Infant and child mental health: ensuring optimal well-being for all children.

What happens when things go wrong and how does the system respond?

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‘Felicity’ 2 mo
- Admitted RCH with profound growth delay, becoming dehydrated
- Refusing to drink or feed, breast or bottle
FH: First child to young professional couple
mother with past history of anorexia nervosa
Intervention: paediatric, MCHN, ward nursing staff, infant mental health

Babies and toddlers can’t wait. (Bomperad)
- babies are in a state of developmental flux.
- early childhood periods of profound opportunity for intervention
- change can happen, Parents are willing to do their best
- service delivery for infants and toddlers needs to be arranged from
  - infant mental health,
  - primary health care,
  - maternal and child health nursing,
  - generic and specialised family support and intervention services,
  - child protection
- need for early collaborative approaches to infant and toddler mental health

Clinical Assessment in Infancy
- Background information/full family history
- Direct Observation
  - Individual, Dyadic, Triadic
  - Strange situation, Still face procedure
  - Crowell procedure
- Video review
- Psychometric measures
  - Parent report – checklists
    - ITSEA, BITSEA (infant toddler social emotional assessment)
    - Ages and Stages Questionnaire - Social and Emotional (ASQ-SE)
  - Bayley’s Scales of Infant and Toddler Development
- Standardised Interviews
  - Working model of the child
  - Parent Developmental Interview
  - Newborn Behavioral observation (Nugent)
- Clinician Rating Scales
  - Reflective Functioning scales (based on PDI)
  - Emotional Availability Scale
  - ADBB: Alarm Distress Baby Scale
  - PIB-GAS

The Alarm Baby Distress scale
ADBB: Antoine Guedeney
- Observational/interactional method of assessing infant withdrawal
- Assessment of the infant mood and relationship with an examiner
- Based on an understanding of depressed mood in infancy
- Modified version, Mathey

ADBB Items
1. Facial Expression
2. Eye contact
3. General level of activity
4. Self stimulatory gestures
5. Vocalisations
6. Briskness of response to stimulation
7. Ability to engage in relationship
8. Ability to maintain attention of examiner
Newborn response to still face paradigm: Nagy 2008

BRIEF REPORTS
Innate Intersubjectivity: Newborns’ Sensitivity to Communication Disturbance
Emese Nagy
University of Dundee

In most of our social life we communicate and relate to others. Successful interpersonal relating is crucial to physical and mental well-being and growth. This study, using the still-face paradigm, demonstrates that even human neonates (< 90, 3–96 hr after birth) adjust their behavior according to the social responsiveness of their interaction partner. If the interaction partner becomes unresponsive, newborns will also change their behavior, decrease eye contact, and display signs of distress. Even after the interaction partner resumes responsiveness, the effects of the communication disturbance persist as a spillover. These results indicate that even newborn infants sensitively monitor the behavior of others and react as if they had innate expectations regarding rules of interpersonal interaction.

Keywords: neonate, still-face, interaction, intersubjectivity

Developmental Psychology 2008, Vol. 44, No. 6, 1779–1784

What is Infant Mental Health?

• Early relationships have permanent effects on brain development, health and later mental health
• Social emotional and physical health are inseparable
• The baby is a person with a mind
• Responsive caregiving can mediate the effects of chronic problems: poverty, prematurity
• Intervention can be effective for the infant's emotional, social, physical development
• Babies can be traumatised by disruption of attachment relationships, witnessing violence as well as direct physical violence

Infant and Preschool Mental Health

• Who works with the infant and the family?
• Therapeutic intervention can occur in any setting...
  - Key Concepts
  - Baby has a mind
  - Parental Reflective capacity, mentalizing
  - [THERAPIST REFLECTIVE CAPACITY]
  - We have a responsibility to engage the infant and parents
  - Developmental transactional models
  - Behaviour has meaning

Mental health problems occur across any age

Helen Egger 2006 | J Ch Psycol Psych

“Review highlights how early we are in the process of characterising the nosology and epidemiology of preschool behavioural and emotional disorders, particularly depression and anxiety disorders... How late we are in recognising the distress and impairment of preschool children and their families”.

