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Parent Perceptions of Infant and Early Childhood Mental Health Care

Angela Goethel[1], Stephanie Thorson-Olesen[2*]

[1]Viterbo University, La Crosse, WI, USA
[2]Antioch University, Seattle, WA, USA

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***Corresponding author:**
Email: asgoethel@viterbo.edu, sthorsonolesen@antioch.edu

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Abstract

The mental health care of future generations is a global imperative. Therefore, this study used a modified consensual qualitative research design to explore the perspective of parents living in the United States about the barriers to accessing parent training programs for better supporting the mental health of infants and young children. Participants (N=20) responded to an online survey with open-ended questions to share their perceptions. The results indicated domains that include parental awareness, accessibility, support, and predicted benefits of infant and early childhood mental health care. This includes the recommendation for consistent screening and assessment practices, within integrated service models.

Introduction

The first five years of a child's life are critical to their development. Infant and early childhood mental health focuses on children's social-emotional development from birth to five years old (Zero to Three, 2021). The immediate consequences of infant and early childhood mental health concerns include distress for the children and their families. In contrast, the long-term consequences include an increased strain on family, community, educational, and medical resources. When unaddressed, mental health challenges in young children tend to become persistent and increase in severity, and they are related to poor developmental, social, academic, psychological, vocational, and community outcomes (Bagner et al., 2015; Gleason et al., 2016; Ryan et al., 2017). The neurological and biological underpinnings of mental health in children under five are vulnerable. Child-related risk factors such as prematurity, health conditions, or developmental delays can adversely impact them (Lucas et al., 2017). Significant stress on parents tends to reduce their capacity for responsive caregiving, which may increase a child's risk of poor mental health (Lyons-Ruth et al., 2017). This highlights the importance of attending to parenting styles (Bayer et al., 2011). Additional parent-related risk factors include parental mental health concerns, less affectionate and precipitous reasoning (e.g., jumping to conclusions, making impulsive decisions), and less predictable discipline practices (e.g., hypervigilant or controlling approaches to older children). Family-related risk factors include financial instability, conflict or discontent in the home, and significant grief. Demographic-related risk factors include young or nongraduated parents, single parenthood, low financial resources, and nonbiologically related adult figures in the home. Community-related risk factors include increased use of childcare and socioeconomic disadvantage (Bayer et al., 2011). Meanwhile, significant predictors of

externalizing symptoms in early childhood include punitive discipline practices, compromised child health, and family events involving grief or illness. Predictors of internalizing symptoms in early childhood include compromised child health, status as a female or only child, maternal mental health concerns, punitive discipline practices, and residing in socioeconomically disadvantaged areas (Bayer et al., 2011). Feldman (2007) explored interactional patterns in the parent-child relationship and family system. This illustrated challenges with rigid parenting styles (controlling, competitive, or disharmonious relationships). Increased dysregulation is linked to an increased rigidity in relational patterns. When a child's or parent's capacity for responsiveness and reciprocity is lacking, this dyadic partnership is compromised, increasing the child's risk of poor developmental outcomes. Another research focus has been the impact of health conditions on dyadic interactions (Festante et al., 2019). Significant perinatal medical events can impact the infant's neurological and social development. This compromises healthy reciprocal parent-infant interactions. Infants in this at-risk group demonstrated lower responsiveness to and engagement with caregivers during early interactions. Additionally, parents of infants with significant complications reported experiencing increased difficulties recognizing their infant's signals and synchronizing their responses. Delayed ability to regulate arousal occurs more frequently when infant neurological development is compromised. As such, not only are impacted infants prone to being more emotionally dysregulated, but they also tend to be more difficult to soothe. Furthermore, the increased need to focus on an infant's medical needs has been associated with reduced parental emotional engagement. The dysfluencies and disorganization in these relationships are noted to become persistent without intervention (Festante et al., 2019).

The COVID-19 pandemic has brought many further compounding risk factors to parents with infants and young children (Tesson et al., 2021). Many parents have faced the perinatal period and adjustment to a new baby without the protective support of friends or family. Infants presenting with risk factors, such as medical conditions, mental health concerns, or developmental delays, have not had timely access to support. Likewise, parents have experienced delays in accessing needed support despite increased stress, anxiety, hypervigilance, depression, and decreased sleep quality (Tesson et al., 2021). Furthermore, many parents have faced a loss or reduction of income, and individuals experiencing socioeconomic disadvantages have been disproportionately impacted by such pandemic-related challenges (Chu, Schwartz, Towner, Kasparian, & Callaghan, 2021). This has presented more risk factors for the parent-child relationship, including increased parenting stress and mental health concerns combined with delayed identification and support of child- or parent-related concerns (Chu et al., 2021; Tesson et al., 2021). Negative themes identified by parents include worries about how COVID-19 has impacted their children; health concerns for self, family, or friends; increased parent stress and burden; desire for a return to normal, worries about the future, irritation, and frustration, political discontent, difficult realizations, and guilt. Challenging or traumatic experiences during a child's first few years tend to have particularly negative and long-lasting impacts when not addressed (Lyons-Ruth et al., 2017). Despite this potential for adverse outcomes, parenting, and attachment behaviors within parent-child dyads are changeable and tend to be responsive to early intervention.

