



Learning the Language of Babies: An Introduction to the World of Infant Mental Health Assessments

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Objectives

- ▶ To identify areas/fields in which infant mental health knowledge is important
 - ▶ To recognize the parts of an infant mental health evaluation
 - ▶ To discuss some evidenced based areas of treatment in infant mental health
 - ▶ To describe training areas and to begin to determine the next level of training needed for personal infant mental health training goals
- 



Introduction

- ▶ What we are going to do today:
 - ▶ Define IMH
 - ▶ Look at an overview of attachment
 - ▶ Discuss select IMH assessment measures
 - ▶ Review a few of evidence based treatments
 - ▶ Discuss training in IMH



Part I

- ▶ What we are going to do today:
 - ▶ Define IMH
 - ▶ Look at an overview of attachment



Infant Mental Health

- ▶ Ability for the child to:
 - ▶ experience, regulate, and express emotions
 - ▶ form close relationships
 - ▶ Explore the environment
 - ▶ Learn
- ▶ How does this ability affect development?
- ▶ Early childhood mental health=health



Why do we need IMH specialists?





Presenting Problems

Ages 0-3

- ▶ Chronic feeding or sleeping difficulties
- ▶ Inconsolable “fussiness” or irritability
- ▶ Incessant crying with little ability to be consoled
- ▶ Extreme upset when left with another adult
- ▶ Inability to adapt to new situations
- ▶ Easily startled or alarmed by routine events



Presenting Problems

Ages 0-3

- ▶ Inability to establish relationships with other children or adults
- ▶ Excessive hitting, biting and pushing of other children
- ▶ Very withdrawn behavior
- ▶ Flat affect



Presenting Problems

Age 3-6

- ▶ Compulsive activities (e.g. head banging)
- ▶ Wild tantrums
- ▶ Withdrawn, little interest in social interaction
- ▶ Repeated aggressive or impulsive behavior



Presenting Problems

Ages 3-6

- ▶ Difficulty playing with others
- ▶ Little or no communication
- ▶ Lack of language
- ▶ Loss of earlier developmental achievements



Focus of Infant Mental Health

- ▶ Promotion
 - ▶ Prevention
 - ▶ Treatment
- 



Promotion

- ▶ For all young children and families
- ▶ Aimed at maintaining social and emotional well-being
- ▶ Examples
 - ▶ Public awareness campaign
 - ▶ Home visiting or family support programs



Prevention

- ▶ Children at risk of poor developmental outcomes
- ▶ Early identification and intervention strategies
- ▶ Screening
- ▶ Examples
 - ▶ Focus on improving quality of infant care
 - ▶ Focus on reducing violence in community
 - ▶ Focus in decreasing domestic violence



Treatment

- ▶ For children and families already showing symptoms
- ▶ Examples
 - ▶ Therapeutic day care
 - ▶ Psychotherapy for young children with families
 - ▶ Medications



The Pyramid Model





IMH Venues

- ▶ Therapist
 - ▶ Court
 - ▶ Pediatric Clinics
 - ▶ Child Psychiatry Clinics
 - ▶ Hospital
 - ▶ Preschool
- 



IMH “Need-to-Knows”

- ▶ Development
 - ▶ Attachment
- 



Development Basics





8-12 weeks

- ▶ What we see on the outside:
 - ▶ More focused
 - ▶ Better organized
 - ▶ More communicative
 - ▶ More efficient learners
 - ▶ More enjoyable social partners
 - ▶ social smile



Changes in the Brain

- ▶ Growth of synapses in the cortex
- ▶ Myelination of visual pathways
 - ▶ Cause enhanced cognitive capacities
- ▶ Reflected in
 - ▶ Classical and operant conditioning
 - ▶ Habituation
 - ▶ Receptive and expressive communication
 - ▶ Social smiling
- ▶ Remember longer with less exposure



What Do These Changes Mean?

- ▶ Babies will anticipate repeated patterns and notice alterations.
 - ▶ If negative alterations
 - ▶ Disruptive effects on regulatory and interactive behaviors
- ▶ Infants are aware of caregiver's behavior, which affect baby's behaviors.



Emotions emerging

- ▶ Joy
 - ▶ Contentment
 - ▶ Sadness
 - ▶ Anger
 - ▶ Distress
- 



7-9 Months

- ▶ The Discovery of Intersubjectivity
 - ▶ Baby understands that their own thoughts and feeling can be shared
 - ▶ Baby understands that others have thoughts and feelings
 - ▶ Baby uses other's affective states to regulate their own emotions and behaviors



7-9 Months

- ▶ Object permanence
 - ▶ The ability to retain a mental image of an object
 - ▶ Leads to stranger weariness and separation protest
- ▶ Increased ability to be mobile leads to an increase in exploration
- ▶ Success leads to an emerging sense of self efficacy, the belief or expectation that they will be successful in attaining goals



7-9 Months

- ▶ Onset of focused attachment
- ▶ Can see attachment patterns of secure and insecure
- ▶ Why is this important?
 - ▶ The language of the baby



18 to 20 months

- ▶ An advance in symbolic representation
- ▶ Increase in language competence
 - ▶ Toddlers can regulate behaviors in service of social goals
- ▶ Working Models of relationships are developed
 - ▶ Through interactions with their caregivers
 - ▶ Can use patterns of the past to predict the future
 - ▶ Lead to an objective sense of self
- ▶ Can recognize self in pictures



Emotions develop

- ▶ Shame
 - ▶ Guilt
 - ▶ Embarrassment
 - ▶ True empathy
- 



24-60 months

- ▶ Children consolidate, refine and expand these abilities into a sense of self in relation to others and their place in the world
- 



Attachment Basics





Early Interactions

- ▶ Loving, supportive caregivers=positive template of relationships
- ▶ Negative caregivers=negative working model of relationships



Types of Attachment

- ▶ Secure
 - ▶ Insecure
 - ▶ Avoidant
 - ▶ Ambivalent
- 

Country	Number of studies	Percentage of each attachment type		
		Secure	Insecure-avoidant	Insecure-resistant
Great Britain	1	75	22	3
Germany	3	57	35	8
Netherlands	4	67	26	7
Sweden	1	74	22	4
Japan	2	68	5	27
Israel	2	64	7	29
United States	18	65	21	14
China	1	50	25	25
Mean		65	21	14

Van Ijzendoorn & Kroonenburg (1988) meta-analysis of studies comparing attachment type across different cultures



Secure Attachment

- ▶ Through repeated positive experiences with a caregiver, infants develop a secure attachment to that person.
 - ▶ Infants who are securely attached have learned to trust that other people will take care of them
- 



Secure Attachment

- ▶ Children who are securely attached tend to:
 - ▶ have less extreme reactions to stress
 - ▶ be more willing to try new things and to explore independently
 - ▶ be better problem solvers
 - ▶ form better relationships with others



Video Example



Characteristics of Secure Attachment

Children	Adults
Able to separate from parent	Have trusting, lasting relationships
Seek comfort from parents when frightened	Tend to have good self-esteem
Return of parents is met with positive emotions	Comfortable sharing feelings with friends and partners
Prefers parents to strangers	Seek out social support



Insecure Attachment

- ▶ Infants whose experiences with a caregiver are negative or unpredictable are more likely to develop an insecure attachment.
 - ▶ Have learned that adults are not reliable
 - ▶ Do not trust easily.
- 



Insecure Avoidant

- ▶ Do not orientate to their attachment figure while investigating the environment.
- ▶ Very independent of the attachment figure both physically and emotionally
- ▶ Do not seek contact with the attachment figure when distressed.
- ▶ Likely to have a caregiver who is insensitive and rejecting of their needs .
- ▶ The attachment figure may withdraw from helping during difficult tasks and is often unavailable during times of emotional distress.



Insecure: Ambivalent/Resistant

- ▶ Ambivalent behavioral style towards the attachment figure.
- ▶ Exhibit clingy and dependent behavior, but will be rejecting of the attachment figure when they engage in interaction.
- ▶ Fails to develop any feelings of security from the attachment figure.
- ▶ Exhibit difficulty moving away from the attachment figure to explore novel surroundings.
- ▶ When distressed they are difficult to soothe and are not comforted by interaction with the attachment figure.
- ▶ This behavior results from an inconsistent level of response to their needs from the primary caregiver.

Ainsworth (1970)



Insecure Children

- ▶ Insecure-ambivalent children
 - ▶ Have a tendency to anxiously but unsuccessfully seek positive peer interaction
- ▶ Insecure-avoidant children
 - ▶ Appear aggressive and hostile
 - ▶ may actively repudiate positive peer interaction.