Babies and toddlers do have mental health problems

Few large scale epidemiological surveys of mental health problems and infants and toddlers

• BITSEA (Brief Infant Toddler Social Emotional Assessment) 10.4% of infant’s aged 12 to 36 months were judged to be in the “of concern range” for social emotional development/behaviour problems.
• There was a high correlation with mental health problems aged 6 commencing primary school:
  - The early detected problems were largely ones which endured into primary school

Brieg-Gowan and Carter(2008)
ICD 10 diagnoses axis I, II and III
In Children aged 1 ½ years
(N : 211) Copenhagen Child Cohort 2000

Axis I Psychiatric Syndrome
• Developmental Disorders 2.8%
  • Hyperactivity/Attention Deficit Disorder 2.4%
  • Disorders of Conduct and Emotions 4.3%
• Reactive Attachment Disorder 0.9%
• Eating Disorder 2.8%
• Sleeping Disorder 1.4%
• Adjustment Disorder 3%
• Other 0.5%

Axis II Specific Developmental Disorder
• Developmental Disorder 1.9%

Axis III Intellectual Level
• Psychomotor Retardation 1.4%


Preschool Feelings Checklist

MY CHILD:

0 -6 months

• Hyper-vigilance

6-12 months

• Increased anxiety in strange situations

12-18 months

• Unusual clinginess with caregiver

1. Re experiencing traumatic event
   1. Re-enactment play

2. Dissociative response
   1. Dazed expression
   2. Stereotypical behaviour
   3. Extreme withdrawal
   4. Periodic unresponsiveness

3. Numbering of responsiveness
   1. Emotionally subdued
   2. Socially withdrawn
   3. Restricted play

4. Hyper-arousal
   1. Irritability
   2. Emotional lability
   3. Temper tantrums
   4. Hyperactivity

5. Sleep disturbance
   1. Frightened
   2. Night terrors
   3. Anxiety

6. Emotions
   1. Crying
   2. Expressions of fear

7. Sleepy inappropriate
   1. No sleep
   2. Irregular sleep

8. Play
   1. Sarcasm
   2. Rote play

9. Motor behavior
   1. Appetite
   2. Fine engine

10. Expressions of anger
    1. Aggression
    2. Bullying

11. Aggression
    1. Physical
    2. Verbal

12. Imitations
    1. Emotional
    2. Expressions

13. Emotions
    1. Depression
    2. Anxious

14. Perceiving danger
    1. Sensitivity
    2. Distrust

15. Activity
    1. Hyperactivity
    2. Social withdrawal

16. Community and school performance
    1. Prosocial behavior
    2. Hyperactivity

17. Sleep
    1. Sleeping problems
    2. Frightened

18. Eating
    1. Appetite
    2. Nausea

19. Fear
    1. Separation
    2. Miscellaneous

20. Mood
    1. Mood swings
    2. Depression

21. Other
    1. Physical symptoms
    2. Mental

22. All diagnoses = 16.1%

PTSD & Infants (non verbal)

Infant is capable of perceiving danger/threat...can perceive range of emotions (fear, anger... joy), esp in carer

Less able to process cognitively... And make ‘sense’ the infant depends on carer to interpret the world and its safety

Loss of responsive carer is a trauma in itself

“Development of children’s internalising and externalizing problems from infancy to 5 years of age.”

• follow-up of 733 children recruited aged 6 to 7 months through to 5 years of age.
• Include CBCL,
  • 20% exhibited consistently elevated symptoms for each problem.
• Maternal stress, harsh discipline important problems.
• Recommend importance of effective population approaches to preventing mental health problems, with RCT of preventive interventions
• Bayer, Ukoumunne, Mathers, Wake, Abdi & Hiscock (2012) ANZPsych

Post traumatic response: Infant & toddler

• 0 -6 months
  • Hyper-vigilance

• 6-12 months
  • Increased anxiety in strange situations

• 12-18 months
  • Unusual clinginess with caregiver

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Interventions with infants and families

- Universal level
  - Education/ Mental health promotion
  - Maternal and child health services.
  - Touchpoints model, USA
  - Perinatal screening
- Specialized level
  - Neonate in maternity services: Stern-Bruschweiler, NBO
  - Infant mental health screening (BITSEA)
  - Focused for at-risk groups of families & children.
    - Neonate in maternity services: Stern-Bruschweiler, NBO
    - Infant mental health screening (BITSEA)
    - Early Parenting Centres
      - Nurse family partnership model (NFP)
      - For teenage parents: AMPLE at RWH
      - Healthy Steps: paediatric IMH collaboration USA (Talmi)
- Early intervention
  - Specialized for at-risk groups of families & children.
    - Tummies to toddlers, Bumps to Babes model
    - Risk specific: eg PASDA, Playsteps
    - Early Parenting Centres
      - Nurse family partnership model (NFP)
      - For teenage parents: AMPLE at RWH
      - Healthy Steps: paediatric IMH collaboration USA (Talmi)