Methods

Attachment Theory

Attachment theory is one area that can be emphasized through early intervention because it concerns how parent-child interactions impact a child's development. When a baby is born, learning and development are facilitated amid routine, reciprocal, and affectionate interactions between the child and their primary caregivers (Emde, 2014; Festante et al., 2019; Lucas et al., 2017). Interventions focusing on attachment help parents increase their sensitivity and responsiveness to their children (Ryan et al., 2017). Bowlby's attachment theory examines early caregiver-child interactions, finding that secure and reciprocal caregiver-child interactions are critical to healthy social-emotional development (Cortazar

& Herreros, 2010; Ryan et al., 2017; Sommers -Flanagan & Sommers-Flanagan, 2015; Weatherston & Ribaudo, 2020). Interruption of or insecurity in these significant relationships can have implications throughout the child's life (Cortazar & Herreros, 2010; Garhart Mooney, 2010; Maltese et al., 2017; van der Horst, 2008). Researchers have explored the connection between secure attachment and personality development through direct, in-home observations of infants with their mothers (Garhart Mooney, 2010). Infants demonstrating secure attachment tend to explore their environment more readily, displaying confidence in their access to comfort if needed. Parents experiencing distress tend to pass some distress on to their babies. These observations suggest that availability and responsive caring are related to developing secure attachment for infants and young children (Garhart Mooney, 2010).Neuroscience has further supported attachment theory by demonstrating that babies' brains are primed to respond to these give-and-take interactions (Festante et al., 2019). Babies and young children are not passive receivers in these exchanges. They actively sustain the dyadic interactions, reinforcing continued parent engagement through responsive and imitative vocalizations, facial expressions, and gestures (Festante et al., 2019). Research has also found that the quality and synchronization of these exchanges are predictive of the child's attachment style and developmental trajectory across the cognitive, communication, social-emotional, behavioral, and motor domains (Feldman, 2007).

Predictable, responsive, and nurturing interactions with caregivers allow infants and young children to learn to cope with stress in their environment and, through coregulation, to regulate their emotional experiences (Feldman, 2007; Feldman & Greenbaum, 1997; Lyons-Ruth et al., 2017). These parent-child interactions' quality and reliability are critical for children developing positive mental health and are central to many evidence-based interventions for early mental health concerns (Hackworth et al., 2018; Ward et al., 2020; Weatherston & Ribaudo, 2020). In heterosexual couples with maternal-related risk factors, a father's increased involvement is a potential protective factor. Feldman (2007) posits that a second adult who is not experiencing mental health symptoms can support both mother and child. Meanwhile, infant risk groups demonstrate increased dysregulation, directly impacting family interactions. The multifaceted and multidirectional pathways identified highlight the importance of intervening within didactic and family interactional patterns because small changes can have a significant impact (Feldman, 2007).

Primary Care Providers

Primary care providers promote positive parenting practices, identify early mental health concerns, and make referrals to appropriate services. Current estimates indicate that a third of primary care providers' consultation load is behavior concerns (Ryan et al., 2017). Despite this, children with increased developmental risk are less likely to have an established primary care provider or adequate medical coverage. Ensuring parents understand and can access pathways to appropriate services is critical for early identification and intervention. Significant social and professional support in the lives of children, parents, and families can facilitate referrals or provide a "warm handoff" to someone who can assist. Opportunities for parents to voice their concerns to a primary care provider have been associated with higher identification rates of mental health concerns, especially for children with the highest risk levels (Ryan et al., 2017). Family, friends, or coworkers are other sources parents may contact for guidance in supporting their child.

Early Interventions

The increased cohesiveness within family relationships promoted by early intervention tends to correspond with increased synchrony and reciprocity in parent-child interactions (Feldman, 2007). This interdependent relationship between adult and child mental health and the parent-child relationship makes interventions that include the child and caregivers particularly effective (Lyons-Ruth et al., 2017). Early intervention can promote healthy attachment, and behavioral concerns can also be considered by the end of a child's first year (Bagner et al., 2015). Some behavioral health diagnoses can be identified from age two (Bagner et al., 2015).Bagner et al. (2015) designed a randomized control trial to assess the

effectiveness of parent-child interaction training (PCIT) adapted for use in the home setting. Mothers of children aged 12 to 15 months old with significant concerns related to social-emotional development were recruited through their primary care settings. These settings provided care primarily to individuals experiencing socioeconomic stability disparities and lack of access to clinical services. Most of the 60 participants self-identified with an ethnic or racial minority group. During weekly 60 to 90 minute sessions, parents learned the PCIT skills (i.e., praising, reflecting, imitating, describing, and expressing enjoyment) and were taught to ignore challenging and disruptive behaviors. Parents participating in the PCIT intervention reported significant behavioral progress compared to the baseline and control groups. They indicated increased rates of compliance and decreased levels of aggression, defiance, and internalizing concerns. Furthermore, the intervention had a preventative effect on externalizing behaviors and internalizing concerns. Mothers demonstrated increased positive and decreased negative behaviors during infant-led play interactions, sustained at the six-month follow-up observation. The study thus demonstrated the promise of PCIT during the critical period between a child's first and second birthdays (Bagner et al., 2015).