Avoidant Attachment Distress

- ▶ Are avoidant children truly less distressed?
 - ▶ Measuring the attentional capacity of children, heart rate, or stress hormone levels
 - ▶ Results?
- 



Behavior Outcomes

- ▶ Children who are insecurely attached may:
 - ▶ refuse to interact with others
 - ▶ avoid other people
 - ▶ exaggerate distress
 - ▶ show anger, anxiety or fear

Internal working model of self (dependence)

Positive
(low dependence)

Negative
(high dependence)

Positive (low avoidance)	Secure Comfortable with intimacy and autonomy	Preoccupied Preoccupied with relationships, high emotional reactivity
Internal working of others (avoidance)		
Negative (high avoidance)	Dismissing Dismissive of attachment; counter-dependent	Fearful Afraid of intimacy and rejection; believes self to be worthy of rejection; high emotional reactivity

Fig. 1 Bartholomew's four-category model of adult attachment (after Bartholomew & Horowitz, 1991).



Bowlby

“[S]ince much of the development and organization of [attachment] behavioral systems takes place whilst the individual is immature, there are plenty of occasions when an atypical environment can divert them from developing on an adaptive course.”



Disorganized Attachment

- ▶ Veered off of the adaptive course
- ▶ Usually extreme experiences
 - ▶ Maltreatment
 - ▶ Trauma
 - ▶ Abuse
- ▶ Children or their caregivers have been through a frightening event

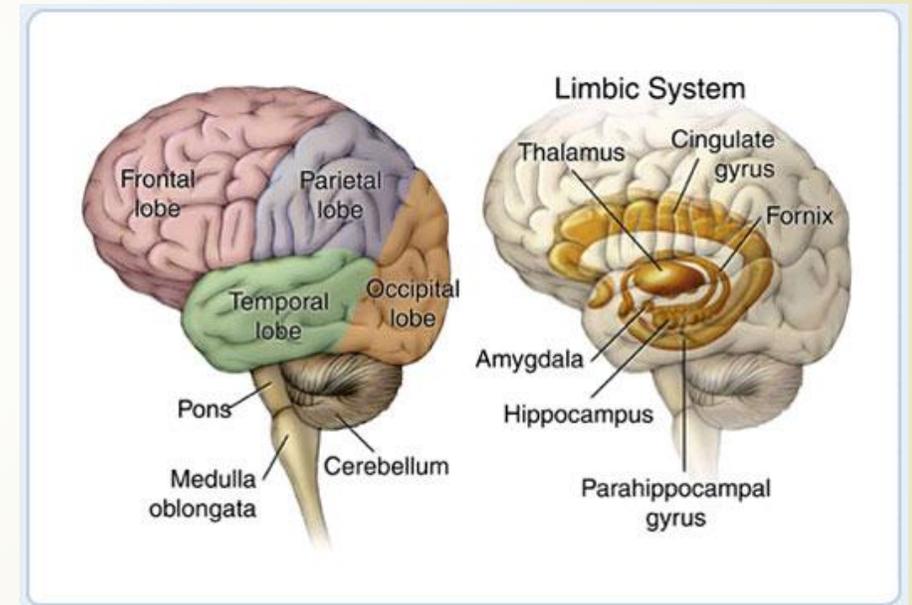


DISORGANIZATION



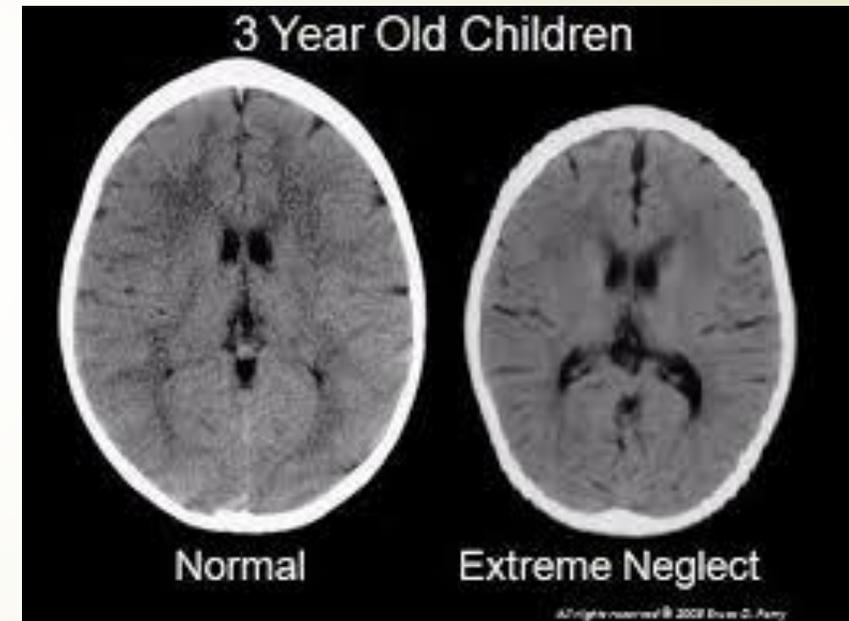
Relationships affect the Brain

- ▶ Relationship patterns give us a glimpse into the brain
- ▶ Attachment affects the right side of the brain
 - ▶ Connected to autonomic nervous system
 - ▶ Limbic system
 - ▶ Arousal systems



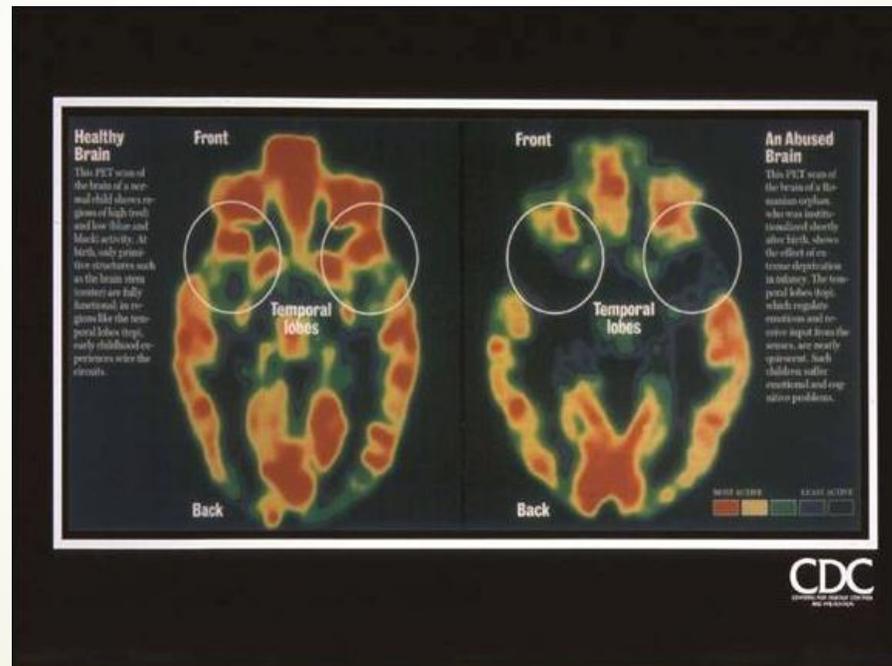
Brain Changes in Trauma

- ▶ Emotional and Autonomic Nervous system regulation are blunted in traumatized children
- ▶ Cortisol (stress hormone) is elevated constantly
- ▶ Long term exposure = metabolic shutdown
 - ▶ Become detached and withdrawn to protect self
 - ▶ May use dissociation for protection
 - ▶ Limbic system can be permanently affected



What's the Significance?

- Abnormal metabolic and autonomic responses prime the child for lifelong psychopathology and unhealthy relationships





Extrinsic Risk Factors

- ▶ Increased in presence of “environmental” risk factors:
 - ▶ Child abuse and neglect
 - ▶ Poverty
 - ▶ Institutional or orphanage care
 - ▶ Marital conflict and partner violence
 - ▶ Parents with drug and alcohol problems
 - ▶ Parents with a history of loss or trauma



What We See in the Child

- Social difficulties
 - role-inappropriate parent-child interactive behavior in middle childhood
 - peer rejection and poor social adjustment in middle childhood
- Aggression
 - aggressive and disruptive behavior in middle childhood



What We See in the Child

- ▶ These children can display stereotypies such as hitting themselves repeatedly or rocking back and forth.
- ▶ Internalizing problems
 - ▶ low self-esteem
 - ▶ internalizing problems
- ▶ Dissociative disorders in adolescence



Going Beyond Attachment

- ▶ Attachment can be Compromised
 - ▶ Extreme rearing conditions
 - ▶ Social neglect
 - ▶ Institutional care
- ▶ Not insecure attachments – NO ATTACHMENT
 - ▶ Requires pathogenic caregiving



DSM-V Criteria for Reactive Attachment Disorder of Infancy or Early Childhood

- ▶ A pattern of markedly disturbed and developmentally inappropriate attachment behaviors, evident before 5 years of age, in which the child rarely or minimally turns preferentially to a discriminated attachment figure for comfort, support, protection and nurturance. The disorder appears as a consistent pattern of inhibited, emotionally withdrawn behavior in which the child rarely or minimally directs attachment behaviors towards any adult caregivers, as manifest by both of the following:
 - ▶ Rarely or minimally seeks comfort when distressed.
 - ▶ Rarely or minimally responds to comfort offered when distressed.



