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EARLY RELATIONAL HEALTH
FOR PRIMARY CARE PROVIDERS

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EARLY RELATIONAL HEALTH FOR PRIMARY CARE PROVIDERS

In this resource:

- What is early relational health?
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- Supporting early relational health in pediatric primary care

What is early relational health?

Early relational health (ERH) is healthy, foundational relationships between very young children (birth - age 3) and their caregivers.

Healthy early relationships develop through positive, responsive back-and-forth interactions between the child and caregiver.

Healthy early relationships help lay a foundation for development and well-being in childhood and across the lifespan, as well as caregiver well-being and family resilience.

"Early relational health is defined as a **foundational, culturally embedded** and developing set of **positive, responsive, and reciprocal interactions** from birth that nurture and build **emotional connections between caregivers, infants and young children** and result in emerging confidence, competence, and emotional well-being for all."
(Willis & Eddy, 2022)

Why it matters

- Young children are wired to connect with their caregivers, and adults' brains undergo changes in the transition into parenthood that program them for connection with their baby. This connection and attunement are fundamental needs for both the child and the caregiver. Their absence is a risk factor for toxic stress which is linked to long-term adverse child development and health outcomes. (Garner et al., 2021)
- Serve-and-return interactions between young children and responsive, engaged caregivers during this sensitive period of development support brain development in many ways, including building neural circuitry involved in language, cognition, socio-emotional skills, and self-regulation. (Serve and Return, n.d.)
- Healthy relationships between young children and their caregivers help build family environments that are positive, meaningful, and enjoyable.
- Strong foundational relationships also foster resilience, buffering against some of the negative effects of early adversity on child development. For example, data from the 2016-2017 National Survey of Children's Health showed that a larger percentage of children facing high levels of adversity (ACE scores 4-9) who had strong family connectedness were flourishing (30.5%) compared to children experiencing lower levels of adversity (ACE score 0) who had lower levels of family connectedness (26.8%). (Garner et al., 2021)
- The quality of the relationship also affects caregivers' well-being. When caregivers feel able to connect with their child, this can be a source of strength that builds their sense of competence and confidence in their parenting role, and brings a sense of joy in moment-to-moment interactions.

Safe, stable, nurturing relationships (SSNRs)

Early relational health is characterized by relationships that are:

- **Safe**: Caregivers provide social and physical environments for their child that are free from physical or psychological harm. Children feel a sense of security knowing that their caregiver is there to protect them.
- **Stable**: Caregivers foster social, emotional, and physical environments for children that are predictable and consistent.
- **Nurturing**: Caregivers meet their child's physical, emotional, and developmental needs with warmth, sensitivity, and consistency.

According to the American Academy of Pediatrics, SSNRs "are biological necessities for all children because they mitigate childhood toxic stress responses and proactively build resilience by fostering the adaptive skills needed to cope with future adversity in a healthy manner." (Garner et al., 2021)

What ERH looks like:

When a 6-month-old begins to crawl, their parent shares their joy in crawling toward an object or person of interest. When a 9-month-old babbles to the caregiver during a diaper change, the caregiver shows attentiveness and responds. When a toddler cries, they look to their parent, and lift their arms up, knowing their parent will pick them up to offer comfort. Positive, strong relationships can take many forms. They do not require parents to enact a narrowly prescribed set of behaviors. Rather, they take shape through back-and-forth interactions where the caregiver is attuned to the child's expressions and responds in a predictable and nurturing way, within that family's social and cultural context.

Supporting ERH means:	✓ Promoting positive, healthy relationships between young children (birth – age 3) and their caregivers through caregiver-child interactions
Supporting ERH doesn't mean:	✗ Rating parent behavior ✗ Teaching parenting

Early relational health screening considerations

Supporting ERH in pediatrics

Pediatric primary care is a near-universal point of contact for caregivers of very young children. Universal support for early relational health can include promotion of family relational strengths, screening for relational vulnerabilities, and identification of barriers to developing and sustaining SSNRs. By identifying concerns early and connecting families to appropriate resources, pediatricians can build families' capacity for cultivating healthy foundational relationships with their young children. Framing ERH screening as a check-in that is offered to all families to build on their relational strengths can help address stigma or worry parents might associate with assessment.

Measuring ERH = Valuing ERH

"*What one measures is what one values.*" Assessing early relational health is a strategy for elevating this core building block for child development and family resilience as an observable, important "vital sign" (Willis & Eddy, 2022). The early relational health lens offers a strengths-based complement to tools for early identification of toxic stress.
(Garner et al., 2021)

A quality tool is just that – a tool. By itself, it won't do all the work.

