What Is Infant Mental Health?

*Healthy Social and Emotional Development*

"Infant mental health is the developing capacity of the child from birth to 3 to:

- experience, regulate and express emotions;
- form close and secure interpersonal relationships;
- and explore the environment and learn—
- all in the context of family, community, and cultural expectations for young children."

—ZERO TO THREE Infant Mental Health Task Force, 2001

What is Trauma

- An event that overwhelms the child ability to cope
  - Causes fear, helplessness
  - Can be expressed by sadness, withdrawal, or disorganized / agitated behavior.
- Witnessing or experiencing an event that poses a real or perceived threat to the life or well-being of the child or someone close to him/her
How are Children Traumatized?

- Family Violence
- Substance Abuse
- Physical and Sexual Abuse
- Exposure to Natural and Technological Disasters
- Exposure to Media Violence
- Community Violence

Effects of Trauma on Young Children

Traumatic Stress can change a child’s development, behavior and functioning affecting:

- Biology and physiology
- Relationships and attachment
- Behavior and emotion regulation
- Cognitive skills
- Emotional and social development

A Continuum from Stress to Trauma
**Positive Stress**
A necessary aspect of healthy development that occurs in the context of stable, supportive relationships.
Brief increases in heart rate and mild changes in stress hormone levels.

**Tolerable Stress**
Stress responses that could disrupt brain architecture, but are buffered by supportive relationships.
Allows the brain an opportunity to recover from potentially damaging effects.

**Toxic Stress**
Strong, prolonged activation of the body’s stress response systems in the absence of the buffering protection of adult support.
Can damage developing brain architecture and create a short fuse for the body’s stress response systems, leading to lifelong problems in learning, behavior, and both physical and mental health.

**Trauma Triggers and Trauma Play**

- Colors
- Noises
- Smells
- Other reminders of trauma

Examples – traumatized 2-year old twins and triggers, traumatized 3-year old playing
-- Ideas of group........
Relationships and the Brain

“We are hardwired for relationships.”
Allan Schore

How Early Experiences Affect Brain Development

• Parents and other caregivers play a crucial role in providing the nurturing and stimulation that children require

• A child’s experience determines how his brain will develop

The Adverse Childhood Experiences (ACE) Study

- The largest study of its kind ever done to examine the health and social effects of adverse childhood experiences over the lifespan (18,000 participants)
- Basic Findings: Trauma exposure is associated with a higher number of common health problems
Short and Long Term Effects of Traumatic Experiences on Development

• The foundations of many mental health problems in children and adults are established early in life.

• What happens to a child is a result of interaction between:
  – early risk factors
  – genetic predisposition
  – exposure to significant environmental adversities (i.e., harsh, inconsistent parenting as a result of poverty, exposure to substance abusing parent, poor quality child care, parental mental illness, parent in prison, etc.)

Adverse Childhood Experiences—ACE Study
Felitti, Anda, et al. (1998)

The ACES are Among Many Childhood Traumas and Adversities Measured by the National Child Traumatic Stress Network. N=10,991.
Rates of Maltreatment by Age
- Most maltreatment happens to younger children.
- Maltreatment has greater negative effects at younger ages.

How the ACES Work
- Advance Childhood Experiences
  - Abuse and neglect (e.g., psychological, physical, sexual)
  - Household Dysfunction (e.g., domestic violence, substance abuse, mental illness)
- Impact on Child Development
  - Neurological Effects (e.g., brain abnormalities, stress hormone dysregulation)
  - Psychosocial Effects (e.g., poor attachment, poor socialization, poor self-efficacy)
- Health Risk Behaviors (e.g., smoking, obesity, substance abuse, promiscuity)
- Long-Term Consequences
  - Disease and Disability
    - Major Depression, Suicide, PTSD
    - Drug and Alcohol Abuse
    - Heart Disease
    - Cancer
    - Chronic Lung Disease
    - Sexually Transmitted Diseases
    - Intergenerational transmission of abuse
  - Social Problems
    - Homelessness
    - Prostitution
    - Criminal Behavior
    - Employment
    - Parenting problems
    - High utilization of health and social services
    - Shortened lifespan