DSM-V Criteria for Reactive Attachment Disorder of Infancy or Early Childhood

- ▶ A persistent social and emotional disturbance characterized by at least 2 of the following:
 - ▶ Relative lack of social and emotional responsiveness to others.
 - ▶ Limited positive affect.
 - ▶ Episodes of unexplained irritability, sadness, or fearfulness which are evident during nonthreatening interactions with adult caregivers.
- ▶ Does not meet the criteria for Autistic Spectrum Disorder.

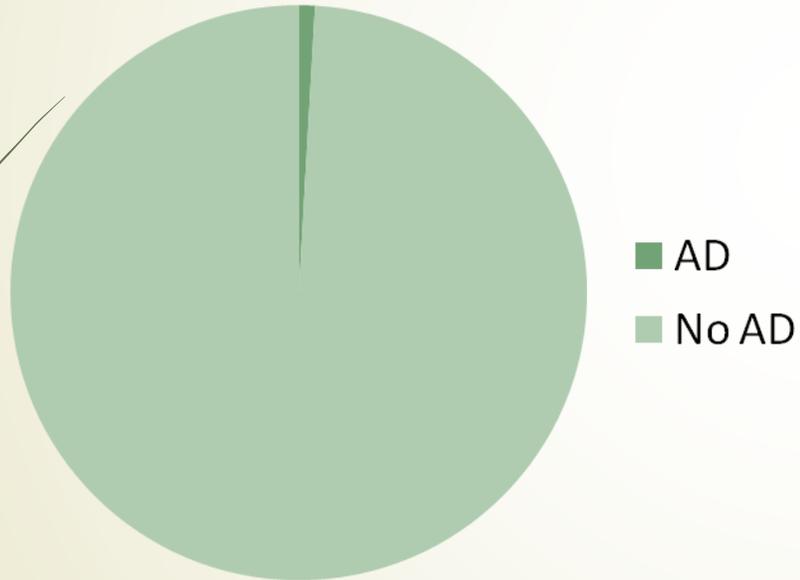


DSM-V Criteria for Reactive Attachment Disorder of Infancy or Early Childhood

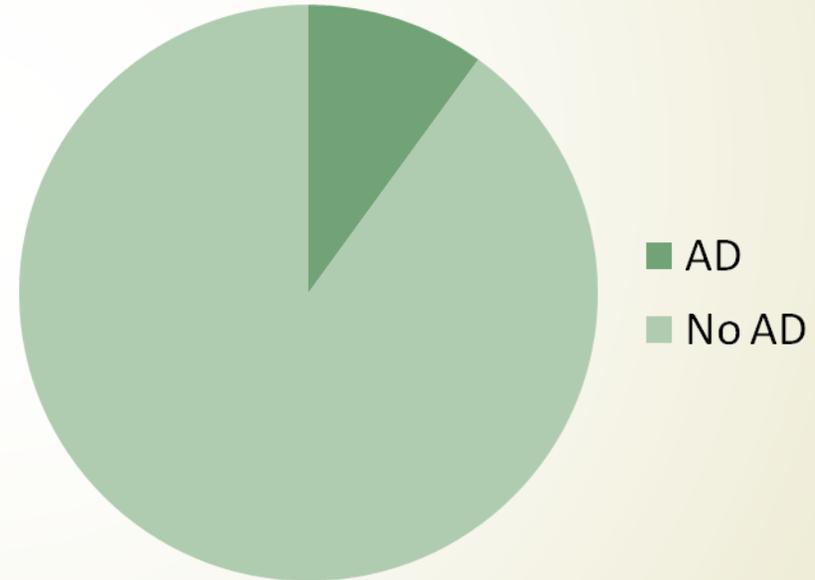
- ▶ Pathogenic care as evidenced by at least one of the following:
 - ▶ Persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection (i.e., neglect).
 - ▶ Persistent disregard of the child's basic physical needs.
 - ▶ Repeated changes of primary caregiver that prevent formation of stable attachments (e.g., frequent changes in foster care).

How Common is RAD?

Cohort



At Risk Children





DSM-V Criteria for Disinhibited Social Engagement Disorder

- ▶ A pattern of behavior in which the child actively approaches and interacts with unfamiliar adults by exhibiting at least 2 of the following:
 - ▶ Reduced or absent reticence to approach and interact with unfamiliar adults.
 - ▶ Overly familiar behavior (verbal or physical violation of culturally sanctioned social boundaries).
 - ▶ Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
 - ▶ Willingness to go off with an unfamiliar adult with minimal or no hesitation.

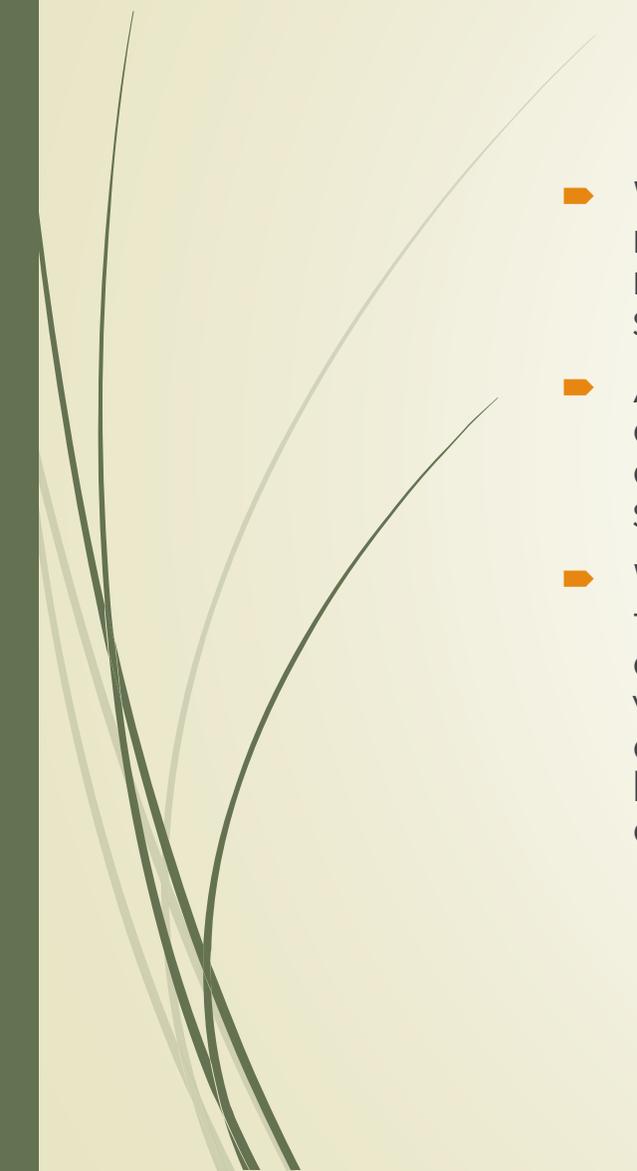


DSM-V Criteria for Disinhibited Social Engagement Disorder

- ▶ The behavior in A. is not limited to impulsivity as in ADHD but includes socially disinhibited behavior.
- ▶ Pathogenic care as evidenced by at least one of the following:
 - ▶ Persistent failure to meet the child's basic emotional needs for comfort, stimulation, and affection (i.e., neglect)
 - ▶ Persistent failure to provide for the child's physical and psychological safety.
 - ▶ Persistent harsh punishment or other types of grossly inept parenting.
 - ▶ Repeated changes of primary caregiver that limit opportunities to form stable attachments (e.g., frequent changes in foster care).



Group Work



- ▶ Whitney is a 30 month old female with a history of being born addicted to methamphetamines. She was taken into DHS custody, and returned to her mother at 4 months after her mother completed a parenting program, a substance abuse workshop, and had consistently negative drug screens.
- ▶ At 12 months, Whitney was taken into DHS custody after her mother was arrested due to possession of methamphetamines. Whitney had been found alone in an apartment in a dirty diaper, malnourished, sitting on the floor surrounded by drug paraphernalia.
- ▶ Whitney was placed in an emergency foster home for 1 week before being transferred to a traditional foster home with a foster mother, foster father, and 1 other foster child. This foster family stated that Whitney was sullen and withdrawn and didn't like to crawl around a great deal. Whitney would stare off into nowhere a great deal of the time. At night, Whitney would cry and have difficulty sleeping. This foster family kept Whitney during the day (no daycare.)