Another study focused on an earlier period of development, given the high number of women who experience increased stress levels and mental health challenges after giving birth. Parents' emotional availability and engagement during the first 18 months of life are central to the development and adjustment of their babies. Potharst et al. (2017) thus assessed the effectiveness of the Mindfulness with Your Baby intervention model, designed for parent -infant dyads within the first 18 months. Mothers learned to use mindfulness during increased stress, and home practice was integrated. The mothers reported higher levels of mindful parenting with increased self-compassion while participating in this intervention. Medium to significant effects were demonstrated, consistent at the eight-week follow-up. At the one-year follow-up, continued improvement in mindfulness and self-compassion was observed. The mothers reported increased well-being and parenting confidence, reduced symptomology, and stress. The reduction in parenting stress was significant at eight-week and one-year follow-ups. Participants further reported higher levels of responsiveness in their parenting, reduced negative affect, and rated their infants less irritable (Potharst et al., 2017). One international study (Lucas et al., 2017) explored the effectiveness of an intervention designed to facilitate social-emotional and psychological development in young children, the Care for Child Development (CCD) model, and considered implications for future application. The researchers developed a database about where and how CCD was implemented. Thirty implementation sites were identified through consultation with staff at the World Health Organization, UNICEF, and other trainers. The results indicate that CCD had been implemented at 23 sites across 19 countries in various childcare and human services settings and had been feasible and affordable (Lucas et al., 2017). This study identified a strong need and interest in maximizing the development of children worldwide. The recommendations include the development of policies, nationally and globally, to expand CCD implementation and integration within the family and children's services. Additionally, CCD fits well within an integrated and cross-disciplinary care model (e.g., medical, educational, and human services), providing more robust support (Lucas et al., 2017).

Parent Perceptions of Parent Training Education

While many feasible practices exist, identification and referral rates outpace parent enrollment and participation. Over 60% of parents offered early intervention services do not enroll, and about half of those who do enroll stop attending (Gleason et al., 2016). In one study, parents identified various methods for enlisting a parenting professional (Allen et al., 2018). These included searching the internet, asking clinical professionals, inquiring at work, checking with insurance, obtaining recommendations and referrals, and talking with friends. Anticipated benefits included receiving support, learning, gaining new perspectives, having a more collaborative parenting experience, and paying less money. Participants identified preferences for internet services, services with a solid coach-client

rapport, client-centered services, and services focused on family strengths and goals. Potential shortcomings posited by participants included uncertainty surrounding credentials, financial concerns, time constraints, and insufficient insurance coverage. The responses suggest that participants were curious about coaching and receptive to support from various professionals (i.e., psychologists, parenting educators, therapists, family life coaches, and clergy). Additionally, subjects considered it vital to understand professionals' training and endorsements. Another theme was concern related to the expense of services (Allen et al., 2018). Oh & Bayer (2015), in their study on parental help-seeking behaviors, confirmed that parents need to be interested in and know of available services and must also be told when it is essential to seek support for their child. Additional recommendations include universal screening and other prevention models in routine infant and early childhood health services.

Pellecchia et al. (2018) completed a systematic review of 35 studies to identify frequently used parent engagement strategies and to examine their effectiveness through meta-analysis. The studies of interest utilized strategies to engage parents of young children with social-emotional or behavioral challenges from historically underserved populations. The researchers coded the studies to determine the effectiveness of the strategies used. The results suggest that retention is linked to community and home-based intervention strategies (Pellecchia et al., 2018). Providing services at home or in a nearby community setting, such as a school, may solve transportation challenges and power imbalances. Additionally, the use of peer mentorship partially predicted retention. This was particularly true with parents of children with significant medical needs, consistent with the importance of shared experience in reducing feelings of isolation. Pellecchia et al. (2018) recommend for future studies to include strategies for increasing engagement and to consider the interplay between socioeconomic indicators and engagement strategy effectiveness. A "small talk" intervention was utilized in another study which helped promote connectedness and continued group participation (Hackworth et al., 2018).