How ACES Cross Generations
Factors that influence how children experience trauma

- The number and severity of the traumatic episodes
- Proximity to the event
- The personal significance of the traumatic event for the child
- The extent to which the child’s support system is disrupted after the trauma (i.e., child maltreatment, disasters, foster care)

Other Factors affecting Outcomes

- Age and developmental stage
- Perception of the danger
- Child’s relationship to victim and/or perpetrator
- Presence/availability of adults who can offer help and protection
- Genetic predisposition
- Previous history of trauma experiences
The Importance of Protective Factors and Resilience

- “Ordinary Magic”  
  - Protective factors are the building blocks of resilience  
  - Doing OK despite adversity  
  - Resilience does not require something rare or special  
  - More or “enough” perceived resources—in their minds, bodies, families, and communities

What matters is not rare or extraordinary

- Attachment relationships and social support  
- Reasonable cognitive capacity (intelligence)  
- Opportunities to learn and be effective  
- Self-efficacy (“I can do it”) motivation  
- Regulation of emotion, arousal, behavior  
- A sense of belonging or meaning in life—a “sense of place” (examples, child welfare, disasters)

Resilience can be promoted

- Successful prevention programs alter the balance of risks and assets  
  - mobilize powerful systems for human development  
- Interventions that work combine strategies promoting competence with those that reduce problems
Simple Intervention: Angels in the Nursery
• Think of memories of time when you were little when you felt especially loved, understood and safe. Are these smells, sights, sounds or other sensations that are connected with the memory?

It’s All About Relationships
• What is most important for healthy social and emotional development is the important person (sometimes more than one) who interacts with the baby and is the most emotionally invested in the baby.

  • “Who fills this role is far less important than the quality of the relationship she or he establishes with the child”
  
  > From Neurons to Neighborhoods, National Academy of Science, 2000

Why Early Relationships Are Important Positive
• Babies who had a positive experience with their primary caregiver will transfer positive expectations to new caregivers, making it easier for a new caregiver to understand the baby’s needs.

  • Early relationships form the basis for all later relationships

  > Dozier, M., et. al (2001), Child Development, 72(5); Emde, IMH
Why Early Relationships Are Important

Negative

- Babies who had a negative experience with their caregiver will “continue to have low expectations for nurturing care and behave in ways that do not elicit nurturance”

- However, for example, with sensitive foster mothering, the baby can still learn that her needs can be met and become securely attached

Why Early Relationships Are Important

- For babies, this special adult is **not** interchangeable with others

- Babies grieve when their attachment relationships are disrupted
  - Neurons to Neighborhood, National Academy of Science, 2000

“Good Relationships Are Catching”

- “How you are is as important as what you do.”
  - Jeree Pawl
RED FLAGS: Signs in Baby that Emotional Needs are Not Being Met

• Sad or bland affect (emotions)
• Lack of eye contact
• Non-organic failure to thrive
• Lack of responsiveness
• Prefers “stranger” to familiar caregiver
• Rejects being held or touched

RED FLAGS: Signs in Toddlers that Emotional Needs are Not Being Met

• Dysregulated, aggressive behaviors
• Problems with and deficits in attention
• Lack of attachment; indiscriminate attachment
• Sleep problems or disorders
• All beyond what is “usual” behavior for children of this age

What to Observe

• Eye contact between parent/caregiver and infant
• How caregiver holds baby
• Mutual touching of caregiver & infant
• Talking and other ways caregiver and infant communicate
• Responsiveness and reciprocity (give and take) between caregiver and infant
• Sensitivity of caregiver and infant to each other
Diagnostic Classification 0-5 (DC: 0-5)

- According to the authors of the new DC:0-5, the revision required a “balancing act”
  - The goal was to avoid pathologizing children, demonstration normal variations of typical development
  - At the same time, it was important to identify children with a clinically impairing disorder to increase the chance of access to evidence-based treatments


