self-efficacy. *Journal of Reproductive and Infant Psychology, 36*, 421-433.

Gibbs, D. A., Martin, S. L., Johnson, R. E., Rentz, E. D., Clinton-Sherrod, M., & Hardison, J. (2008). Child maltreatment and substance abuse among U. S. Army soldiers. *Child Maltreatment, 13*, 259-268.

Gibbs, D. A., Martin, S. L., Kupper, L. L., & Johnson, R. E. (2007). Child maltreatment in enlisted soldiers' families during combat-related deployments. *The Journal of the American Medical Association, 298*, 528-535.

Gilmer, C., Buchan, J. L., Letourneau, N., Bennett, C. T., Shanker, S. G., Fenwick, A., & Smith-Chant, B. (2016). Parent education interventions designed to support the transition to parenthood: A realist view. *International Journal of Nursing Studies, 59*, 118-133.

Gold, C. M. (2017). *The developmental science of early childhood: Clinical applications of infant mental health concepts from infancy through adolescence*. New York, NY: W. W. Norton & Company.

Goldberg, A. E., Frost, R., & Noyola, N. (in press; 2019). Sexual minority parent families: Research and implications for parenting interventions. In J. Pachankis & S. Safren (Eds.), *The handbook of evidence-based mental health practice with LGBT clients*. New York, NY: Oxford.

Gorman, L. A., Fitzgerald, H. E., & Blow, A. J., (2010). Parental combat injury and early child development: A conceptual model for differentiating effects of visible and invisible injuries. *Psychiatric Quarterly, 81*, 1-21.

H

Henderson, J. M., France, K. G., Owens, J. L., & Blampied, N. M. (2010). Sleeping through the night: The consolidation of self-regulated sleep across the first year of life. *Pediatrics, 126*, e1081-e1087.

Hicks, L. M, Dayton, C. J., Brown, S., Mizik, M., & Raveau, H. (2018). Mindfulness moderates depression and quality of prenatal attachment in expectant parents. *Mindfulness, 9*, 1604-1614.

Hicks, L. M, Dayton, C. J., & Victor, B. G. (2018). Depressive and trauma symptoms in expectant, risk-exposed, mothers and fathers: Is mindfulness a buffer? *Journal of Affective Disorders, 238*, 179-186.

Holmes, M. R., Yoon, S., Berg, K. A., Cage, J. L., & Perzunski, A. T. (2018). Promoting the development of resilient academic functioning in maltreated children. *Child Abuse & Neglect, 75*, 92-103.

Howard, L. M., Piot, P., & Stein, A. (2014). No health without perinatal mental health [Comment]. *The Lancet, 384*, 1723-1724.

Howell, K. H., & Miller-Graff, L. E. (2014). Protective factors associated with resilient functioning in young adulthood after childhood exposure to violence. *Child Abuse & Neglect, 38*, 1985-1994.

Hughes, M., Joslyn, A., Wojton, M., O'Reilly, M., & Dworkin, P. H. (2016). Connecting vulnerable children and families to community-based programs strengthens parents' perceptions of protective factors. *Infants & Young Children, 29*, 116-129.

Part 7 References

I

Institute of Medicine and National Research Council (2013). *New directions in child abuse and neglect research*. Washington, DC: The National Academies Press.

J

JBS International, Inc., & Georgetown University National Technical Assistance Center for Children's Mental Health. (2015). *Creating trauma-informed provider organizations*. Retrieved from https://gucchdtacenter.georgetown.edu/data/issues/2015/0215_article.html

Jessee, A., Mangelsdorf, S. C., Wong, M. S., Schoppe-Sullivan, S. J., Shigeto, A., & Brown, G. L. (2018). The role of reflective functioning in predicting marital and coparenting quality. *Journal of Child and Family Studies, 27*, 187-197.

Johnson, K., Woodward, A., Swenson, S., Weis, C., Gunderson, M., Deling, M., … Lynch, B. (2017). Parents' adverse childhood experiences and mental health screening using home visiting programs: A pilot study. *Public Health Nursing, 34*, 522-530.

Jones, D. E., Feinberg, M. E., Hostetler, M. L., Roettger, M. E., Paul, I. M., & Ehrenthal, D. B. (2018). Family and child outcomes 2 years after a transition to parenthood intervention. *Family Relations, 67*, 270-286.

Julian, M. M., Muzik, M., Kees, M., Valenstein, M., & Rosenblum, K. L. (2018). Strong Military Families intervention enhances parenting reflectivity and representations in families with young children. *Infant Mental Health Journal, 39*, 106-118.

