Promoting Social Emotional Development:
Infant Mental Health in a Part C Program

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Infant Mental Health

Social, emotional and cognitive well-being of a baby who is under three years of age, within the context of a care giving relationship (Fraiberg, 1980)
Infant Mental Health

- Capacity for love & learning begins early
- How parent cares for their child impacts emotional health of child
- Parental history & past relationship experiences influence the development of relationships

(Finello, 2005)
The Development of Emotional & Behavioral Regulation

Balance shifts between other regulation to self regulation

Development over time

Sameroff & Fiese, 2000
Scope of IMH Practice

What about the baby?

What about the parents who care for the baby?

What about their early developing relationship & the context for early care?

What about the practitioner?
All babies and young children can benefit from a sustained, primary relationship that is nurturing, supportive and protective.

(Stinson, Tableman, & Weatherston, 2000; Shirilla & Weatherston, 2002)
Core Beliefs

• Optimal growth & development occur in relationships
• New baby offers family new opportunity for growth & change
• Early years affect development across the life span

• Early attachment relationships may be impacted by parental histories (loss & trauma)
• Therapeutic process may reduce risks
Impact of Exposure to Trauma on the Developing Brain
How is maltreatment of children 0-3 significant?

- Children younger than 12 months comprised 41% of fatalities
- Children younger than six years comprised 85% of fatalities
- One-third of children in the child welfare system are under six years old

(Sources: Congressional findings for CAPTA reauthorization; & National Center for Abuse & Neglect, 1997)
Our Texas Children
Maltreatment Data

Children in Foster Care in Texas:

21.8%  Birth to 2 years
14.6%  3 to 5 years

Confirmed victims of child/abuse neglect in Texas:

8,208  under 1 year of age
14,039  1-3 years of age
12,668  4-6 years of age

(Texas Department of Protective & Regulatory Services 2005 Data Book)
Our Texas Children
Risk Factor Data

Children Living in Poverty                   22.7%
Working Families - < 200% FPL               38%
*Mothers* drank ETOH – 1\textsuperscript{st} trimester 41.9%
Depressive symptoms – postpartum          49.1%
Children in Family Violence Shelters       2.7%

Black children continue to experience death rates over 40% higher than their White & Hispanic counterparts

*(Texas KIDS COUNT Annual Data Book, 2007)*
Needs & Vulnerabilities of Young Children

In Parker County, Texas, on May 29, 2007, Berta Estrada and her four children were found dead. She had hanged herself and her children.

Ms. Estrada had sought the safety of a shelter part of the previous year and obtained a protective order against her common-law husband. Newspaper accounts said there had been more trouble from him recently.

Although Ms. Estrada and her three oldest children were dead, 8-month-old Evelyn survived. TV news accounts the morning of the event repeatedly stated:

“The good news is, the baby’s OK”
Myths About Babies & Maltreatment: Don’t worry about them because...

• They’ll never remember (false)
  – Implicit memory operates at least from birth
  – Explicit (narrative) memory operates by age 3
  – Infant amnesia refers only to this narrative memory

• All children are resilient (false)
  – Resiliency depends on protective factors such as multiple healthy caregivers, consistent structure
  – Maltreated children often have a great many risk factors and relatively few protective factors
Brain Development & Maltreatment

• Brain development is “fed” by the stimulation that comes from early experience as babies and toddlers interact with their world

• Lack, or disruption, of certain experiences represents missed opportunities that can be irreplaceable

• This may alter “brain-mediated functions such as empathy, attachment, and affect regulation” (Perry, 1997, p.132)

• The brain grows, organizes, and functions in response to developmental experience – in a “use-dependent” fashion

• Persistent threat “exercises” lower brain centers at the expense of higher, cortical regions - the child may become over reactive with limited coping skills

• Cortical & sub cortical areas are smaller in children with global environmental neglect; cortical atrophy sometimes seen
The combination of neglect and trauma is very malignant, with underdevelopment of higher centers and overdevelopment of lower centers.

The Major Parts of the Brain

- Cerebrum: Thinking part of brain
- Brain Stem: Staying alive
- Cerebellum: Movement & Balance
Babies and families in crisis cannot wait. The stakes are too high.
Risk Factors to Family Mental Health

- Abuse/neglect history – child welfare involvement
- Poverty/homelessness
- Family conflict
- Parent/caregiver mental illness
- Teen parents
- Domestic violence
- Parent criminology/incarceration
- Substance abuse
- Parent cognitive deficits
- Caregiver disruptions – multiple placements
- Emotional trauma (child)
- Physical trauma (child)
- Prenatal exposure to drugs/alcohol
- Sleep/feeding/behavior problems
- Developmental delay or significant medical concerns
Red Flags in Parent/Family

- Disengagement with child or parenting role
- Limited supports – high stressors
- Punitive parenting practices
- Lack of knowledge about parenting
- Poor emotional regulation
- Difficulty managing anger
- Boundary confusion
Red Flags in Child

- Fearful or clingy behaviors
- Hyper-compliance or noncompliance
- Hyper-vigilance and/or disassociation
- Impulsivity
- Over/Under activity levels
- Defiance
- Indiscriminate affection/comfort-seeking or lack of
- Tantrums that are not typical in frequency, duration and/or intensity
- Disruption in routines
Red Flags in the Relationship

- Lack of mutual enjoyment
- Difficulty reading other’s cues
- Poor goodness of fit between parent & child
- Limited adaptive flexibility
- Developmentally inappropriate expectations
- Interactions involve significant conflict
- Maltreatment
- Caregiver disruption/loss
- Role reversal
Domains of the Parent-Child Relationship

**Parent**
- Emotional Availability
- Nurturance/Empathy
- Protection
- Provision Comfort
- Teaching
- Play
- Discipline/Limit Setting
- Care/Routines

**Child**
- Emotion Regulation
- Security/Self-Esteem
- Vigilance/Safety
- Acceptance Comfort
- Learning/Mastery
- Imagination
- Self-Control
- Self-Regulation

(Larrieu & Bellows, 2004)
The Infant Mental Health Approach
The Infant Mental Health Approach

What Should Be the Focus of Efforts?