Group Work



- ▶ After two months, This foster family felt that they did not have the ability to take care of Whitney due to her high needs. No one was sleeping in the house and they felt that something was wrong with Whitney that they couldn't handle.
- ▶ Whitney was placed in an emergency foster placement for 3 weeks while a new foster home was found.
- ▶ At 15 months, Whitney was placed in a therapeutic foster home with no other foster children. She began day care at this time in Educare.
- ▶ Visitation with Whitney's mother was re-started as well, and continued for another 12 months until her mother was arrested again with charges of possession and prostitution. During that time, Whitney and her mother went to therapy. Mother eventually relinquished her rights 3 months later.
- ▶ Whitney's behavior continued to deteriorate during this 12 months. Foster mother attempted to soothe Whitney, but Whitney pushed away or stared off ignoring her. Whitney acted worse after visitations with her mother – throwing tantrums and not sleeping.
- ▶ At 30 months, Whitney's foster mother decided that she would like to adopt Whitney.



Timeline Review

- ▶ 0-4 months: Traditional Foster placement
- ▶ 4-12 months: Biological mother
- ▶ 12 months – 12months 1 week: Emergency foster placement
- ▶ 12months 1 week – 14 months 1 week: Traditional foster placement
- ▶ 14 months 1 week – 15 months: Emergency foster placement
- ▶ 15 months – 30 months: Traditional foster placement on path towards adoption



Group Work



- ▶ What are the steps that you would take if you received this case?
- ▶ What other help would you need to work with this family?
- ▶ What would you like your role to be?
- ▶ Do you currently have the knowledge to provide the services that you would like to provide?
 - ▶ If not, what are your areas of strength and areas to grow?



Next Up:
Attachment Informed Assessment



Questions?





Part II

- ▶ What we are going to do today:
 - ▶ Discuss select IMH assessment measures



Attachment-informed assessment

- ▶ Formal Assessment
- ▶ Assessment in clinical settings
- ▶ Both can be broken down into
 - ▶ History
 - ▶ observations



A history of the child's attachments

- ▶ Chronological account of the significant attachment figures available to the child since birth,
- ▶ Disruptions in care, abandonment or losses, alternate caregivers, neglect of care and abuse
- ▶ Availability of the current primary caregiver and contact with other caregivers
- ▶ Child's behavior with each caregiver
- ▶ Response to changes of caregivers
- ▶ In older children, relationships with peers and siblings 2 Details and observations of the infant or child's current behavior. Of particular interest in relation to attachment quality and disruptions or disorder are:



Details and observations of the infant or child's current behavior

- ▶ Of particular interest in relation to attachment quality and disruptions or disorder are:
 - ▶ Help or comfort-seeking behavior
 - ▶ Response to pain or distress
 - ▶ Who do they go to? Do they show distress?
 - ▶ Quality of interaction and ability to use caregiver or another adult for comfort
 - ▶ Ability to explore and play in a new setting,
 - ▶ response to limit setting
 - ▶ nature of the interaction with the clinician.



Observations Provide Information

- ▶ Parental sensitivity to the child
- ▶ Child responsiveness to parental care and attention
- ▶ The fit between them
- ▶ Child and parent safety
- ▶ Parents' capacity to work together to care for the child and the quality of their relationship.



The relationship and interaction with the child is affected by:

- ▶ Immediate contextual factors
- ▶ Individual aspects and characteristics of the caregiver and child
- ▶ Events in the past, especially the parents' experience of being parented.



What parents bring to parenting?

- ▶ Their psychological and social strengths and resources
- ▶ Their fantasies of what and who the child will be for them
- ▶ The history that precedes conception and birth, including their experiences in their own family and their experiences of being parented
- ▶ Their expectations of themselves as parents, influenced by their own experiences of family life
- ▶ Their psychopathology – the parents' past and family psychiatric history and current difficulties including parental substance abuse
- ▶ Parental age and life stage



Communication between parent and infant or young child

- ▶ Contingent
 - ▶ parent is responsive to the child's cues, rather than intrusive and insensitive
- ▶ Collaborative
 - ▶ both parties are active participants in the interaction
 - ▶ build or repair their communication together to restore optimal and comfortable levels of arousal
- ▶ Emotionally attuned
 - ▶ the parent is able to identify and tune into the child's emotional state and to organize their response appropriately.



Developmental Assessments



- ▶ The Neonatal Behavioral Assessment Scale (NBAS) (Brazelton & Nugent, 1995) or Newborn Behavioral Observation System (NBO)
 - ▶ Designed to capture the early behavioral responses of infants to their environment, before their behavior is shaped by parental care.
 - ▶ Assumption is that a baby is both competent and complexly organized and an active participant in the interaction with caregivers.
 - ▶ Seeks to help understand the infant's side of the interaction



Developmental Assessments



- ▶ The Bayley Scales of Infant Development (BSID) (Bayley, 1993)
 - ▶ Children 1-42 months of age,
 - ▶ Child's language development, problem-solving skills, gross and fine motor development, attentional capacity, social engagement, affect and emotion, and the quality of the child's movement and motor control



Developmental Assessments



- ▶ The Wechsler Preschool and Primary Scale of Intelligence (WPPSI) (Wechsler, 2002)
 - ▶ Children older than 30 months
 - ▶ It evaluates children's verbal comprehension, perception, organization and processing speed abilities
 - ▶ Gives clinicians a developmental perspective of the child's intelligence.
- ▶ The Vineland Adaptive Behavior Scales (Sparrow et al, 1984).
 - ▶ A parent interview
 - ▶ Obtains information on children's adaptive functioning in real-life situations covering the domains of daily skills, communication, socialization, motor functioning and maladaptive behavior.



Assessing Quality of Relationship: Screeners

- ▶ *Examples:*

- ▶ *DC:0-3/DC:0-3R* offers measures to assess the quality of the parent-infant relationship:
 - ▶ Parent-Infant Relationship Global Assessment Scale
 - ▶ Relationship Problems Checklist
 - ▶ Functional Rating Scale for Emotional and Social Functioning Capacities
- ▶ Measures are directly integrated into the multi-axial scheme.



Parent-Infant Relationship Global Assessment Scale (PIR-GAS)

- ▶ DC:0–3R
- ▶ Similar to the GAF
- ▶ Scores from 0-100
 - ▶ 91–100 Well Adapted
 - ▶ 81–90 Adapted



PIRGAS

- ▶ 21–30 Severely Disordered
- ▶ 11–20 Grossly Impaired
- ▶ 1–10 Documented Maltreatment



Relationship Problem Checklist

- ▶ The clinician should refer to the listing of descriptive features in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC:0-3R) before using the Relationship Problems Checklist.
- ▶ Each quality of the parent–infant relationship is described in terms of
 - ▶ characteristic behavioral quality
 - ▶ affective tone
 - ▶ psychological involvement.
- ▶ The listed features are not intended to be criteria but guidelines for description.



Relationship Problem Checklist

- ▶ Relationship qualities
 - ▶ Overinvolved
 - ▶ Under involved
 - ▶ Anxious/Tense
 - ▶ Angry/Hostile
 - ▶ Verbally Abusive
 - ▶ Physically Abusive
 - ▶ Sexually Abusive

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC:0-3R), by ZERO TO THREE

Other Useful Rating Scales and Questionnaires

Rating Scale/Questionnaire	Comments	Reference
Child Behavior Checklist (CBCL) for 1.5-5 year olds	<ul style="list-style-type: none"> • Two questionnaires to assess adaptive and maladaptive functioning of 1½-5 year olds. Rated by parents, day care providers and teachers • A recent international project using the CBCL identified consistencies in aggregations of emotional and behavioral problems in preschoolers across the 24 societies participating in the study (Ivanova et al, 2010; Rescorla et al, 2011). • Proprietary 	Achenbach & Rescorla, 2000
Strengths and Difficulties Questionnaire (SDQ)	<ul style="list-style-type: none"> • It rates 25 attributes, some positive and other negative. The SDQ has an impact supplement that helps in the assessment of impairment related to behaviors the child is presenting with. Parent and teacher versions for three and four year-olds in several languages • Free of charge 	Goodman, 1997
The Ages and Stages Questionnaire (ASQ-3)	<ul style="list-style-type: none"> • Developed to identify infants and young children (0-5) with potential developmental problems. Five areas are screened: communication, gross motor, fine motor, problem solving, and personal-social. Completed by parents/caregivers • Proprietary 	Squires & Bricker, 1999

Other Useful Rating Scales and Questionnaires

Rating Scale/Questionnaire	Comments	Reference
The Ages and Stages Questionnaire: Social Emotional (ASQ:SE)	<ul style="list-style-type: none">• A culturally versatile tool for clinicians to identify and monitor children at-risk for social, emotional and behavioral delays. The ASQ-SE rates a child's development in the behavioral areas of self-regulation, compliance, communication, adaptive, autonomy, affect and interaction with people• Proprietary	Squires et al, 2003
Preschool Age Assessment (PAPA)	<ul style="list-style-type: none">• A structured parent interview for diagnosing psychiatric disorders in preschool children (two to five years old). Used as a research tool, it can be used in also clinical work.• Proprietary; formal training required.	Egger & Angold, 2004
The Parenting Stress Index – Short Form (PSI-SF)	<ul style="list-style-type: none">• Screens for stress in the parent-child relationship, dysfunctional parenting, parental behavior problems and child adjustment difficulties within the family.• Available in several languages.• Proprietary.	Abidin, 1995



Temperament Scale Examples

- ▶ Infant Toddler Temperament Tool (IT³)
 - ▶ Activity level
 - ▶ Regularity
 - ▶ Adaptability
 - ▶ Distractibility
 - ▶ Sensitivity
 - ▶ Persistence
 - ▶ Intensity
 - ▶ Approachability
 - ▶ Mood
- ▶ Carey Temperament Scales
- ▶ Temperament Assessment Scale for Children

<http://ecmhc.org/temperament/index.html>



Temperament

- ▶ Take 5 minutes to fill out your temperament scale
- 



Relationship Components

- ▶ Internal and External Components
- ▶ External
 - ▶ recurrent patterns of *behavioral interaction*.
- ▶ Internal component
 - ▶ recurrent patterns of subjective experience or *internal representation*.
- ▶ Each of these has effects on infant behavior and psychopathology.