RCH Infant Mental Health

1. Clinical Service Delivery: Infant Mental Health Assessment and Treatment
   - Community CAMHS Teams: referrals from families and other professionals
   - Hospital Consultation & Liaison: eg NICU, PICU, general medical regular clinical meetings.
   - Early intervention (infants whose parents have serious mental illness: direct intervention, secondary consultation, teaching, training)
   - Perinatal Emotional Health program

Secondary Consultation:
- Intrahospital
- Local MCHN
- Mother Baby Psych units

2. Clinical Research
   - Robin Study, NICU
   - Cardiology Research
   - Complex Feeding Clinic
   - Neonatal Behavioral Observation (NBO with babies in NICU: RWH)
   - Research Methods Training (ADB, EAS)

3. Teaching and Training:
   - Master of Mental Health Sciences, infant stream (21st year)
   - Engaging Infants, Introductory 2 Day Training IMH, Annual
   - NBO training
   - Reflective Family Play, Diane Philipp, Toronto
   - Working with High Risk Infants, with Berry Street (3 day training)

4. Advocacy and Community Development:
   - Involvement with World Association for Infant Mental Health
   - IACAPAP contribute to Queen Elizabeth Centre intervention programs
   - Parent-Infant Program
   - East London program for parents with mental illness
   - Mother Baby Inpatient Units Melbourne
   - RCH Infant Mental Health

Goals of the process of engagement with the baby

Why make a specific connection with the infant in her own right?
- Acknowledge the importance of the infant’s own self and identity, the baby as a person
- Acknowledge the infant’s own capacities for understanding and giving meaning to behaviour
- The interview becomes the infant’s interview, as if it was her own possession

Parental Embodied Mentalizing

Shai & Belsky (2011)

Parental reflective capacity/mentalizing:
- Parents’ capacity to appreciate, even unconsciously, their infant’s mental states…Not just measured with semantic and verbal expression, but includes: Embodied Mentalizing Capacity: which is to
  a. implicitly conceive, comprehend and extrapolate the infant’s mental states from the infant’s whole-body movement
  b. adjust their own kinaesthetic patterns accordingly.

<To engage with the baby or toddler the therapist could do the same>

Neonatal Behavioral Observation

NBO @thewomens Melbourne

Meeting the baby & Relationship Building

The 18 items include observations of the infant’s:
- capacity to habituate to external light and sound stimuli (sleep protection)
- the quality of motor tone and activity level
- capacity for self-regulation (including crying and consolability)
- response to stress (indices of the infant’s threshold for stimulation)
- visual, auditory and social-interactive capacities (degree of alertness and response to both human and non-human stimuli)

The AMPLE Intervention  RWH

Part 1: Introducing Babies
- with video clips to vulnerable teen expectant couples

Part 2: ‘Let’s meet your baby’
- Builds on the antenatal intervention via:
  - Seeing their baby’s capacity and urge to socially connect with them from birth, using the NBO (Newborn Behavioural Observations)
  - Conversation about their perception of their baby’s personality (likes and dislikes) before birth and as a newborn
  - Recollections of the antenatal video clips and how they relate to their experience so far of their own baby
  - Memento of the session (brief video or photo)

Interpretation of findings
- Brief relationship support incorporating the NBO as part of maternity care makes a difference to young lives:
  - Associated with improved mother-infant interaction 4 months after brief intervention.
  - Acceptable to a culturally diverse population of young mothers
  - Potentially affordable, reproducible and fits with routine maternity care

‘Supporting the adolescent mother-infant relationship: Preliminary trial of a brief, perinatal attachment intervention’
Susan Nicolson, Fiona Judd, Frances Thomson-Salo, Archives of Women’s Mental Health 2013

RCH Treatment Model

Understand the emotional meaning of the situation that the infant and parents find themselves in.

