

Knowing when to seek help



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Parenting Toolkit series-IHS*

Objectives

By the end of this presentation, participants will be able to:

- Describe different attachment styles in infants and toddlers
- Identify areas of concern, and reasons to refer, parents and infants
- Identify concerning behaviors in toddlers and preschoolers

A baby alone does not exist. A baby can be understood only as part of a relationship.

D.Winnicott

We are hardwired to be held in
the mind and heart of another.

Theorists whose ideas help us understand IMH

- Selma Fraiberg
- John Bowlby
- Mary Ainsworth
- Alicia Lieberman
- Charles Zeanah

“Ghosts in the Nursery”

- Selma Freiberg
- The parents’ own internalized mental representations of their childhood, caregivers, and affective history
- good ghosts / bad ghosts

John Bowlby

- Father of “attachment theory” (1950’s): proposes that infants build nonverbal, internal working models of early relationships with each caregiver
- These models are unconscious, yet they serve as templates for expecting other close relationships later in life to be similar (depressed or happy, kind or cruel, orderly or chaotic)

Bowlby (cont.)

- When the baby's attachment figure is present emotionally for her, she can explore freely and the quality of her play will be more focused and creative
- When the attachment figure disappears or is rejecting, the quality of play suffers

Mary Ainsworth

- 1979-*Strange Situation* on 16 pairs of mothers and babies in Baltimore, MD
- Three major categories of attachment
 - Secure
 - Anxious/Resistant
 - Anxious/Avoidant
- Mary Main and Judith Solomon later added
 - Anxious/Disorganized/Disoriented

Mary Ainsworth

- Once attached, mobile infants are able to use the attachment figure as a secure base for exploration of the environment and as a safe haven to which to return for reassurance (Ainsworth, 1967; Schaffer & Emerson, 1964)
- Maternal sensitivity was associated with more harmonious mother-infant relationships. Babies whose mothers had been highly responsive to crying, now tended to cry less, relying for communication on facial expressions, gestures, and vocalizations (Bell & Ainsworth, 1972)

Alicia F. Lieberman

- Wrote “The Emotional Life of the Toddler, “Psychotherapy with Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment”
- Quotes Freud: *“Mental health consists of loving well and working well”* to remind us that children’s work is their play
- Babies are naturally social creatures
- Individual differences are an integral component of babies’ functioning
- Every individual exists in a particular environmental context that deeply affects the person’s functioning
- Infant mental health practitioners make an effort to understand how behaviors feel from the inside, not how they look from the outside
- The intervener's own feelings and behaviors have a major impact on the intervention

Developmentally salient anxieties

- Fear of loss of parent
- Fear of loss of parent's love
- Fear of injury/damage to self
- Coping with guilt and shame

Attachment Milestones and Behaviors

- Eye contact/social smile
- Cuddle/molding
- Reciprocity between infant/parent
- Stranger anxiety 5-8 months

Attachment Milestones and Behaviors

- Separation anxiety 7-9 months
- Secure base/safe haven 9+ months
- Preference for parent 7+ months : Internal Working Model
- Partnership 30+ months

Attachment Milestones and Behaviors¹⁶

- Following/searching
- Reaching
- Signaling/calling to
- Holding/clinging/sitting with
- Seeking to be picked up

The Strange Situation Procedure

Number of Episode	Persons Present	Duration	Brief Description of Action
1	M, B, O	30 sec.	Observer introduces mother and baby to experimental room, then leaves
2	M, B	3 min	Mother is non-participant while baby explores; if necessary, play is stimulated
3	M, B, S	3 min	Stranger enters. After 3 min. mother leaves the room
4	B, S	3 min or less	First separation episode
5	M, B	3 min	First reunion episode. Mother greets and or comforts the baby, then tries to settle him again in play. Mother then leaves
6	B	3 min or less	second separation episode
7	B, S	3 min or less	Continuation of second separation. Stranger enters
8	M, B	3 min	Second reunion episode. Mother enters; Stranger leaves.

Securely attached

60-70 %

Explores with M in room; upset with separation; warm greeting upon return; seeks physical touch and comfort upon reunion

Insecure: avoidant

15-20 %

Ignores M when present; little distress on separation; actively turns away from M upon reunion

Insecure: resistant

10-15 %

Little exploration with M in room, stays close to M; very distressed upon separation; ambivalent or angry and resists physical contact upon reunion with M

Insecure:

Disorganized/disoriented

5-10 %

Confusion about approaching or avoiding M; most distressed by separation; upon reunion acts confused and dazed – similar to approach- avoidance confusion in animal models

Patterns of Attachment: Disorganized

- Have increased hypothalamic-pituitary-adrenal reactivity
- Show psychophysiological markers at increased reactivity
- Show increased behavioral agitation
- Are at increased risk for problems over time

Maternal Risk Factors

- Maltreatment of the infant
- Maternal depression
- Adolescent parenthood
- Alcohol consumption