Relationship Domains

Parent

- ▶ Emotional Availability
- ▶ Warmth/Empathy/Nurturance
- ▶ Provision of Comfort
- ▶ Protection

Child

- ▶ Emotion Regulation
- ▶ Security/Trust
- ▶ Comfort Seeking
- ▶ Vigilance/Self-Protection



Relationship Domains

Parent

- ▶ Play
- ▶ Teaching
- ▶ Structure/ Instrumental Care/Routines
- ▶ Limit-Setting/Discipline

Child

- ▶ Play
- ▶ Learning/Mastery/Curiosity
- ▶ Self-Regulation/Routines
- ▶ Self-Control



Components of Infant-Parent Relationship



How do we measure these components?



Assessing Infant-Caregiver Relationships

- ▶ Internal Components
 - ▶ Working Model of the Child Interview
- ▶ External Components
 - ▶ Crowell Play Procedure



Caregiver Interviews

- ▶ Disorders of Attachment Interview
 - ▶ Working Model of the Child Interview
- 



Working Model of the Child Interview (WMCI)

- ▶ Semi-structured; about one hour
 - ▶ Designed to elicit narrative accounts of child and caregiver's relationship with the child
 - ▶ May be audiotaped or videotaped for coding purposes
- 



Internal Working Models

- ▶ Provide rules by which a person perceives self and others and responds to others in relationships.
- ▶ Which information is attended to
- ▶ How information is perceived
- ▶ Affects engendered by perceptions
- ▶ Memories evoked
- ▶ Responses elicited



So What are We Listening For?

- ▶ Content
 - ▶ Qualitative features
 - ▶ Affective tone
 - ▶ Typology
- 



WMCI Qualitative Features

- ▶ Richness of perceptions
 - ▶ Coherence
 - ▶ Intensity of involvement
 - ▶ Openness to change
 - ▶ Acceptance
 - ▶ Caregiving sensitivity
 - ▶ Infant difficulty
 - ▶ Irrational fear of loss
- 



WMCI Affective Features

- ▶ Joy
- ▶ Pride
- ▶ Sadness
- ▶ Disappointment
- ▶ Fear
- ▶ Guilt
- ▶ Shame
- ▶ Anger
- ▶ Indifference



WMCI Typologies

- ▶ Balanced
 - ▶ Full
 - ▶ Restricted
 - ▶ Strained
- ▶ Key thoughts/words
 - ▶ Full, rich differentiated impression of child
 - ▶ Parent knows this child
 - ▶ Child is valued as an individual
 - ▶ This relationship is important to caregiver
 - ▶ Strengths/weaknesses acknowledged
 - ▶ Emotionally well integrated



WMCI Typologies

- ▶ Disengaged
 - ▶ Impoverished
 - ▶ Suppressed
- ▶ Key Thoughts/Words
 - ▶ Emotional distance
 - ▶ Aloofness
 - ▶ Indifference
 - ▶ Descriptions are generic, pat, unelaborated
 - ▶ Normalize
 - ▶ Overly cognitive
 - ▶ Poverty of detail
 - ▶ Little flexibility or sense of discovery
 - ▶ Lack of engrossment in relationship



WMCI Typologies

- ▶ Distorted
 - ▶ bewildered/confused
 - ▶ distracted
 - ▶ self-involved
 - ▶ role-reversed
- ▶ Key thoughts/words
 - ▶ Internally inconsistent/incoherent
 - ▶ Engrossment without convincing connection to child
 - ▶ Unable to focus incisively on topic of child
 - ▶ Unsuccessful struggle to feel close to child
 - ▶ insensitive



Video Examples





Let's compare prenatal and postnatal responses...



Examples



- ▶ Describe your impression of your baby's personality now...
- ▶ Mother A (Prenatal)
 - ▶ I feel this is a very, very emotional and intense child--very active. Very verbal and very intense. I'll know when it's upset and when it's happy. I cried when something beautiful happened at work. I was sure the baby cried too. The baby kicked and kicked. It felt what I was feeling.



Examples

- ▶ Describe your impression of your baby's personality now...
- ▶ Mother A (Postnatal)
 - ▶ Definitely not quiet. He's got a mind of his own. He's very alert. If he had his way, he wouldn't sleep all day. He likes to stay up and observe things. Likes human contact, likes a lot of love.



Examples



- ▶ Describe your impression of your baby's personality now...
- ▶ Father (Prenatal)
 - ▶ Quiet, genuinely warm. Sensitive. Given to deep emotional feelings. More of a quiet kind of child. Reflective.



Examples

- ▶ Describe your impression of your baby's personality now...
- ▶ Father (Postnatal)
 - ▶ Alert--he observes things. Not high strung. Sensitive. Kind of an observing baby. A happy baby. Dependent.



Examples

- ▶ Describe your impression of your baby's personality now...
- ▶ Adolescent Mother (Prenatal)
 - ▶ He's smart--he kicks back when I punch him. He's stubborn--he'll be like a pest, a little brat, bugging everybody. Probably a little spoiled. I think he'll be the shy type until he knows the person. When he's around people he doesn't know he'll be quiet.



Examples



- ▶ Describe your impression of your baby's personality now...
- ▶ Adolescent Mother (Postnatal)
 - ▶ He's spoiled--he always ends up getting what he wants. I try to discipline him and tell him, "No!" I try to let him cry himself to sleep. He's really stubborn. He's real alert and he's strong. He's playful and stubborn. He's a lot like his father, who's also real stubborn-- always has to get his way.



Disturbances of Attachment Interview

- ▶ Semistructured interview
- ▶ Administered by clinicians to caregivers who know the child and the child's behavior well.
 - ▶ Interview about things the child does
 - ▶ To understand the child better
- ▶ Specific probes are designed to elicit more information; they are not intended to be exhaustive.
- ▶ This interview takes about 20 minutes



DAI Questions

- 1) Does s/he have one special adult that s/he prefers? Who is it? How does s/he show that he prefers that person? Could you give me a specific example? Are there any other adults that are special, like this? Who does he prefer most of all?
- 0** Clearly differentiates among adults
 - 1** Sometimes or somewhat differentiates among adults
 - 2** Rarely or minimally differentiates among adults



DAI Questions

- 5) How are his/her moods? Is s/he generally happy or is s/he one to be more irritable or sad or serious? Would you say s/he is like that most of the time or some of the time? How much of the time is s/he sad, serious, or irritable.
- 0** Clearly regulates emotions well with ample positive affect and developmentally expectable levels of irritability and/or sadness.
- 1** Sometimes or somewhat has difficulty regulating emotions with less positive affect and more irritability and/or sadness than is expected developmentally
- 2** Rarely or minimally regulates emotions well; instead, has little positive affect and definitely elevated levels of irritability and/or sadness.



DAI Questions

- 8) Do you think s/he would be willing to go off with a stranger? Why do you think so? Could you give me a specific example? Do you think s/he would do this some of the time or most of the time? Has this way of interacting with strangers changed? Was s/he more/less willing at an earlier age to go off with someone s/he didn't know?
- 0** Clearly is not willing to go off readily with relative strangers.
 - 1** Sometimes or somewhat is willing to go off readily with relative strangers.
 - 2** Willing to go off readily with relative strangers.



Observational Dyadic Procedures

- ▶ Still Face
- ▶ Strange Situation
- ▶ Crowell
- ▶ Nursing Child Assessment Satellite Training
- ▶ Early Relational Assessment
- ▶ Hair Combing Task
- ▶ Newborn Observational Scale/Neonatal Behavioral Assessment Scale



Chapter to Review

- ▶ Clinical Use of Observational Procedures in Early Childhood Relationship Assessment
- ▶ Authors:
 - ▶ Devi Miron
 - ▶ Marva L. Lewis
 - ▶ Charles H. Zeanah, Jr.