- Need for immediate intervention: baby can’t wait (Bomperad)
- Use psychoanalytic, behavioural and family systems theories
- Selective use of key theories eg psychoanalytic/attachment, psycho-physiological regulation.
- May include selective use of other intervention models eg developmental guidance, interaction coaching, brief serial treatment, long term psychotherapy
- work with systems
  - sharing our hypothesis and work with other hospital/community staff

RCH treatment model: Specificity of the intervention

- make an emotional connection with the infant - gaze, touch, talking, playfulness.
- Help the infant ‘symbolize’... play is integral ..crucial
- Help the parents understand the baby’s mind/body.
  - holding and containing of projective identification
  - making links
  - unhooking projections
  - space for ambivalence
- Transformational Therapeutic moment (Stern et al)

The RCH approach is:

- There are common features in psycho-therapeutic interventions
- Therapist responds with (initiates) age-appropriate, affective communication with sensitivity, authenticity and vitality
- Using voice with infant, then interaction and vocalisation, and gestural language with an older infant
- Similar to embodied parental mentalizing (Shai, Belsky 2011)
- Space of silence also allows time for watching, for a baby to digest and respond, for their response to be heard, for taking turns.
- The intervention may appear ‘sloppy’ (Stern 2004)
- FTS

Minding the Baby program Yale
Arietta Slade et al

- Aim in therapy is to enable parents to develop a reflective stance
  - Able to envision mental states in themselves, and in their children
  - Begins with the ability to identify basic mental states, namely thoughts, feelings, desires, intentions and beliefs, both in self and other
  - From recognition stems a capacity to think about and imagine them in a variety of ways – to mentalize
- Development of Reflective functioning occurs within the context of a relationship with clinician
- The therapeutic relationship is crucial to enabling change across a range of dimensions.
- Understanding and developing the therapeutic relationship is crucial to every aspect of the work.
Minding the Baby program

• In wondering, you become the voice for the mother’s, and the other’s internal experience
• Help the mother wonder about both herself, and the child, as separate entities
• Use of video
• Capacity to play
• Play evokes feelings, ideas, fantasies and worries, which are experiences that can be “played” with in potentially an unthreatening way
• A parent’s mentalizing capacity – as it pertains specifically to her relationship with her child – is predictive of secure attachment organisation in the child
• Targeting parental mentalization capacities should be central to parent-infant interventions
• Reflective capacities serve a range of protective functions in relation to trauma

Universal and Preventive Approaches: Challenges and Opportunities

• General lack of data on timing, intensity and duration of intervention and training and skills required with work with targeted populations
• Need for more descriptive, exploratory investigations regarding family-centred, community-based coordination of services-oriented programs.
• Dropout rates impact service delivery and evaluation of programs
• Need for adequate resources and commitment for rigorous evaluation, including random assignment.
• Cultural competence for specific subgroups.
• Infrastructure may not be adequate.
• Cost-effectiveness studies to make choices about investment in early childhood

Infant Mental Health Training

• Training:
  1. Master of Mental Health Science, Infant stream, University of Melbourne
  2. NBO Training Melbourne RWH contact:
  3. RCH Engaging Infants 2 day training
     February 2017
• ‘The Baby as Subject’: Campbell Paul and Frances Salo Karnac, 2010

Contact email: campbell.paul@rch.org.au

Conclusions

• Infants and toddlers can experience significant mental health distress: prevalence 15 to 20% of the population
• Infants can experience mental health disorders developmentally analogous to older children
• Early childhood healthcare professionals can provide mental health interventions
• Keep the baby at the centre of the intervention, but always engaging her parents
• Ensure we have opportunities for consultation, support and reflective supervision for what can be emotionally painful work

References

• ‘Demystifying Infant Mental Health: What the Primary Care Provider Needs to Know’
• Infusing Mental Health Services into Primary Care for Very Young Children and Their Families
  • Kaplan-Sand, Talmi, Augustyn, Zero to Three Journal, November 2012

Recommended Books

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood By Zero To Three

Handbook of Infant Mental Health (2nd edition) by Charles Zeanah

Psychotherapy with Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment By Alice F. Lieberman, & Patricia van Oers

Mind to Mind: Reflecting on the Future of Psychoanalysis: Mentalization, Internalization, and Representation. Edited by Bliedtner, Jutta, Grisetti-Stude, Shiranne Bergner

Parenthood and Mental Health: A Bridge Between Infant and Adult Psychiatry By World Psychiatric Association

Infancy and Early Childhood By Zero To Three

Exploring In Security: By Jeremy Holmes

Becoming Attached: First Relationships. By Robert Karen
Resources
Australian Association for Infant Mental Health
http://www.aaimhi.org/index.php
World Association for Infant Mental Health
http://www.waimh.org
ZERO TO THREE: National Center for Infants, Toddlers and Families
www.zerotothree.org
Alarm Baby Distress Scale
www.adbb.net
The Anna Freud Centre
http://www.annafreud.org/

Upcoming Conferences:
AAIMHI 2017 – stay tuned  http://www.aaimhiconference.org/
WAIMH – Prague 29th May to 2nd June 2016  http://www.waimh.org