K

Karre, J. K., Perkins, D. F., & Aronson, K. R. (2018). Research on fathers in the military context: Current status and future directions. *Journal of Family Theory & Review, 10*, 641-656.

Keys, E. M., McNeil, D. A., Wallace, D. A., Bostick, J., Churchill, J., & Dodd, M. M. (2017). The New Parent Checklist: A tool to promote parental reflection. T*he American Journal of Maternal/Child Nursing, 42*, 276-282.

Klass, C. S. (2008). *The home visitor's guidebook: Promoting optimal parent and child development*. (3rd ed.). Baltimore, MD: Brookes Publishing.

Koshanska, G., & Kim, S. (2013). Difficult temperament moderates links between maternal responsiveness and children's compliance and behavior problems in low-income families. *The Journal of Child Psychology and Psychiatry, 54*, 323-332.

L

Lee, S. J., Neugut, T. B., Rosenblum, K. L., Tolman, R. M., Travis, W. J., & Walker, M. H. (2013). Sources of parenting support in early fatherhood: Perspectives of United States Air Force members. *Children and Youth Services Review, 35*, 908-915.

Lemmon, K., & Stafford, E. (2014). Advocating for America's military children: Considering the impact of parental combat deployment to Iraq and Afghanistan. *Family Court Review, 52*, 343-354.

Letourneau, N., Tryphonopoulos, P. D., Duffett-Leger, L., Stewart, M., Benzies, K., Dennis, C., & Joschco, J. (2012). Support intervention needs and preferences of fathers affected by postpartum depression. *Journal of Perinatal and Neonatal Nursing, 26*, 69-80.

Liu, J. J. W., Reed, M., & Girard, T. A. (2017). Advancing resilience: An integrative, multi-system model of resilience. *Personality and Individual Differences, 111*, 111-118.

M

Manning, L. G., Davies, P. T., & Cicchetti, D. (2014). Interparental violence and childhood adjustment: How and why maternal sensitivity is a protective factor. *Child Development, 85*, 2263-2278.

McIntosh, J. E., & Tam, E. S. (2017). Young children in divorce and separation: Pilot study of a mediation-based co-parenting intervention. *Family Court Review, 55*, 329-344.

Menschner, C., & Maul, A. (2016). *Key ingredients for successful trauma-informed care implementation* [Brief]. Center for Health Care Strategies, Inc. Retrieved from http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Middlemiss, W., Cowan, S., Kildare, C., & Seddio, K. (2017). Collaborative translation of knowledge to protect infants during sleep: A synergy of discovery and practice. *Family Relations, 66*, 659-669.

N

Narayan, A. J., Kalstabakken, W. E., Labella, M. H., Nerenberg, L. S., Monn, A. R., & Mastern, A. S. (2017). Intergenerational continuity of adverse childhood experiences in homeless families: Unpacking exposure to maltreatment versus family dysfunction. *American Journal of Orthopsychiatry, 87*, 3-14.

National Home Visiting Resource Center. (2017). *2017 Home visiting yearbook*. Arlington, VA: James Bell Associates and the Urban Institute.

National Scientific Council on the Developing Child (2004). *Young children develop in an environment of relationships: Working Paper No. 1*. Retrieved from www.developingchild.harvard.edu.

Nese, R. N. T., Anderson, C. M., Ruppert, T., & Fisher, P. A. (2016). Effects of a video feedback parent training program during child welfare visitation. *Children and Youth Services Review, 71*, 266-276.

O

Office of Planning, Research, & Evaluation. (2016). *Mother and infant home visiting program evaluation (MIHOPE), 2011-2015*. Retrieved from https://www.acf.hhs.gov/opre/research/project/maternal-infant-and-early-childhood-home-visiting-evaluation-mihope

O'Hara, M., Legano, L., Homel, P., Walker-Descartes, I., Rojas, M., & Laraque, D. (2015). Children neglected: Where cumulative risk theory fails. *Child Abuse & Neglect, 45*, 1-8.

Part 7 References

P

Panlilio, C. C., Jones Harden, B., & Harring, J. (2018). School readiness of maltreated preschoolers and later school achievement: The role of emotion regulation, language, and context. *Child Abuse & Neglect, 75*, 82-91.

Parfitt, Y., Pike, A., & Ayers, S. (2013). The impact of parents' mental health on parent-baby interaction: A prospective study. I*nfant Behavior and Development, 36*, 599-608.