Guidelines

- ▶ Standardize assessment setting and procedures
 - ▶ Include structured and unstructured activities in assessments
 - ▶ Ensure efficiency of assessment procedure
- 



Guidelines

- ▶ Ensure developmental and cultural appropriateness of the procedure to the extent possible
 - ▶ Ensure ease of interpretability of observations
 - ▶ Videotape procedures when possible
- 



Standardized assessment

- ▶ Use same format and same setting for assessment
 - ▶ Administrators
 - ▶ materials
- ▶ Any variation is from dyad as opposed to assessment
- ▶ Compare child in different relationships



Un/Structured

- ▶ Less structured
 - ▶ Less demanding
 - ▶ Less likely to constrain the behavior of the caregiver
 - ▶ i.e. free play
- ▶ More structured
 - ▶ Can elicit specific behaviors of interest
 - ▶ Looks at individual differences in a standard situation
 - ▶ i.e. separation/reunion, feeding in the NCAST

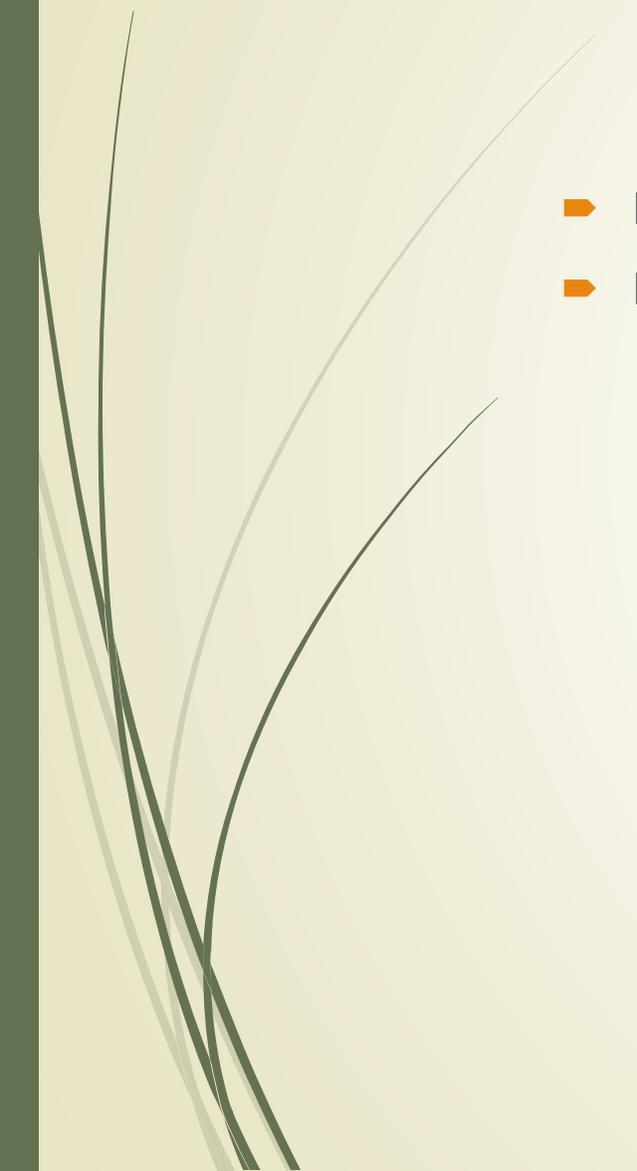


Efficiency

- ▶ Observational methods
 - ▶ Provide a “short cut” of learning characteristics of the dyad
 - ▶ Behavior is elicited rather than waiting
 - ▶ i.e. tasks to see anger/frustration



Developmental Appropriateness

- ▶ Pay attention to age ranges
 - ▶ Look at developmental level as well
- 



Cultural Thoughts

- ▶ Most procedures are developed for white Americans
- ▶ One with the most studies across cultures
 - ▶ SSP
- ▶ Hair brushing procedure
 - ▶ Developed for African Americans



Interpretability

- ▶ How are you going to use the information from observation?
 - ▶ Research
 - ▶ Coding
 - ▶ Clinical
 - ▶ Observational procedures important
 - ▶ Need training but not formal coding training
- ▶ Videotape
 - ▶ Important
 - ▶ Patterns
 - ▶ Therapy Uses
 - ▶ Diagnoses



Hair Combing Task

- ▶ Dr. Lewis
- ▶ Video tape of hair combing
- ▶ Can take minutes to hours
- ▶ Proximity differences found
 - ▶ Close
 - ▶ Moderate
 - ▶ Functional
- ▶ Look at amount of touch and verbal back and forth



Parent Child Early Relationship Assessment

- ▶ Semi structured
- ▶ 2-60months old
- ▶ 4 five minute segments
 - ▶ Feeding segment
 - ▶ Structured task segment
 - ▶ Free play segment
 - ▶ separation-reunion segment
- ▶ Can assess relationship and guide treatment
- ▶ Training required in infant development and caregiver infant interactions



NCAST Teaching and Feeding Scale

- ▶ 0-36 months
- ▶ Used in low and high risk groups
- ▶ Formal scoring recommended – clinical and research
- ▶ Used in Nurse Family Partnership
- ▶ NCAFS (0-12 months) – feeding time behaviors
- ▶ Feedback given immediately to caregiver
- ▶ Extensive training needed



Face to Face Still Face Procedure (FFSF)

- ▶ 0-6 months old
- ▶ Caregiver and infant sit face to face
- ▶ Step One – play and talk with baby as you usually do
- ▶ Step Two – episode of “still face”
 - ▶ Separation
- ▶ Step Three – interact with baby again
 - ▶ Reunion
- ▶ Can be used to make interpretations about the dyad’s perceptions about the relationship



Still Face Example





Strange Situation

▶ 20 minutes





Secure Attachment Example





Insecure-Resistant Example





Insecure-Avoidant Example





Crowell Play Procedure

- ▶ Originally made for 24-54 months, but expanded to 12-60 months
- 



Crowell Play Procedure AKA Parent Child Play Procedure

- ▶ Clinic-based assessment
- ▶ Requires 30-45 minutes
- ▶ Combination of more and less structured activities
- ▶ Videotaped for later review
- ▶ Limited constraints on behavior
- ▶ Clinically useful and formally codeable



Crowell Episodes

- ▶ Free Play
- ▶ Clean-Up
- ▶ Bubbles
- ▶ Structured Teaching Tasks (2-4)
- ▶ Separation
- ▶ Reunion



Video Examples





Free Play





Bubble Example





Task Example





Separation

- ▶ Parent domains
 - ▶ Emotional availability
 - ▶ Nurturance/valuing/empathic responsiveness
 - ▶ Comforting/response to distress
- ▶ Infant domains
 - ▶ Emotional regulation
 - ▶ Security/trust/self-esteem
 - ▶ Comfort seeking



Separation

- ▶ Looking at
 - ▶ Stress
 - ▶ Activate attachment system
 - ▶ Self Soothing/Coping Behaviors



Reunion

- ▶ Parent domains
 - ▶ Emotional availability
 - ▶ Nurturance/valuing/empathic responsiveness
 - ▶ Comforting/response to distress
- ▶ Infant domains
 - ▶ Emotional regulation
 - ▶ Security/trust/self-esteem
 - ▶ Comfort seeking



Reunion

- ▶ How does the dyad reunite?
 - ▶ Caretaker's response to child's distress
 - ▶ Congruence between separation and reunion
 - ▶ Resumption of play/exploration
- 



Alterations to the Crowell

- ▶ Modified Crowell
 - ▶ Free time decreased from 10 to 5 minutes
 - ▶ Tasks decreased to 2
- ▶ Baby Crowell
 - ▶ 6-12months



Newborn Observation Scale/Newborn Assessment System

- ▶ Newborn Assessment System
 - ▶ Research based system used for assessment and diagnosis
- ▶ Newborn observation system
 - ▶ Clinical based for observation and relationship building
- ▶ Both need formal training – Brazelton Institute



Newborn Observation Scale/Newborn Assessment System





Ethical and Professional Considerations

- ▶ Working with babies/young children
 - ▶ Schedule around feeding and sleeping times
 - ▶ Schedule short breaks for snacks or rest
 - ▶ May need to modify or discontinue procedures
 - ▶ Never leave child unmonitored/alone
 - ▶ Be aware of own biases towards parenting practices
 - ▶ Save suggestions for intervention phase
 - ▶ Monitor verbal and non verbal communication
- 



Ethical and Professional Considerations

- ▶ Videotaping
 - ▶ Extremely helpful for accurate assessment and treatment
 - ▶ Confidentiality and Anonymity
 - ▶ Consent forms
 - ▶ HIPPA
 - ▶ What is the use of the tapes?
 - ▶ Clinical?
 - ▶ Research?