Partnership with families drives ERH promotion. Screening tools should be implemented in the context of authentic, trusting partnerships with families to engage in conversations about their relational strengths, resources, and vulnerabilities.

ERH is contextual.

Factors beyond the individual can add substantially to family stress and thereby impact family relationships. This could include poverty, food and housing insecurity, community violence, and exposure to racism or discrimination. At the same time, families draw on cultural values and community resources to engage in developmentally nurturing ways with their children. This can be a source of agency and resilience in environments with high levels of adversity.

Measurement of caregiver-child interaction has a history of bias and systemic oppression. Equitable ERH practices require awareness of this history and an anti-bias approach.

Observation of family-baby interactions by a professional for the purposes of rating, scoring, or screening can be detrimental to families from historically marginalized communities (Charlot-Swilley et al., 2022). For example, implicit racial or cultural biases and stereotypes can negatively influence what an outside observer sees in a parent-child interaction and can lead them to make inaccurate interpretations. Historically, methods for observing parent-child interaction were developed by White researchers and have centered observers' interpretations rather than family voice and collaborative, contextually grounded meaning-making (Thomas, 2022). Also, families may be distrustful or have concerns about being judged by outsiders based on past experiences of bias or racism (Willis & Eddy, 2022); for example, experiences with healthcare systems that treat race as a risk factor rather than addressing systemic inequities in social determinants of health and healthcare (Charlot-Swilley et al., 2022; Thomas, 2022). An equity-centered approach requires awareness regarding risks of bias in assessment of caregiver-child interaction, and an intentional positioning of the family, not the professional, as the expert on that family's relationships.

Recent tools offer alternative strategies to promote equitable ERH assessment and promotion. One strategy involves establishment of a safe environment of trust, respect, and authentic partnership to support families in identifying their own relational strengths and vulnerabilities (see ERH-C, Charlot-Swilley et al., 2022). Another strategy involves using a standardized, video-based measure to increase objectivity and consistency in ERH assessment – to avoid relying solely on individual clinicians' subjective judgments during fleeting in-person observations (see ERHS, Willis et al., 2021).

More broadly, equitable ERH practice requires critical reflection on these histories and engagement in building partnerships in which families, community, and clinicians co-create systems and practices to support family ERH capacities (Thomas et al., 2022).

> "In this approach, the pediatric primary care setting – **if it embraces an anti-racist, equitable and diversity-informed framework in partnership with families** – offers transformational opportunities to support healthy parent-child relationships for so many more families. As noted, advancing ERH will require careful strategies and practical solutions for pediatric practices and medical models which do not traditionally allow for including workflow adjustments rooted in **relationship-based, trust building practices that elevate the inherent wisdom of families and the parent-child relationship**."
> (Thomas et al., 2022)

Early relational health screening tools

Below are several ERH measurement tools that have been proposed for use in clinical practice.

Tool	Early Relational Health Screen (ERHS)
Administration	Video-based observation on caregiver-child interaction (3-12 minutes; length and materials required vary by child age) and caregiver interview (2-6 minutes).
Domains	Overall emotional tone of relationship, observable patterns of behavior in interactions (i.e., mutual engagement, mutual enjoyment), and caregivers' thoughts about the relationship (i.e., their beliefs about the child's experience in the relationship, their questions, desired supports).
Scoring and interpretation	Scoring criteria are freely available online and include a decision tree for using results to determine next steps for monitoring and referral.
Age range	Designed to be administered at 4, 6, 12, 18, and 24 months.
Notes	The current version of the ERHS is designed for video coding observations, but according to the authors, coders could be trained to conduct observations in vivo (Willis et al., 2022). ERHS authors encourage further research and development on the ERHS including continued work regarding validity, feasibility, and co-construction with families toward culturally grounded, equitable ERHS applications (Willis et al., 2022).
More information	ERHS website Willis, D. W., Condon, M. C., Moe, V., Munson, L., Smith, L., & Eddy, J. M. (2022). The context and development of the early relational health screen. Infant Mental Health Journal, 43, 493-506. https://doi.org/10.1002/imhj.21986 Note: although article is behind a paywall, "Supporting Information" section is freely accessible and includes administration guidelines, scoring criteria, and worksheet to guide next steps.
Access measure	https://ecmeasures.instituteforchildsuccess.org/measure/2500ce1e-5dab-4a41-9a62-2aec6fe1b5a8