Spectrum of Attachment Styles and Disorders

No preferred adult caregiver- RAD; inhibited vs disinhibited ("disorder of attachment")

Preferred caregiver but cannot use adult for safety while exploring (role reversal)- "secure base distortion"

Abrupt separation/loss from caregiver leads to grief reaction- "disrupted attachment"

Zeanah, Boris

Attachment styles; 4 described above

The Need for Mental Health Promotion & Services

- An estimated 9 to 13% (ages 9-17) have serious diagnosable emotional or behavioral health disorders (Friedman, 2002)
- Strong need for early intervention programs:
 - Children who are identified as hard to manage at ages 3 and 4 have a high probability (50:50) of continued behavioral difficulties in adolescence (Campbell & Ewing, 1990; Egeland et al., 1990; Fischer, Rolf, Hasazi, & Cummings, 1984)
 - When aggressive and antisocial behavior has persisted to age 9, further intervention has a poor chance of success (Dodge, 1993)

Low Rates of Treatment Delivery

- Of the young children who show *early signs* of challenging behavior, fewer than 10% receive services for these difficulties (Kazdin & Kendall, 1998)
- Of the children and adolescents with a *diagnosable condition*, less than a third actually receive any type of treatment (Leaf et al., 1996)

The 20/20 Problem

Up to 20% of children have diagnosable problems

Only about 20% of those having a problem receive services

The situation has not changed in 25 years.

There are evidence based practices that are effective in changing this developmental trajectory...the problem is not what to do, but rests in where and how we can support children and help families access services

Social Programs that work in Early Childhood

- Nurse-Family Partnership (A nurse home visitation program for low-income, pregnant women)
- Triple P System (A system of parenting programs for families with children age 0-8)
- Abecedarian Project (High-quality child care/preschool for children from disadvantaged backgrounds)
- Perry Preschool Project (High-quality preschool for children from disadvantaged backgrounds)

Why do we see Infants/Toddlers?

- Prevention, prevention, prevention is COST effective
- Early intervention programs are designed to affect children directly (through the provision of structured experiences) and indirectly (through their impact on the caregiving environment). Child-focused interventions involve developmentally guided educational opportunities or specifically prescribed therapies or both. Caregiver-focused interventions include varying combinations of information, instruction, emotional support, and assistance in securing needed resources and related services

Why do we see Infants/Toddlers? 28

- For Infants-dysregulation of physiologic function
 - fussiness/colicky behavior
 - feeding and sleeping problems
 - failure to thrive
- For Toddlers-behavioral disturbances
 - aggression/** defiance
 - impulsivity/ over activity
 - developmental delays
 - subtle physiologic, sensory, motor-processing problems

In other words

Infants and Toddlers

- Displays very little emotion
- Does not show an interest in sights, sounds or touch
- Rejects or avoids being touched or held or playing with others
- Unusually difficult to soothe or console
- Unable to comfort or calm self
- Extremely fearful or on-guard
- Does not turn to familiar adults for comfort or help
- Exhibits sudden behavior changes

In other words

Preschool Children

- Cannot play with others or objects
- Absence of language or communication
- Frequently fights with others
- Very sad
- Unusually fearful
- Inappropriate responses to situations

In other words³¹

Preschool children

- Withdrawn
- Extremely active
- Loss of earlier skills
- Sudden behavior changes
- Very accident prone
- Destructive to self and/or others

Consequences of Aggression

- **New Mexico** has the highest rate of expulsion from state-funded prekindergarten programs in the nation—21.1 children per 1,000 enrolled (NPS Study)
- State-run Pre-K programs have 3x the rate of expulsion of grades K-12 (Gilliam, 2005)
- Reason for EXPULSION is almost always AGGRESSION
- Longer-term consequences: aggressive school-age children → toward ANTISOCIAL behavior in adolescence or adulthood (Frick and Marsee, 2006)

Behavior Disorders of Childhood

Discriminating between “difficult” children and those with a formal diagnosis is hard

Behavior problems are on a continuum

There are a number of common behaviors across disorders

In a number of studies, more than 50% of children receiving special education services are identified as having a diagnosable behavioral disorder.