Part 3

- ▶ What we are going to do today:
 - ▶ Review a few of evidence based treatments
 - ▶ Discuss training in IMH



Infant Treatment Modalities

- ▶ ABC
- ▶ PCIT
- ▶ CBT for Preschoolers
- ▶ Child Parent Psychotherapy
- ▶ COS
- ▶ NIDCAP



California Evidence-Based Clearinghouse for Child Welfare

- ▶ The purpose of the CEBC Scientific Rating scale is to evaluate each practice based on the available research evidence. The topic area expert assists with identifying practices that meet the following criteria:
 - ▶ Programs that have strong empirical support.
 - ▶ Programs that are in common use in California.
 - ▶ Programs that are being marketed in California.



California Evidence-Based Clearinghouse for Child Welfare

- ▶ Ratings:
 - ▶ 1. Well-Supported by Research Evidence
 - ▶ 2. Supported by Research Evidence
 - ▶ 3. Promising Research Evidence
 - ▶ 4. Evidence Fails to Demonstrate Effect
 - ▶ 5. Concerning Practice
 - ▶ NR. Not able to be Rated on the CEBC Scientific Rating Scale



Attachment and Biobehavioral Catchup (ABC)

- ▶ Developed by Mary Dozier, Ph.D.
- ▶ Caregivers of infants 6 months to 2 years old who have experienced early adversity
- ▶ Program Goals:
 - ▶ Increase caregiver nurturance, sensitivity, and delight
 - ▶ Decrease caregiver frightening behaviors
 - ▶ Increase child attachment security and decrease disorganized attachment
 - ▶ Increase child behavioral and biological regulation



ABC

- ▶ parent coaches provide parenting training in the parent's home for weekly one-hour sessions over a period of 10 weeks.
- ▶ Sessions use:
 - ▶ Manual
 - ▶ “in the moment” feed back about the parent's interactions with his or her child
 - ▶ Observation of the parent's behavior
 - ▶ video feedback to highlight parents' strengths, challenge weaknesses, and celebrate changes in behaviors.
- ▶ Rated 1 on the California Evidence-Based Clearinghouse for Child Welfare scientific rating scale.



Preschool PTSD Treatment (PPT)

- ▶ Michael Scheeringa, M.D.
- ▶ 12 sessions
- ▶ 3-6 years-old
- ▶ Theory-driven, manualized protocol based on cognitive-behavioral therapy (CBT) with modifications for young children.
- ▶ Similarities with Cognitive-Behavioral Therapy for Sexually Abused Preschool Children (CBT-SAP) (Cohen and Mannarino, 1996) and Trauma Focused Coping (TFC) for 8 to 18 year-old children (March and Amaya-Jackson, 1998).



CBT for Preschoolers

- ▶ Treatment with young children can be conceptualized as having multiple ports of entry for the clinician to intervene into the family system (Stern, 1995).
- ▶ The therapist can target the child's behavior, the child's internal representations of how they feel about themselves and others, the parent's internal representations about themselves and their children, the parent-therapist relationship, and/or the parent-child relationship (Lieberman, Silverman, & Pawl, 2000)
- ▶ Rated 3 on the California Evidence-Based Clearinghouse for Child Welfare scientific rating scale.



CBT for Preschoolers

- ▶ Overview of PPT
- ▶ Session 1: Psychoeducation, overview
- ▶ Session 2: Behavior management for defiance module
- ▶ Session 3: Learn CBT tools – identify feelings.
- ▶ Session 4: Learn CBT tools – relaxation exercises.
- ▶ Session 5: Tell the story
- ▶ Session 6: Easy narrative exposure
- ▶ Session 7: Medium narrative exposure
- ▶ Session 8: Medium narrative exposure
- ▶ Session 9: Worst moment narrative exposure
- ▶ Session 10: Worst moment narrative exposure
- ▶ Session 11: Relapse prevention
- ▶ Session 12: Review/Graduation



Circle Of Security

- ▶ <https://vimeo.com/145329119>
- ▶ Circle of Security- Home Visiting – 4 (COS-HV4):
 - ▶ Increase security of attachment of the child to the parent
 - ▶ Increase parent's ability to read child's cues
 - ▶ Increase empathy in the parent for the child
 - ▶ Decrease negative attributions of the parent regarding the child's motivations
 - ▶ Increase parent's capacity to self-reflect
 - ▶ Increase parents capacity to pause, reflect, and choose security promoting caregiving behaviors
 - ▶ Increase parent's capacity to regulate stressful emotional states triggered by the child's behavior
 - ▶ Rated 3 on the California Evidence-Based Clearinghouse for Child Welfare scientific rating scale.
- ▶ Circle of Security Parenting (COS-P)
 - ▶ Not Rated on the California Evidence-Based Clearinghouse for Child Welfare scientific rating scale.



Child Parent Psychotherapy (CPP)

- ▶ Trauma-exposed children aged 0-5
- ▶ Dyad is the unit of treatment
- ▶ Trauma and the caregivers' relational history
 - ▶ How it affect's the caregiver-child relationship and the child's developmental trajectory.
- ▶ Goal: support and strengthen the caregiver-child relationship to restore and protect the child's mental health.
- ▶ Treatment also focuses on contextual factors that may affect the caregiver-child relationship
- ▶ Targets: caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health.
- ▶ Dyad is guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.



CPP

- ▶ Focus on the parent-child relationship as the primary target of intervention:
 - ▶ Safety
 - ▶ Affect regulation
 - ▶ Reciprocity in Relationships
 - ▶ Focus on the traumatic event
 - ▶ Continuity of Daily Living
- ▶ Reflective supervision
- ▶ Rated 3 on the California Evidence-Based Clearinghouse for Child Welfare scientific rating scale



Parent Child Interaction Therapy

- ▶ Shiela Eyeberg
 - ▶ A dyadic behavioral intervention for children for ages 2 – 7 years and their parents or caregivers
 - ▶ focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship.
 - ▶ Parents are taught and practice these skills with their child in a playroom while coached by a therapist.
 - ▶ PCIT is time-unlimited
 - ▶ About 14 weeks, with hour-long weekly sessions.
- 



PCIT Goals

- ▶ Build close relationships between parents and their children using positive attention strategies
- ▶ Help children feel safe and calm by fostering warmth and security between parents and their children
- ▶ Increase children's organizational and play skills
- ▶ Decrease children's frustration and anger
- ▶ Educate parent about ways to teach child without frustration for parent and child



PCIT Goals

- ▶ Enhance children's self-esteem
 - ▶ Improve children's social skills such as sharing and cooperation
 - ▶ Teach parents how to communicate with young children who have limited attention spans
 - ▶ Teach parent specific discipline techniques that help children to listen to instructions and follow directions
 - ▶ Decrease problematic child behaviors by teaching parents to be consistent and predictable
 - ▶ Help parents develop confidence in managing their children's behaviors at home and in public
- 



PCIT

- ▶ Rated 1 on the California Evidence-Based Clearinghouse for Child Welfare scientific rating scale



The Newborn Individualized Developmental Care and Assessment Program (NIDCAP)

- ▶ Program created for the newborn intensive care unit
- ▶ Observing and then interpreting behaviors of infants within their environment and as reactions to care they receive,
- ▶ Developmental care plans developed based on these observations and within the context of the infant's overall goals and efforts at self regulation.
- ▶ Intensive and special care, neurodevelopmentally supportive
- ▶ individualized, and family-centered framework
- ▶ With programs like NIDCAP
 - ▶ Shorter intensive care and overall hospital stay
 - ▶ Better weight gain
 - ▶ Improved behavioral outcomes that endure beyond infancy.
 - ▶ Enhances brain structure and function when measured by EEG and MRI



Reflective Supervision

- ▶ “Supervision is a context for learning and professional development.” (Zero to Three)
- ▶ Three building blocks of reflective supervision
 - ▶ Reflection
 - ▶ Collaboration
 - ▶ Regularity
- ▶ A Practical Guide to Reflective Supervision
 - ▶ Edited by Sherryl Scott Heller and Linda Gilkerson

Let's look at Infant Mental Health Treatment in Action...





Case Example





Training in Infant Mental Health

- ▶ Depends on what you want to do
 - ▶ Clinical
 - ▶ Assessments and treatments require training and supervision
 - ▶ Research



What's going on in Oklahoma?