Tool	Welch Emotional Connection Screen (WECS)
Administration	Video-based observation of face-to-face interaction between mother and infant (2 minutes).
Domains	Attraction, Vocal Communication, Facial Communication, Sensitivity/Reciprocity.
Scoring and interpretation	After rating all four domains, clinician makes an overall, dichotomous decision of emotional connection (yes/no).
Age range	4 months
Notes	Tested with mother-infant dyads only. Observed behaviors related to emotional connection only; other caregiver behaviors/perspectives related to ERH are not assessed. No consideration of cultural variation of ERH/emotional connection discussed in validation study.
More information	WECS website Frosch, C. A., Fagan, M. A., Lopez, M. A., Middlemiss, W., Chang, M., Hane, A. A., & Welch, M. G. (2019). Validation study showed that ratings on the Welch Emotional Connection Screen at infant age six months are associated with child behavioural problems at age three years. Acta paediatrica, 108(5), 889-895. https://doi.org/10.1111/apa.14731
Access measure	https://ecmeasures.instituteforchildsuccess.org/measure/b6046fb5-9de2-448b-af44-3f7e5874033d

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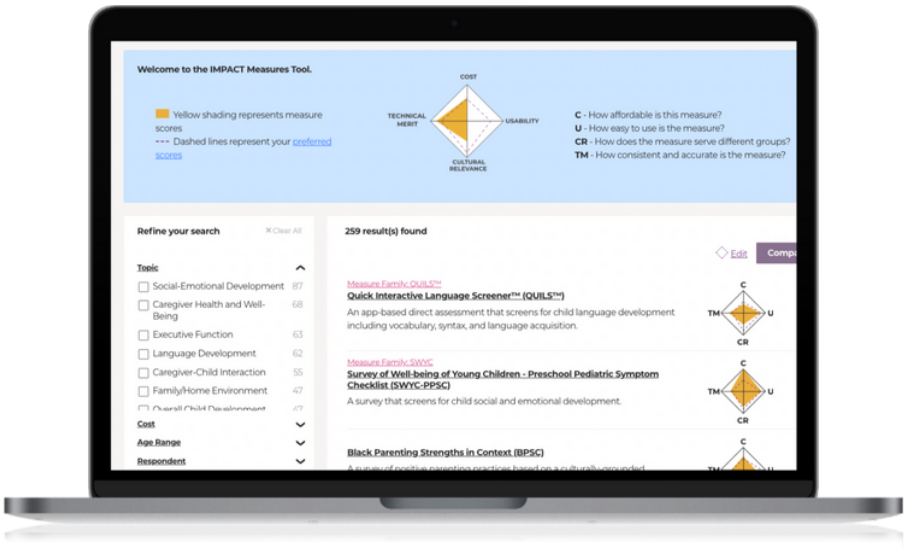
Tool	Early Relational Health – Conversations (ERH-C)
Administration	Interaction between the family and baby is video recorded (timing and length determined jointly by family and facilitator). The family and facilitator watch the video together and the facilitator listens and supports family in identifying strengths they see in the interactions and concerns or questions they have about their baby's relationships and development. Family voice is central.
Domains	Elements of implementation process: Preparing, Accessing, Pausing and Co-Creating, Storytelling, Witnessing, Mutual Reflection, Claiming, Mutual Insight.
Scoring and interpretation	The ERH-C is explicitly designed as a family reflection model, not a quantitative measure. Intentionally does NOT rate caregiver behaviors or calculate ERH scores. Instead, facilitator and family engage in observation and reflection together.
Age range	Designed for use with caregivers and their infants. Age not specified.
Notes	Implementation of ERH-C requires paradigm shift toward organizational-level reflection and co-creation with families. ERH-C developers provide guiding questions for organizations including prompts about approaching ERH-C through an equity and justice lens, organizational questions for implementation, family access to ERH information, and data documentation.
More information	Charlot-Swilley, D., Condon, M. C., & Rahman, T. (2022). At the feet of storytellers: Implications for practicing early relational health conversations. Infant Mental Health Journal. https://doi.org/10.1002/imhj.21981

Interested in exploring other measurement options?

Visit the IMPACT Measures Tool® to get started. This free online database can help you identify available measures to serve your children and families.

With over 250 measures available, this website provides science-backed ratings of each measure based on the categories of cost (price and accessibility of measure), usability (time and resources to complete), cultural relevance (cultural groups and languages the measure was developed and adapted to serve), and technical merit (accuracy and consistency of the measure).

Filter by topic (i.e., "caregiver-child interaction"), age range, and language to help you find other tools that may be useful for your purpose and community. Many other measures of parent-child interaction exist but may have limitations for use in pediatric settings (for example, they may take too long to administer, require extensive training, or were developed primarily for research purposes). To learn more, visit https://ecmeasures.instituteforchildsuccess.org/.



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