Objective

Previous research has been limited to information collected primarily from parents who enroll and continue in parent training, education, or coaching programs (Allen et al., 2018; Hackworth et al., 2018; Woodfield & Cartwright, 2019). More information is needed about the perceptions of other parents on the need for services and on perceived barriers to accessing and participating in these services (Hackworth et al., 2018; Woodfield & Cartwright, 2019). This can inform more effective recruitment and program design considerations and reduce the barriers faced by families who need to access infant and early childhood mental health services. Therefore, this study aimed to explore parents' perceptions of the barriers to accessing parent training programs to support the mental health of children, specifically from birth through five years old. A modified consensual qualitative research (CQR-M) design supports an inductive approach, beginning with a primary research question and supporting questions rather than hypotheses. While CQR traditionally uses interviews to collect rich narratives, the modified version allows for shorter responses collected through an online survey to be analyzed and accommodates the busy lives of parents with a child aged five and under. This study was designed to explore the inner experiences and priorities of the participants. The research questions were presented in an open-ended format to remove the parameters and limits set by more closed or structured formats. Additionally, using open-ended questions allowed the researchers to suspend judgments and interpretations until the responses had been thoroughly, systematically, and objectively reviewed and analyzed, per the guidelines established by this design (Hill, 2012). This study adhered to the American Counseling Association. (2014) and was approved by the Institutional Review Board.

Participants

The participants were parents living in the United States, with children in the infant and early child development period. The researchers were in the Midwest at the time of the study, though the sample was not limited to that region. It is noteworthy that in the United States, the federal government provides

funding to offset the cost of childcare, though the availability of the aid varies extensively by state. In addition, parental leave policies also vary by state and employer. For this study, the term "parent" referred to an adult with legal custody primarily responsible for caring for, nurturing, and protecting a minor child (Children's Code, 2019-20). The infant and early childhood development period was defined as the first five years following birth (Zero to Three, 2021). The researchers used snowball sampling by asking mental health and educational professionals to share recruitment materials with people who fit the sample requirements. Recruitment materials included information about the research study, an invitation, and a link to review the informed consent and consider continued participation. The materials were provided in the following formats: email, flyer, and social media posts.

Data Sources

This project first utilized a demographic survey. The items incorporated factors positively and negatively associated with mental health outcomes and factors associated with participation to determine if conclusions related to the representative nature of the obtained sample could be drawn. The researchers used descriptive statistics to explore demographic trends. The qualitative survey addressed the following primary research question: "What barriers do parents identify to obtaining training to support their child's mental health?" To support the exploration of this primary research question, the following open-ended survey questions were developed:

• What concerns (social, emotional, behavioral) might prompt you to seek support for your child?
• Who would you talk to first if you had a concern for your child's wellbeing (social, emotional, or behavioral)? This could be anyone (e.g., family, friends, community members, teachers, or other professionals).
• Infant and early childhood mental health services support children's social, emotional, and behavioral development from birth through age five. What infant and early childhood mental health services are you aware of?
• How would you find infant and early childhood mental health services?
• What might make it difficult to find or obtain childhood mental health services?
• Parent education and training assist parents in supporting their child's development. How might parent education or training opportunities be helpful?
• How likely would you be to participate in training to support your child's wellbeing? (Very Likely, Somewhat Likely, Unsure, Somewhat Unlikely, Very Unlikely)
• What might get in the way of your participation in parent education and training?

Data Analysis

Before data analysis, the team members completed bracketing, during which they identified, documented, and considered their experiences, biases, and assumptions (Hill, 2012). The data analysis team included the primary researcher and two data analysts. All team members were affiliated with a Counselor Education and Supervision program at a small private university in the Midwest United States. All members were between 37 and 49 years old and identified as cisgender females. The primary researcher also had prior training and experience in infant and early childhood development and 10 years of experience working as a school psychologist and as a mental health counselor-in-training with young children ages three through five. One team member believed her lack of parenting experience gave the team a unique lens through which to consider the data. In traditional CQR design, the researcher transcribes interviews prior to data analysis (Hill, 2012; Hill & Knox, 2021). The CQR-M design allowed the team to collect responses through Qualtrics. These responses were then downloaded as a spreadsheet. Data analysis in both traditional CQR and CQR-M begins with a review of data and the development of domains, which are the primary overarching categories or themes that emerge during data analysis (Hill, 2012). These domains allowed the primary researcher and data analysis team of this study to provide a framework to further sort and conceptualize the data. Domain lists were not developed before data analysis, as the research design was aimed to allow the domains to emerge from the participant responses. In CQR, once the research team establishes the domains, core ideas are constructed by providing

a straightforward and succinct summary of the data within each domain (Hill, 2012; Hill & Knox, 2021). This involves summarizing large chunks of data from each participant. Because of the CQR-M approach used for this study, participants' responses brief and were not necessary (Hill, 2012). The researchers explored core ideas during cross-analysis to consider categories and subcategories. Each data segment was sorted into categories to confirm the emerging domain and category structure. The last step is to calculate the frequency of responses and designate one of the following descriptors: general (included in all but one), typical (at least half and up to the 'general' threshold), variant (at least four and up to the 'typical' threshold), and rare (at least two or three; Hill, 2012). The team reviewed responses for saturation and stability in the domain and category structure. Additionally, quotations were used to provide the reader with specific examples during the factual reporting of the data. An external auditor with extensive expertise in CQR reviewed the team consensus at each stage of the data analysis process. As domains were established, categories and subcategories were outlined, and data was sorted within this structure. This external auditor reviewed the factual reporting of the results and the final discussion of results to ensure and endorse reasonable interpretations.