- ▶ Institute for Building Early Relationships (IBEaR)
 - ▶ State collaborations to further research and education in the area of infant mental health
- ▶ Oklahoma Association of Infant Mental Health
 - ▶ Affiliate of the World Association of Infant Mental Health
 - ▶ Multi-disciplinary collaboration, education, workforce development, and advocacy for best practices
- ▶ Child Parent Psychotherapy Training
- ▶ Safe Babies Court Team
- ▶ Top rated early childhood educational facilities
- ▶ Increase in IMH interest in many fields – i.e. medicine



Outside of Oklahoma

- ▶ World Association of Infant Mental Health (conference every other year)
- ▶ NTI yearly conference
- ▶ Trainings, trainings and more trainings
- ▶ Irving B. Harris Foundation Fellowship
 - ▶ Training is for psychiatrists, psychologist, social workers, and pediatricians



Endorsement Option

- ▶ <https://vimeo.com/134323646>
- ▶ For more information regarding Oklahoma
 - ▶ www.okaimh.org



2 Examples of Programs doing IMH

- ▶ Infant Parent Program
 - ▶ 0-3 years old
 - ▶ Partially funded by public mental health system
 - ▶ Target population: children whose well being is threatened by abuse, neglect, or disorders of attachment
- ▶ Child Trauma Research Project
 - ▶ 3-5 years old
 - ▶ Target population: preschoolers who have witnessed their mothers being battered by a male partner



Infant Parent Program

- ▶ Assessments are done in joint sessions with parent and child
- ▶ Same clinician for assessment and tx
 - ▶ Masters level
 - ▶ Pre/post doc therapists
 - ▶ Variety of disciplines
 - ▶ SW, psychology, nursing, psychiatry
 - ▶ In IMH training program
 - ▶ Supervised by licensed psychologists
 - ▶ 1 hour of supervision per week for every case they carry



Infant Parent Program

- ▶ Topics are introduced as a natural part of conversation
- ▶ Observations are done naturally as well
- ▶ 1/3 of the cases require formal evaluation of child's developmental functioning
 - ▶ Performed by a developmental neuropsychologist



Infant Parent Program

- ▶ Formal evaluation of child's developmental functioning
- ▶ 3 appointments 1 week apart, 1.5 hours in length
- ▶ Session 1
 - ▶ Initial Interview
 - ▶ WMCI
- ▶ Session 2
 - ▶ Developmentally appropriate toys
 - ▶ Transition from free play to administering an instrument
 - ▶ Instrument
 - ▶ i.e. Bayley, Mullen Scales, Communication and Symbolic Behavior Scales



Infant Parent Program

- ▶ Session 3: Final session
 - ▶ Feedback session
 - ▶ Only caregivers
 - ▶ May lead to diagnostic formulation necessitating a referral to an early intervention program



Child Trauma Research Project

- ▶ Standardized approach to information gathering
- ▶ Clinical and research components
- ▶ Evaluations done by psychologists
- ▶ 4-6 weeks of assessments
 - ▶ Unstructured clinical interviews
 - ▶ Standardized instruments - 9
 - ▶ Semi-structured procedures
 - ▶ 2 individual sessions with child (occur during 2 of the mother's sessions): done by a different psychologist
 - ▶ 4 sessions with mother



Child Trauma Research Project

- ▶ Interviews with the mother
 - ▶ Third Assessment
 - ▶ CBCL
 - ▶ IFEEL Pictures
 - ▶ Fourth session
 - ▶ Focuses on mother's perception of her child
 - ▶ Attachment Q-Sort
 - ▶ Screening Survey of Children's Exposure to Community Violence – Parent Report Version
- ▶ Interviews with the child
 - ▶ WPPSI and 15 minute play session with mother
 - ▶ Stories from the MacArthur Story Stem Battery and 15 min play session with mother
- ▶ Feedback process

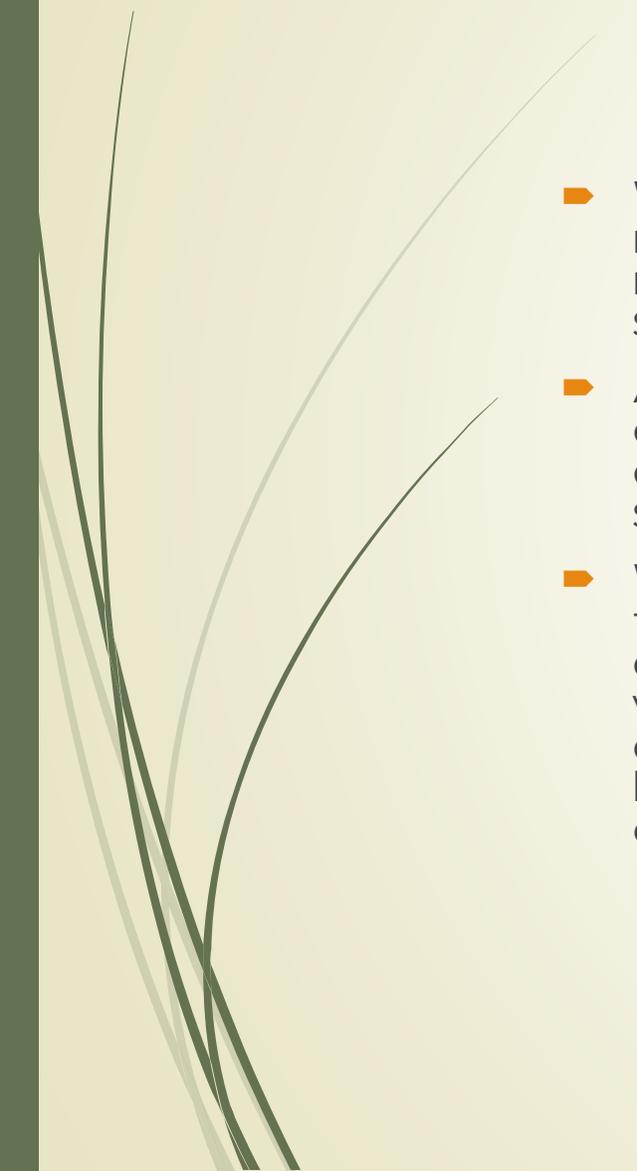


Pros/Cons

- ▶ Infant Parent Program
 - ▶ Allows information to come out organically
 - ▶ Parents get to work at their own pace
- ▶ Child Trauma Research Project
 - ▶ Mothers are grateful to be asked about their experiences
 - ▶ Direct questions
 - ▶ Give permission to speak
 - ▶ Addresses shame



Group Work



- ▶ Whitney is a 30 month old female with a history of being born addicted to methamphetamines. She was taken into DHS custody, and returned to her mother at 4 months after her mother completed a parenting program, a substance abuse workshop, and had consistently negative drug screens.
- ▶ At 12 months, Whitney was taken into DHS custody after her mother was arrested due to possession of methamphetamines. Whitney had been found alone in an apartment in a dirty diaper, malnourished, sitting on the floor surrounded by drug paraphernalia.
- ▶ Whitney was placed in an emergency foster home for 1 week before being transferred to a traditional foster home with a foster mother, foster father, and 1 other foster child. This foster family stated that Whitney was sullen and withdrawn and didn't like to crawl around a great deal. Whitney would stare off into nowhere a great deal of the time. At night, Whitney would cry and have difficulty sleeping. This foster family kept Whitney during the day (no daycare.)



Group Work



- ▶ After two months, This foster family felt that they did not have the ability to take care of Whitney due to her high needs. No one was sleeping in the house and they felt that something was wrong with Whitney that they couldn't handle.
- ▶ Whitney was placed in an emergency foster placement for 3 weeks while a new foster home was found.
- ▶ At 15 months, Whitney was placed in a therapeutic foster home with no other foster children. She began day care at this time in Educare.
- ▶ Visitation with Whitney's mother was re-started as well, and continued for another 12 months until her mother was arrested again with charges of possession and prostitution. During that time, Whitney and her mother went to therapy. Mother eventually relinquished her rights 3 months later.
- ▶ Whitney's behavior continued to deteriorate during this 12 months. Foster mother attempted to soothe Whitney, but Whitney pushed away or stared off ignoring her. Whitney acted worse after visitations with her mother – throwing tantrums and not sleeping.
- ▶ At 30 months, Whitney's foster mother decided that she would like to adopt Whitney.



Timeline Review

- ▶ 0-4 months: Traditional Foster placement
- ▶ 4-12 months: Biological mother
- ▶ 12 months – 12months 1 week: Emergency foster placement
- ▶ 12months 1 week – 14 months 1 week: Traditional foster placement
- ▶ 14 months 1 week – 15 months: Emergency foster placement
- ▶ 15 months – 30 months: Traditional foster placement on path towards adoption



Group Work



- ▶ Have your assessment steps changed for this case?
- ▶ What other help would you need to work with this family?
- ▶ What would you like your role to be?
- ▶ Do you currently have the knowledge to provide the services that you would like to provide?
 - ▶ If not, what are your areas of strength and areas to grow?



Group Work



- ▶ How about your workplace?
- ▶ Would any of these procedures work for you in your current environment?
- ▶ What is working well?
- ▶ What are some suggested changes?
 - ▶ What are some ideas for other assessment set ups?
 - ▶ What needs to happen to implement IMH assessments?
- ▶ Other challenges?



Questions?





Thank You

- ▶ Thanks to Paula Zeanah, Ph.D. for sharing information for our use today.
- 

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