Global Changes in Revision DC: 0-5

- The new edition of DC:0-5 includes:
  - Disorders occurring in children from birth to 5 years old
  - Captures new findings relevant to diagnoses in young children
  - Maintains a multiaxial classification system
  - Is comprehensive and not reliant on other nosologies
  - Includes a number of disorders not previously included in DC:0-3R
  - Defines and specifies symptoms in children less than 1 year whenever possible

Multiaxial System

DC:03R
- Axis I: Clinical Disorders
- Axis II: Relationship Classification
- Axis III: Medical and Developmental Disorder and Conditions
- Axis IV: Psychosocial Stressors
- Axis V: Emotional and Social Functioning

DC:0-5
- Axis I: Clinical Disorders
- Axis II: Relational Context
- Axis III: Physical Health Conditions and Considerations
- Axis IV: Psychosocial Stressors
- Axis V: Developmental Competence
“There is no such thing as a baby”
Winnicott, 1948

Key Changes to DC:0-5
Axis II: Relational Context
- Broader view of relationship context
  - Relationship, not individual, that is rated
  - Contributions on the part of the infant/young child as well as the parent/caregiver are considered
- Two distinct dimensions rated
  - Caregiving Relationship
  - Caregiving Environment

Key Changes to DC:0-5:
Axes III, IV, V
- Axis III: Physical Health Conditions and Considerations
  - Focuses on the physical health context of the child’s clinical presentation
- Axis IV:
  - Revised and reorganized (with international perspective)
- Axis V:
  - Includes expanded focus on the integration of all domains of infancy/early childhood development, including emotional, social-relational, language-social communication, cognitive, and motor and physical domains
Summary of Changes

• Disorders through 5 years
• Effort to be more comprehensive
• Axis I - Clustered into sections with similar disorders
• Each disorder has diagnostic algorithm with criteria to maximize reliability
• Age limitations and duration added
• For most disorders, text that describes what is known about clinical presentation, course

Summary of changes (2)

• Every disorder includes distress of functional impairment as criteria to discern true disorders from transient behaviors
• Defines criteria for new disorders – Early Atypical Autism Spectrum, Inhibition to Novelty, Dysregulated Anger and Aggression of Early Childhood, Relationship Specific Disorder

DC:0-5 (3)

• New Sensory Processing Disorders – Sensory Over-Responsivity, Under-Responsivity, Other Sensory Processing
• Feeding renamed Eating Disorders
• Links to corresponding DSM-5 and ICD-10 Disorders and crosswalk through www.zerotothree.org/dc05resources
• Extensive revision to Axis II- Relational Context
**DC:0-5 (4)**

- Axis III expanded to include examples of medical conditions
- Axis IV – Psychosocial and Environmental Stressors added categories and stressors
- Axis V revised to focus on developmental competencies integrating emotional, social-relational, language-social communication, cognitive, & movement and physical development

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**The Importance of Developing Trauma-Informed Systems**

* (NCTSN; Judge Michael Howard and Dr. Frank Putnam, Ohio, 2009)

- A Trauma-Informed System of Care acknowledges and responds to the role of trauma in the development of emotional, behavioral, educational, and physical difficulties in the lives of children and adults
- The System recognizes and avoids inflicting secondary trauma

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**Secondary Trauma**

- Secondary trauma occurs when child serving systems re-traumatize a child through policies and procedures
- Examples:
  - From child welfare: multiple placements; handcuffing parents in front of their children; visitation; change of caseworkers; foster care
  - From pediatrics: unavoidable separations of young children from caregivers; medical trauma
Implementation of Trauma-Informed Systems:

Quality Improvement Center for Research Based Infant Toddler Court Teams

SAFE BABIES COURT TEAMS

Build Collaborative Partnerships for Children

When Problems are Identified with young children exposed to trauma: Implement Infant Mental Health Strategies

• Do not assume the 0-5 year old child is too young to have problems that can be treated
• Refer to clinician trained in infant mental health for relationship based evaluations
• Refer for evidence based evaluations and treatment for young children and families
Resources

• National
  – www.zerotothree.org
  – www.nctsn.org
  – http://developingchild.harvard.edu/
  – http://www.qicct.org/sites/default/files/QIC-CTProjectOverview%209.4.15.pdf