Results

Parents with children from birth through age five (N = 20) participated in this study. Despite efforts to recruit a sample more representative of the population in the United States, 100% of participants (N = 20) identified as Caucasian. All but one (95%) identified as cisgender female, while one participant declined to share gender identity. Eight participants were 25 to 34 years old, 11 were 35 to 44 years old, and one participant identified as 45 to 54 years old. Ninety-five percent (n = 19) reported being married at the time of this study, while one had never been married. Nineteen out of 20 identified as heterosexual, while one declined to respond.

All participants (N = 20) had completed a minimum of a high school or equivalent degree. Sixteen participants were employed full-time, two were employed part-time, one identified as a homemaker, and one was unemployed and seeking employment. Responses indicated that 55% of participants lived in rural communities, 20% in suburban environments, and 25% in urban settings. The majority lived in dual-income households (n = 18). Three participants identified child support as part of their expected income; however, two (10%) indicated this was unpaid. 40 % (n = 8) of participating parents had one child, 40% (n = 8) had 2 children, 10% (n = 2) had 3 children, and the remaining 10% (n = 2) had 4. Their children were in the following age ranges: 5 to 6 months (n = 1), 7 to 9 months (n = 2), 13 to 18 months (n = 1), 19 months to 2 years (n = 10), 3 years (n = 4), 4 years (n = 5), and 5 years (n = 3). English was the primary language spoken in 100% of households (n = 20). 5% (n = 1) reported also speaking French and 5% (n = 1) Spanish. The analysis of responses and core ideas suggested 4 domains, 13 categories, and 15 subcategories, as seen in Table 1. Results are herein organized and presented by domain. Categories and subcategories that emerged from core ideas are then summarized. The authors use direct quotes to provide participant examples.

Table 1: Domain and Category Structure Table

Domain and Category Structure	n	Designation
Awareness		
Concerns	17	Typical
Behavioral	15	Typical
Social	11	Typical
Emotional	10	Typical

Domain and Category Structure	n	Designation
Services	20	General
County	11	Typical
Clinical	10	Typical
Educational	3	Rare
Limited	11	Typical
Accessibility factors		
Limited availability	11	Typical
Logistics	19	General
Family schedules	16	Typical
Location	5	Typical
Transportation	3	Rare
Childcare	3	Rare
Financial	10	Typical
Cost	6	Variant
Coverage	7	Variant
Relevance	4	Variant
Supports		
Clinical	17	Typical
Social	16	Typical
Educational	8	Variant
County	7	Variant
Internet	4	Variant
Predicted benefit		
Increased Knowledge	15	Typical
Resources & Strategies	12	Typical
Development	7	Variant
Peer Support	5	Variant

Note: *General indicates all but one participant (n = 19 or 20); Typical indicates at least half (n = 10-18); Variant = at least four (n = 4–9); Rare = at least two (n = 2–3)*

Awareness

The first question asked, "What concerns (social, emotional, behavioral) might prompt you to seek support for your child?" The results suggest awareness of concerns, with multiple participants echoing that they would seek support for "all social, emotional, or behavioral concerns." Core ideas included the behavioral, social, and emotional subcategories, with behavioral concerns being the most frequently identified. Fifteen participants (75%) indicated that observations about their child's behavior might determine their seeking of additional support. Examples of behaviors that would prompt parents to seek help included what one participant termed "extreme behavior." Other participants further described "concerns such as large tantrums, biting, or hitting often" and "defiance, physical aggression, hyperactivity that causes concern," including not only "behaviors" but also "attitudes." Eleven participants (55%) stated they might seek support if they had social concerns for their child. Specific observations that would raise concerns included difficulties interacting, getting along, and developing friendships with peers. For example, two participants reported being concerned if their children were "not interacting with other children." Another described this as "struggles with making friends or interacting with peers their age," and yet another believed that "inability to get along with others" would be concerning.

Ten participants (50%) indicated that emotional concerns for their child would prompt them to seek additional support, including anxieties that were not developmentally appropriate, frequent and prolonged dysregulation that did not respond to adult support, or being overly self-critical. One participant reported, "I would seek support if my children were showing any concerns such as being unregulated often and not regulating with adult support." Another indicated they would pay particular attention to "negative self-talk." Participants reported considering several factors, including how long a concern had persisted, whether this was "expected for [their] age," and if this represented a change for their child. One participant said she would be concerned if her children were "acting out of their typical behavior (socially, emotionally, or behaviorally) for an extended period of time." Another noted she would be concerned if behaviors "[had] no identifiable function." Participants also considered whether the concern interfered with the child's or family's functioning. For example, one participant would seek help for any "social, emotional or behavioral concerns that were impacting participation at daycare or negatively impacting our home life in a way I didn't feel I could manage." What other trusted individuals had to say was a factor. As one participant wrote, "Honestly, I am not sure! I suppose any of the above if they seemed concerning to my partner and me, and if the people I consulted about it suggested seeking out care."