Patwardhan, I., Duppong Hurley, K., Thompson, R. W., Mason, W. A., & Ringle, J. L. (2017). Child maltreatment as a function of cumulative family risk: Findings from the intensive family preservation program. *Child Abuse & Neglect, 70*, 92-99.

Perez-Escamilla, R., Segura-Perez, S., & Lott, M. on behalf of the RWJF HER Expert Panel on Best Practices for Promoting Healthy Nutrition, Feeding Patterns, and Weight Status for Infants and Toddlers from Birth to 24 Months. (2017, February). *Feeding guidelines for infants and young toddlers: A responsive parenting approach.* Durham, NC: Healthy Eating Research. Retrieved from http://healthyeatingresearch.org

Plateau, D. P., & Muir, D. (Eds.). (2008). *Non-violent discipline: A guide for training professionals.* Bangkok, Thailand: Save The Children Sweden Regional Office for Southeast Asia and the Pacific.

Porges, S. W. (2004). Neuroception: A subconscious system for detecting threats and safety. *Zero to Three, 24*(5), 19-24.

Puhlman, D. J., & Pasley, K. (2013). Rethinking maternal gatekeeping. *Journal of Family Theory & Review, 5*, 176-193.

R

Roggman, L., & Cardia, N. (Eds.) (2016). *Home visitation programs: Preventing violence and promoting healthy early child development.* Switzerland: Springer International Publishing.

Rollins, J., & King, E. (2015). Promoting coping for children of hospitalized service members with combat injuries through creative arts engagement. *Arts and Health, 7*, 109-122.

Roos, L. E., Kim, H. K., Schnabler, S., & Fisher, P. A. (2016). Children's executive function in a CPS-involved sample: Effects of cumulative adversity and specific types of adversity. *Children and Youth Services Review, 71*, 184-190.

Rose, K. K., Johnson, A., Muro, J., & Buckley, R. R. (2018). Decision making about nonparental child care by fathers: What is important to fathers in a nonparental child care program. *Journal of Family Issues, 39*, 299-327.

Rosen, N. O., Mooney, K., & Muise, A. (2017). Dyadic empathy predicts sexual and relationship well-being in couples transitioning to parenthood. *Journal of Sex & Marital Therapy, 43*, 543-559.

Ruppanner, L., Peralez, F., & Baxter, J. (2018). Harried and unhealthy? Parenthood, time pressure, and mental health. *Journal of Marriage and Family, 81*, 308-326.

Ryan, M. A. K., Lloyd, D. W., Conlin, A. M. S., Gumbs, G. R., & Keenan, H. T. (2008). Evaluating the epidemiology of inflicted traumatic brain injury in infants of U.S. military families. *American Journal of Preventive Medicine, 34*(4), S143-S147. doi:10.1016/j.amepre.2007.12.020

S

Sattler, K. M. P., & Font, S. A. (2018). Resilience in young children involved with child protective services. *Child Abuse & Neglect, 75*, 104-114.

Schachman, K. A. (2010). Online fathering: The experience of first-time fatherhood in combat-deployed troops. *Nursing Research, 59*(1), 11-17. doi:10.1097/NNR.0b013e3181c3ba1d

Scher, A., & Cohen, D. (2015, Mar). Sleep as a mirror of developmental transitions in infancy: The case of crawling. *Monographs of the Society for Research in Child Development, 80*, 70-88.

Shapiro, A. F., & Gottman, J. M. (2005). Effects on marriage of a psycho-communicative-educational intervention with couples undergoing the transition to parenthood, evaluation at 1-year post intervention. *The Journal of Family Communication, 5*, 1-24.

Shapiro, A. F., Gottman, J. M., & Fink, B. C. (2015). Short-term change in couples' conflict following a transition to parenthood intervention. *Couple and Family Psychology, 4*, 239-251.

Stahlschmidt, M. J., Threlfall, J., Seay, K. D., Lewis, E. M., & Kohl, P. L. (2013). Recruiting fathers to parenting programs: Advice from dads and fatherhood program providers. *Child and Youth Services Review, 35*, 1734-1741.

Stanescu, D. F., & Romer, G. (2011). Family functioning and adolescents' psychological well-being in families with TBI. *Psychology, 2*, 681-686.