• The child?
  – This often occurs in play & individual therapy

• The parents?
  – Parenting classes, anger management, adult counseling, etc.

• The relationships between parents and child?
  **Hallmark of Infant Mental Health**
Characteristics of the Infant Mental Health Approach

Concrete resource assistance

*Meeting of basic needs helps to reduce stress & ensures to the family that the practitioner cares about them*

Maslow’s Hierarchy of Needs, 1943

- Physiological
- Safety
- Love
- Esteem
- Self Actualization
Characteristics of the Infant Mental Health Approach

Emotional Support

Compassion offered to a parent, including emotional availability, listening, sensitivity; creates safe holding environment
Characteristics of the Infant Mental Health Approach

Developmental Guidance

*Developmental information and care giving needs; merging of capacities & concerns through careful guidance*
Characteristics of the Infant Mental Health Approach

Advocacy

Offer help when someone cannot ask for it themselves; speaking on behalf of the infant’s or parent’s needs
Relationship Intervention

Infant-parent psychotherapy, Interaction Guidance & other IMH therapeutic strategies offer an opportunity for exploration of experiences, fears, disappointments & losses and for the development of coping skills, regulation, parenting skills & relationships.
The Infant Mental Health Approach

Assessment and Evaluation:

• Often requires multiple sessions
• Need history:
  – Developmental and medical
  – Family history and care giving history (any disruptions?)
  – History of the current problem
• Clinical interviews focusing on parent perceptions
• Structured observations of the child with different caregivers
• Questionnaires such as the ASQ:SE, CBCL, others

see also - AACAP (1997) Practice Parameters for the Psychiatric Assessment of Infants and Toddlers
The Infant Mental Health Approach

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised edition (DC:0-3R)

- Axis I - Child symptoms
- Axis II - Relationship factors
- Axis III - Medical factors
- Axis IV - Psychosocial stressors
- Axis V - Developmental factors

Zero to Three (2005) *Diagnostic classification of mental health and developmental disorders of infancy and early childhood: Revised edition (DC:0-3R)*
<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis List</th>
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<tbody>
<tr>
<td>Active Autism</td>
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<tr>
<td>PDD-NOS</td>
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<tr>
<td>Phobia-unspecified</td>
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<tr>
<td>Anxiety state-unspecified</td>
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<tr>
<td>Acute Stress</td>
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<tr>
<td>Adjustment Disorder – Depressed</td>
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<td>childhood</td>
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<td>Adjustment Disorder – Anxiety</td>
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<td>Adjustment Disorder – Mixed</td>
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<td>Separation Anxiety Disorder</td>
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<td>Posttraumatic Stress Disorder</td>
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<tr>
<td>Depressive Disorder NOS</td>
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<tr>
<td>Mixed Disturbance of Conduct &amp; Emotions</td>
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<tr>
<td>Disruptive Behavior Disorder</td>
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<tr>
<td>Impulse Control Disorder</td>
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<td>Introverted – Withdrawal Disorder</td>
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<tr>
<td>Emotional Disturbance - misery</td>
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<tr>
<td>Introverted Disorder</td>
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<td>Overanxious Disorder</td>
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<td>Non-organic Sleep Disorder</td>
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<td>Persistent Disorder of Sleep</td>
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<td>Night Terrors</td>
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<td>Feeding Disorder – early</td>
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<td>Shyness Disorder of Childhood</td>
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<td>Mental Disorder NOS</td>
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<td>Reactive Attachment Disorder</td>
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Issues in Differential Diagnosis

- Reluctance in diagnosis due to stigma
- “Irrevocable Psychopathology”
- Self-fulfilling prophecy
- Labels being difficult to remove
- Clear differentiation in infants & toddlers
- Focusing on child, rather than parents/family
- Narrowing of program planning
- “Diagnostic overshadowing” – too much focus on diagnostic label

Poulsen, 2005
Needs & Vulnerabilities of Young Children

- Babies can develop PTSD by about 9 months of age
- They can develop attachment disorders by 10 months
- Young children can experience depression, anxiety disorders, and other conditions
- Without intervention, these disorders and challenges may result in impaired functioning which may, in turn, produce further problems for the child and family
- An example is the intergenerational transmission of child maltreatment
The Infant Mental Health Approach

Interventions in Dyadic Sessions:

- Developmental guidance about pressing care issues
- Joint parent-child sessions with play and spontaneous interaction
- Talking for the baby
- Reflection with parent, exploring the meaning of behavior and feelings evoked
- Videotaping interactions, then therapist and caregiver watch and discuss
- Parent-only sessions (or parts of sessions) to explore various issues that impact parenting
- Support parent’s strengths, and set limits where necessary
- Infant massage
Possible goals of dyadic sessions:

- Increase shared positive experiences
- Increase awareness of child cues and “attunement” - what is safe & nurturing
- Develop greater emotion regulation (less reactivity, more coping and self-calming) Improved capacity to relax, regulate arousal
- Develop confidence/skills in limit setting
- Process feelings that emerge during interactions
- Encourage appropriate developmental expectations
- Strengthening relationships
References & Resources


Child Trauma Academy - online: www.childtrauma.org


References & Resources


Tulane Institute of Infant & Early Childhood Mental Health - online: www.infantinstitute.com


Zero To Three - online: www.zerotothree.org
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