The third question asked, "Infant and early childhood mental health services support the social, emotional, and behavioral development of children from birth through age five. What infant and early childhood mental health services are you aware of?" Likewise, some of the core ideas that emerged from the fifth question, which asked "What might make it difficult to find or obtain childhood mental health services?", were relevant to the "awareness" category. The following four subcategories were suggested within services: county services, clinical services, educational services, and limited awareness of services. Participants were most familiar with the county and clinical services available in their area. Eleven participants (55%) identified services available in their counties that provide infant, early childhood, and family mental health services. One participant identified several in their local region: "Parenting Place, the birth to three programs, county supports such as CLTS, CCS, CST." Ten participants (50%) reported an awareness of clinical resources available in their communities, including primary care and behavioral health services available at public and independent clinics. A few parents identified awareness of both county and clinical services. Three participants (15%) identified early childhood intervention services available through their public school systems. One participant listed, "Birth to three, early head start, play-based therapy, early childhood special education." The researchers identified a need for more awareness within this sample population. Eleven participants (55%) reported limited to no awareness of available infant or early childhood mental health services. A few parents noted learning about services only after concerns became relevant, such as a participant who said, "I know of very little, only what we have needed to seek help for emotional and behavioral." A couple of participants believed knowing about services earlier would have been beneficial. For example, one participant recalled, "I was only made aware by my doctor and wish I would have known about this program sooner." Another reflected on the challenges associated with lack of awareness: "It would have been helpful for me to have help immediately after having my child… it was hard to navigate what I needed at that time but know that I needed help."

Accessibility

Another domain explored accessibility and included core ideas from the fifth and eighth questions. Question 5 asked, "What might make it difficult to find or obtain childhood mental health services?" Question 8 asked, "What might get in the way of your participation in parent education and training?" The core ideas included logistics as a primary category with four subcategories: family schedules, location, transportation, and childcare. Family schedules were identified as a primary accessibility factor, with 16 out of 20 (80%) participants identifying lack of time and conflicting obligations as potential barriers to identifying services or participating in parent training programs. One participant stated, "Time! I

swear there is never enough of it!" Finding providers that work outside the typical work hours and taking time off work to attend appointments were identified most frequently, followed by other obligations, like social obligations and visitation schedules, within and across households. Five participants (25%) identified the location of their residence and the services as a primary barrier to locating or participating in services. One participant stated, "The only thing I can think of is if the location of the training was very far away." Another indicated that living in a rural community represented a potential barrier. Related to this, issues with transportation to the location of services" were specifically identified by four participants (20%) as a potential barrier. Finally, three participants (15%) identified needing childcare for other children as a barrier. The core ideas also include limited availability as a category. Eleven participants (55%) identified a shortage of providers and long wait lists as barriers to identifying infant and early childhood mental health support. This was true of clinic-based services with a "lack of availability of services," "lack of providers," and "super long waitlists everywhere for child mental health services." This was also true of county-based services. One participant noted that despite being aware of services available through the county, "services are difficult to get for those who need it."

An additional core idea was finances, with subcategories of coverage and cost. Seven participants (35%) identified access to, and limitations set by, their health insurance as potential barriers. One participant, aware of several services within her local community, stated, "For us personally, I don't know what we could access other than through our HMO." Another participant reported, "Our HMO would restrict where we can go." Other responses indicated that the parents needed to know not only professionals covered by their insurance, but also providers who took their insurance. Six participants (30%) likewise identified "money," "cost of trainings," or "financial commitment" as a barrier to obtaining and participating in services.

Finally, another core idea was relevance as a category. Four participants (25%) identified that the current lack of relevance to the needs they were experiencing was a primary reason they might not participate in parent training. One participant reported she would consider "how relevant [or] useful I feel that it would be to us in the immediate." Another identified specific parameters around relevancy: "At this age in [their] development, I'm looking for opportunities that [they] can attend with me. I would not attend parent-only trainings or virtual trainings." Yet another noted that her professional background made parent training less likely to be relevant: "I just don't currently feel the need—if I didn't come to parenthood with a lot of training, I would be more likely to seek it out." One participant highlighted, "If my child truly needed it… I would make it a priority."