Substance Abuse and Mental Health Services Administration. (2014). Trauma-Informed Care in behavioral health services. *Treatment Improvement Protocol (TIP) Series 57*. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sujan, A. C., & Eckenrode, J. (2017). An illustration of how program implementers can use population-specific analyses to facilitate the selection of evidence-based home visiting programs. *Psychosocial Intervention, 26*, 117-124.

Sullivan, M. E. (2014). Military custody and visitation: Problems and solutions in the twenty-first century. *Family Court Review, 52*, 355-370.

Sylvestre, A., & Merette, C. (2010). Language delay in severely neglected children: A cumulative or specific effect of risk factors? *Child Abuse & Neglect, 34*, 414-428.

T

Taillieu, T. L., Afifi, T. O., Mota, M., Keyes, K. M., & Sareen, J. (2014). Age, sex, and racial differences in harsh physical punishment: Results form a nationally representative United States sample. *Child Abuse & Neglect, 38*, 1885-1894.

Tedgard, E., Rastam, M., & Wirtberg, I. (2018). Struggling with one's own parenting after an upbringing with substance abusing parents. *International Journal of Qualitative Studies on Health and Well-being, 13*. Retrieved from https://doi.org/10.1080/17482631.2018.1435100

Thrive Washington. (2016). NEAR@Home: *Addressing ACEs in home visiting by asking, listening, and accepting*. Region X ACE Planning Team. Retrieved from https://www.nearathome.org/download/

Tomassetti-Long, V. J., Nicholson, B. C., Madson, M. B., & Dahlen, E. R. (2015). Hardiness, parenting stress, and PTSD symptomatology in the U. S. Afghanistan/Iraq Era veteran fathers. *Psychology of Men and Masculinity, 16*, 239-245.

Trier, K. A., Pappas, D., Bovitz, B., & Augustyn, M. (2018). Supporting development during military deployment and after April 2018. Journal of Developmental and Behavioral Pediatrics, 39, 447-449.

Trumbell, J. M., Hibel, L. C., Mercado, E., & Posada, G. (2018). The impact of marital withdrawal and secure base script knowledge on mothers' and fathers' parenting. *Journal of Family Psychology, 32*, 699-709.

Tully, L. A., Piotrowska, P. J., Collins, D. A., Mairet, K. S., Hawes, D. J., Kimonis, E. R., … Dadds, M. R. (2017). Study protocol: Evaluation of an online, father-inclusive, universal parenting intervention to reduce child externalizing behaviours and improves parenting practices. British Medical *Journal of Clinical Psychology, 5*, doi:10.1186/s40359-017-0188-x

Turner, H. A., Finkelhor, D., Hamby, S. & Henly, M. (2017). Victimization and adversity among children experiencing war-related parental absence or deployment in a nationally representative US sample. *Child Abuse & Neglect, 67*, 271-279.

U

United States Department of Agriculture. (2009). *Infant nutrition and feeding: A guide for use in the WIC and CSF programs.* Retrieved from https://wicworks.fns.usda.gov/wicworks/Topics/FG/CompleteIFG.pdf

V

van der Kolk, B. (2014). *The body keeps score: Brain, mind, and body in the healing of trauma*. New York, NY: Penguin Books.

W

Walker, D. I., Cardin, J.-F., Chawla, N., Topp, D., Burton, T., & MacDermid-Wadsworth, S. (2014). Effectiveness of a multimedia outreach kit for families of wounded veterans. *Disability and Health Journal, 7*, 216-225.

Walsh, F. (2016). *Strengthening family resilience* (3rd ed.). New York, NY: The Guildford Press.

Wellstone, Paul, "Sheet Metal Workers Speech" (speech, September, 1999), Wellstone, http://www.wellstone.org/legacy/speeches/sheet-metal-workers-speech.

Wittmer, D. S., & Petersen, S. H. (2006). *Infant and toddler development and responsive program planning: A relationship-based approach*. Upper Saddle River, NJ: Pearson.

Y

Yablonsky, A. M., Yan, G., & Bullock, L. (2016). Parenting stress after deployment in Navy active duty fathers. *Military Medicine, 181*, 854-862.

Z

Zanotti, D. C., DeMarni Cromer, L., & Louie, A. D. (2016). The relationship of predeployment child-focused preparedness to reintegration attitudes and PTSD symptoms in military fathers with young children. *Translational Issues in Psychological Science, 2*, 429-438.

Zhang, N., Zhang, J., Gewirtz, A. H., & Piehler, T. F. (2018). Improving parental emotional socialization in military families: Results of a randomized controlled trial. *Journal of Family Psychology, 32*, 1046-1056.