Common Disruptive Behavior Disorders of Childhood

- Adjustment Disorders
- Attention Deficit Hyperactivity Disorder
- Oppositional Defiant Disorder
- Conduct Disorder
- Bipolar Disorder

- *Considerable overlap between these disorders, rarely is there a definitive diagnosis*
- *Interventions are very much the same.*

Symptoms Common to ADHD, ODD, and Bipolar Disorder

ADHD - Bipolar:

- Distractibility
- Hyperactivity
- Impulsivity
- Restlessness/Fidgetiness
- Silliness, Goofiness, Giddiness
- Learning Disabilities
- Poor Short-Term Memory
- Lack of Organization

ODD - Bipolar:

- Bossiness
- Lying
- Oppositional behavior
- Deliberately annoys people
- Defies rules
- Blames other for mistakes

Causes of Disruptive Behavior Problems in Childhood

- All disorders are on a continuum ranging from normal variation in behavior to a clinically significant problem
- No single cause for any disorder
- No single treatment for any disorder

Risk Factors

- Within-child factors
- Family environment
- Community influences
- *There is never a single 'cause'*

Within Child Risk Factors

- temperament
- health
- gender
- cognitive status, learning difficulties
- sociability
- reaction to stress

Temperament

- Temperament is behavioral individuality in infants, children and adults
- In the same way that babies are born with their own combination of physical characteristics such as hair and eye color, skin tone, and physique, each one has patterns of behavior, or temperament, that are also part of their uniqueness

Temperament

Consider the child's behavior in these major areas:

- Activity & Attention Span
- Sociability
- Emotionality

Family Environment Risk Factors

- Stress
- Parental conflict
- Parental health
- Unhelpful beliefs
- Emotional escalation
- Physical escalation
- Safety & stability of environment
- Harsh parenting
- Unrealistic expectations
- Accidental rewards
- Ignoring desirable behavior
- Ineffective commands
- Ineffective punishment
- Inconsistent management
- Inappropriate models of behavior

Community Risk Factors

- Neighborhood
- Peer group
- Media
- School

Protective Family and Community Factors

- Social support:
 - Neighbors
 - Religious community
 - School
 - Other community organizations
- Positive parental mental health
- Safety at home, at play
- Stable economic resources

Interventions for Disruptive Behaviors

- Attention/distractibility & starting and stopping work
 - Preferential seating in the front, middle of classroom
 - Rewards for on-task behavior
 - Daily report card
 - Nonverbal

- Organizational skills
 - Give clear instructions one at a time
 - Homework folder
 - Rewards for writing down assignments, having agenda book signed, bringing assignments to home/school
 - Daily report card

Interventions for Disruptive Behaviors

- Overactivity
 - Preferential seating on edge of room so child can move around without distracting others
 - Permission for frequent breaks
 - Rewards for staying in seat
 - Daily report card

- Blurting out/ butting in
 - Rewards for raising hand, waiting turn
 - Writing down instead of blurting out
 - Daily report card

Who is an IMH specialist?

Not a member of a particular discipline, but rather someone with a distinct set of core beliefs, skills, training experiences, and clinical strategies who incorporate a comprehensive, intensive and relationship-based approach to working with young children and families.

They may provide concrete assistance

emotional support

developmental guidance

early relationship assessment and

support

advocacy

infant-parent psychotherapy

“There is only one beautiful baby in the world – and every parent has it.”

- Chinese Proverb

How to assess infants/toddlers

Clinician and Parents together observe and facilitate the family's behavioral, affective and physiological responses to each other, clarify concerns about the child, and mutually develop a treatment plan

- Develop a shared understanding of core concerns
- Determine whether psychopathology is present
- Establish a developmentally based differential diagnosis
- Organize parents' understanding of their experience with the child

How to assess infants/toddlers

- Develop a treatment plan that addresses parents' explicit and implicit expectations and facilitates parent-child relationships that support child's healthy development
- Developmental
- Relational
- Multidimensional
- Multiple Disciplines/Interdisciplinary

Assessment

Gather data

Often with child present

The Family Interview

- Parents' explicit and implicit concerns
- Reason for referral
- Child's current difficulties
- Impact of child's symptoms on each parent/couple/family

Assessment

- Child's past and present development in context of the whole family
- Parents' childhood experiences of being parented
- Biopsychosocial functioning of family within home/community and wider culture
- Family medical/psychiatric history
- Observation of free play and structured activity (Crowell)

Assessment

Reason for Referral

- Parents call directly
- Referred by medical, educational or social service personnel
- Parents' account of child's presenting difficulties and their expectations
- Focus equally on child's strengths and good adjustments
- Identify positive attributes of the child and the caregiving environment

Assessment

- Detailed history

- Biological, cognitive, temperamental and socio-emotional life
 - Early behavioral organization
 - Degree of individuation
 - Unique strengths and vulnerabilities
 - Response to previous stressors

Assessment

Family Relational History

- Particularly critical to the evaluation of the infant or toddler
- Child's profound dependence on parents = unique/key role to facilitate healthy development across multiple domains
- Parents' perceptions (WMCI)
 - potential distortions
 - attitudes and expectations of the child
 - review parents' perceptions of their own early relationship histories

Assessment

Clinical Observation

- Observation of the quality of the parent-child behavioral and affective interactions is CENTRAL
- Initial observation as part of history-taking
- Interactive play setting
- Unstructured family play for 15-20 minutes
- Structured play or brief parental separation and reunion may be helpful
- Capacity for and interest in interpersonal relatedness
- **Videotaping** may be an adjunct