Supports

The second and fourth questions explored what supports participants identified: "Who would you talk to first if you had a concern for your child's wellbeing (social, emotional, or behavioral)? This could be anyone (e.g., family, friends, community members, teachers, or other professionals)." and "How would you find infant and early childhood mental health services?" Core ideas included the role of clinical professionals, particularly primary care providers, in addressing parent concerns and linking children with services. Seventeen participants (85%) identified these professionals as critical sources of information. Statements included "I would check in with our family doctor," "I would ask my pediatrician," "I would reach out to my child's PCP," and "talk to my… son's counselor." Notably, participants who indicated some level of uncertainty surrounding whom they might talk to first identified their child's primary care provider as an approachable source. For example, one participant acknowledged, "I'm not sure," adding, "Talk to my pediatrician?" Another wrote, "Not sure, maybe his doctor."Another core idea was the importance of social support. Sixteen participants (80%) reported they would first talk to people they knew and trusted. For one participant, these included "friends, family or coworkers," and another added, "professionals I know." Other specific examples listed by participants included "my mom," "my husband, my dad, my mother-in-law, other professionals," "friends," and "fellow human services colleagues." The participants also noted that experience with

children was a consideration: "I feel that first I would talk to family and my closest friends with children or experience with early learners." The role of educational support emerged as a core idea, with eight participants (40%) identifying educational professionals as individuals they would talk to when seeking support for their child. One parent identified the "school district" as a source of information. Another noted she would "talk with school professionals about resources." Another reported she would talk with the "school guidance counselor." One parent said she would contact her "child's daycare provider." Finally, four participants identified the internet as a potential support. One thought she might use Google, and another suggested she could "possibly look online for specific providers." Another identified the "clinic/hospital website" as a potential source of information on infant and early childhood mental health services.

Predicted Benefit

The sixth question explored what participants predicted as the benefit, asking, "Parent education and training assist parents in supporting their child's development. How might parent education or training opportunities be helpful?" Core ideas included resources and strategies as categories. Twelve participants (60%) believed parent education and training would increase their awareness of available resources and help them develop specific parenting techniques that could be used at home. One parent believed these services could be "very helpful!" and added, "Parent carryover at home is the biggest factor in success for children in therapy." Other parents believed parent training might provide education on "effective discipline strategies and positive parenting techniques," "additional, alternative methods to try at home," "tips, advice, and strategies," and "how to handle different situations that might arise." Another believed it would help her "support [development] with my child." Furthermore, one participant noted that it could be beneficial "to make us aware that early childhood mental health services exist in the first place!" The seventh question was presented in a five-point Likert scale format and asked, "How likely would you be to participate in training to support your child's wellbeing?" Each response was assigned a numerical score (extremely likely = 5; somewhat likely = 4; neither likely nor unlikely = 3; somewhat unlikely = 2; extremely unlikely = 1). On average, group participants indicated a high likelihood of participation with a mean score of 4.1 (median = 5; mode = 5). Fifteen participants (75%) indicated they were either somewhat (n = 2) or extremely likely (n = 11) to participate. Three participants (15%) endorsed neither likely nor unlikely. Two participants (10%) indicated they were extremely unlikely.

Discussion

This consensual qualitative exploration delved into parent perceptions of the barriers to obtaining parent training to support children's mental health from birth to age five. The responses suggest that efforts to remove barriers must consider a variety of factors related to parental awareness, accessibility, support, and predicted benefits. In addition, there may be a difference between a parent's awareness of potential areas of concern and their recognition of significant concerns in their child, as is consistent with previous research (Oh & Bayer, 2015). This represents a potential barrier to accessing services. However, most participants identified at least one social, emotional, or behavioral concern that would prompt them to seek help for their child. Similarly, three-fourths of parents indicated they were somewhat likely or extremely likely to participate in parent training to support their child's needs. Despite the high level of openness to services and the wide range of concerns that might warrant support, over one-third acknowledged a need for more information about infant and early childhood development. To seek help, parents must recognize a problem and know that services are available. A particularly compelling finding within parental awareness is that over half of participants reported limited to no awareness of infant and early childhood mental health services. This result is striking, given the level of education and community-level connectedness reported by this pool of participants. This supports the previous finding that there may be a lack of awareness about what constitutes

mental health and what might indicate potential mental health concerns for infants and young children (Allen et al., 2018). Once concerns have been identified for a child, most parents reported an identified set of supports with which they would engage. The supports most frequently identified include clinical supports like primary care or behavioral health providers and social supports like family, friends, and coworkers. Other supports noted included educational support like school staff and daycare providers, county supports like the United States "Birth to Three" program, social workers, and the internet, including sources like online directories, search engines, and websites. Primary care providers also play a critical role as a support for parents. Most participants identified primary care providers (e.g., pediatrician and family doctor) as within their group of supports they would go to with concerns for their child. Even more notably, those who did not readily identify a social support network did identify their child's primary care provider as a resource they would consider approaching. This is interesting considering the research results from Claussen & colleagues (2020), which indicate that fewer than half of children demonstrating difficulties with emotional regulation have an identified primary care provider. Furthermore, only about half of those recommended for additional screening or assessment receive ongoing monitoring, and less than a quarter demonstrating significant mental health needs receive relevant support (Claussen et al., 2020). Given medical professionals' significant role in re-sponding to concerns and helping connect parents to additional support, if infants and young children have access to routine primary care, this may reduce the barriers parents face. Parents with awareness and support may still face barriers to participation due to accessibility. The most significant contributing factor is conflicts with family schedules (e.g., work schedules, extracurricular obligations, coordinating shared custody), followed by the location of services, transportation, and childcare. The responses suggest a significant consensus around logistics as a perceived barrier to participation. Other barriers include limited availability of providers and appointment times, cost and insurance coverage, and the relevance of the services to the parents' current circumstances. This is consistent with the study by Hackworth et al. (2018), which found that many of these barriers are linked to lower retention and engagement rates. Furthermore, Claussen et al. (2020) observed that very young children experiencing significant social -emotional-behavioral delays are more likely to experience multiple challenges to accessibility. For example, these children are more likely to experience financial insecurity and lack adequate healthcare coverage (Claussen et al., 2020). Another primary theme is the importance of attending to what parents predict might be the benefits of participating in parent education or training opportunities. Participants in this study believed that benefits included increased knowledge about parenting resources, parenting strategies, and typical child development. Some parents identified peer support as an anticipated benefit, noting that it can "also be helpful to know other parents in the same or similar situations." One participant noted that this experience might "take away the feeling that you failed." These responses further support the results of Wiles et al. (2018) in recommending that mental health providers assess parent and family social support. An important consideration for professionals serving infants and young children is integrating and reinforcing social support systems to maximize the likelihood of successful outcomes for childrenand their families. The perspectives offered by parents in this study suggest that various interactingfactors must continue to be addressed in the areas of parental awareness, accessibility, support, and parent understanding of benefits. While this study and framework for interventions are grounded in attachment theory, a model of accessibility should likewise be explored. The Conceptual Framework of Access to Healthcare by Levesque et al. (2013) represents a promising explanatory framework for the discrepancy between the need for and access to services. This framework accounts for social determinants of health and includes the following dimensions: approachability, acceptability, availability, affordability, and appropriateness. Additionally, this framework is bidirectional

and considers individuals and societies to have the capacity to interact with healthcare through perceiving, seeking, reaching, paying, and engaging. Thus, both systematic and individual-or population-level factors are considered .

Limitations and Recommendations

This study was limited to parents living in the United States. In addition, the referrals and self-selection inherent in snowball sampling likely contributed to the limited diversity within the participant pool, further confounding the ability to generalize results (Gliner et al., 2017). While the homogeneous nature of the sample allowed for unexpected insights, future studies should explore ways to gain participation from a broader demographic base, including international and ethnic diversity. This may be facilitated through consultation with other professionals and cultural liaisons. In addition, it is recognized that opportunities for parental leave and childcare widely vary and could impact the results. While the methods in this study were selected to reduce pressure toward socially desirable responses, in-person interviews or focus groups may be considered to gain participation from specific communities. This study was completed using a CQR-M design, allowing data collection through re-mote and electronic means (Hill, 2012). While this leads to efficient data processing from a more significant number of participants, the responses gathered are much shorter and, at times, more challenging to analyze (Hill, 2012). A strength of CQR remains the use of multiple perspectives and consensus (Hill, 2012; Hill & Knox, 2021). However, an interview or focus group format may lend itself to a richer data set with more contextual information to support the data analysis process. The results of this study and the initial exploration of explanatory models of accessibility suggest that future studies might consider integrating accessibility frameworks. Plus, it could be of benefit to explore parent and child support across different regions and countries to identify best practices.

Conclusion

Multiple interacting influences impact the use of infant and early childhood mental health services. Disruptive social, emotional, or behavioral patterns that begin in childhood are of particular concern, not only due to the potential cost to stakeholders but also due to the elevated risk these children face for poor outcomes later in life. These risks include dysfunction across the social-emotional, behavioral, academic, and psychological domains; these children are disproportionately represented in our criminal justice system as adolescents and adults (Ortiz et al., 2020). Healthy parent-child interactions are critical for children worldwide to develop positive mental health and resiliency. Furthermore, compromised interactional patterns are typically responsive to intervention. Many effective practices exist for infants and young children; however, enrollment and participation rates in parent training programs are much lower than referral rates, resulting in missed opportunities for parents and young children to receive these supports (Gleason et al., 2016; Hackworth et al., 2018).

The results of this study are consistent with Hackworth et al. (2018), who note the complex and interactional nature of factors influencing parent participation. The findings indicate that efforts to identify and remove barriers must consider and respond to these factors, including parental awareness, accessibility, support, and predicted benefits. However, additional research is needed to explore further the phenomenon of lagging enrollment and participation rates. One particularly striking finding of this study is the potential need for increased awareness of what constitutes infant and early childhood mental health and of what services are available to support this area of development. The findings also highlight a potential benefit to more consistent screening and assessment practices that identify and engage parents in needed prevention and intervention services. The participant responses featured the critical role that primary care and other clinical providers play as support resources in the lives of children and their parents. Providers worldwide must consider how to better promote the mental well-being of future generations.

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