Infant Mental Health in Practice

Ways of Thinking, Supporting and Being in the work

Erin Troup, LPC, NCC, CT, IMH-E®

SPROUT
CENTER FOR EMOTIONAL GROWTH
AND DEVELOPMENT, LLC

"I think formula should be bottled-up, but not your emotions."

What is Infant Mental Health?

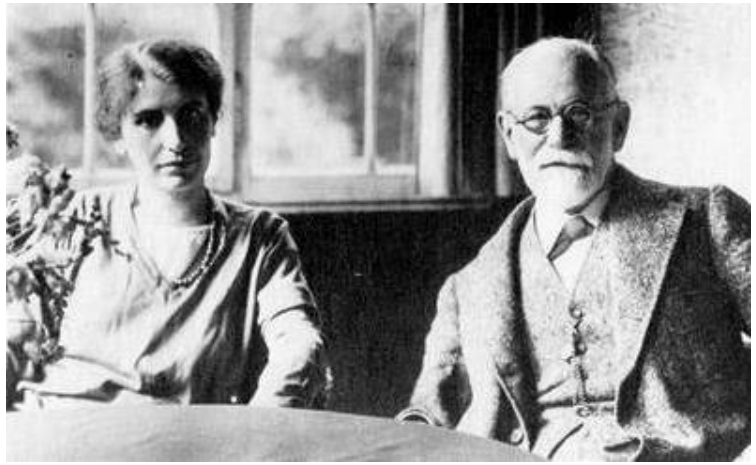
- …concerns the optimal development of infants and toddlers within the context of secure and stable relationships with caregivers.

  – Michigan Association for IMH (2002)

- …the young child's capacity to experience, regulate, and express emotions, form close and secure relationships, and explore the environment and learn.

  – Zeanah and Zeanah (2005)

The Infant/ Early Childhood Mental Health Pioneers- Where we came from



The Father of Attachment Theory

- John Bowlby described attachment as “Lasting psychological connectedness between human beings” (Bowlby 1969, p194).

The Attachment Continuum

- Attachment styles originally created by Mary Ainsworth in 1970 after she observed the patterns of behavior children exhibited after reunification from a brief separation from their Parents. This was called the “Strange Situation”
- She categorized these patterns of reactions into attachment styles including Secure, Ambivalent-Insecure, Avoidant-Insecure.
- Later, Main and Solomon (1986) added a fourth attachment style called Disorganized-Insecure.

Attachment Pattern	Child	Caregiver
Secure	**Uses caregiver as a secure base for exploration.** Protests caregiver's departure and seeks proximity and is comforted on return, returning to exploration. May be comforted by the stranger but **shows clear preference for the caregiver.**	**Responds appropriately**, promptly and consistently to needs.
Avoidant	Little affective sharing in play. Little or no distress on departure, little or no visible response to return, ignoring or turning away with no effort to maintain contact if picked up. **Treats the stranger similarly to the caregiver.**	**Little or no response** to distressed child. Discourages crying and encourages independence.
Ambivalent/ Resistant (anxious)	Unable to use caregiver as a secure base, seeking proximity before separation occurs. Distressed on separation with ambivalence, anger, **reluctance to warm to caregiver and return to play on return.** Preoccupied with caregiver's availability, seeking contact but resisting angrily when it is achieved. Not easily calmed by a stranger.	**Inconsistent** between appropriate and neglectful responses.
Disorganized	Repetitive movement on return such as freezing or rocking. Lack of coherent attachment strategy shown by **contradictory, disoriented behaviors such as approaching but with the back turned**.	**Frightened or frightening behavior,** intrusiveness, withdrawal, negativity, role confusion, affective communication errors and **maltreatment.**

IMH Principles

- Attachment theory, family systems theory, trauma-informed approaches
- Babies exist in the context of their caregiving relationships and within the cultural context of their family
- Experiences during pregnancy and in the first three years lay the foundation for all future development
- Relationships are critical: best way to support babies is to support their parents/families to build/strengthen nurturing relationships with them
- There can be both ghosts and angels in the nursery that will impact the emerging attachment relationships

Early Intervention Principles

- Infants and toddlers learn best through every day experiences and interactions with familiar people in familiar contexts.
- All families, with the necessary supports and resources, can enhance their children's learning and development
- The primary role of the service provider in early intervention is to work with and support the family members and caregivers in a child's life.
- The early intervention process, from initial contacts through transition, must be dynamic and individualized to reflect the child's and family members' preferences, learning styles and cultural beliefs.

Workgroup on Principles and Practices in Natural Environments

OSEP TA Community of Practice:

Early Intervention Principles continued…

- IFSP outcomes must be functional and based on children's and families' needs and priorities
- The family's priorities needs and interests are addressed most appropriately by a primary provider who represents and receives team and community support.
- Interventions with young children and family members must be based on explicit principles, validated practices, best available research and relevant laws and regulations.

Workgroup on Principles and Practices in Natural Environments

OSEP TA Community of Practice:

Mental Health Principles

- Actively involve and support families with a child in treatment, and Provide ongoing support and aftercare for the child and family.
- Attachment theory, family systems theory, trauma-informed approaches
- Treatment Plans are developed jointly with the family and youth.
- Include treatment modalities that are appropriate to the clinical needs of the child/ family
- Be sensitive to trauma-related issues and their treatment.
- Be appropriate to the age and developmental needs of the client.
- Be aware of and support cultural needs of the family
- Follow ethics, laws, Validated Practices

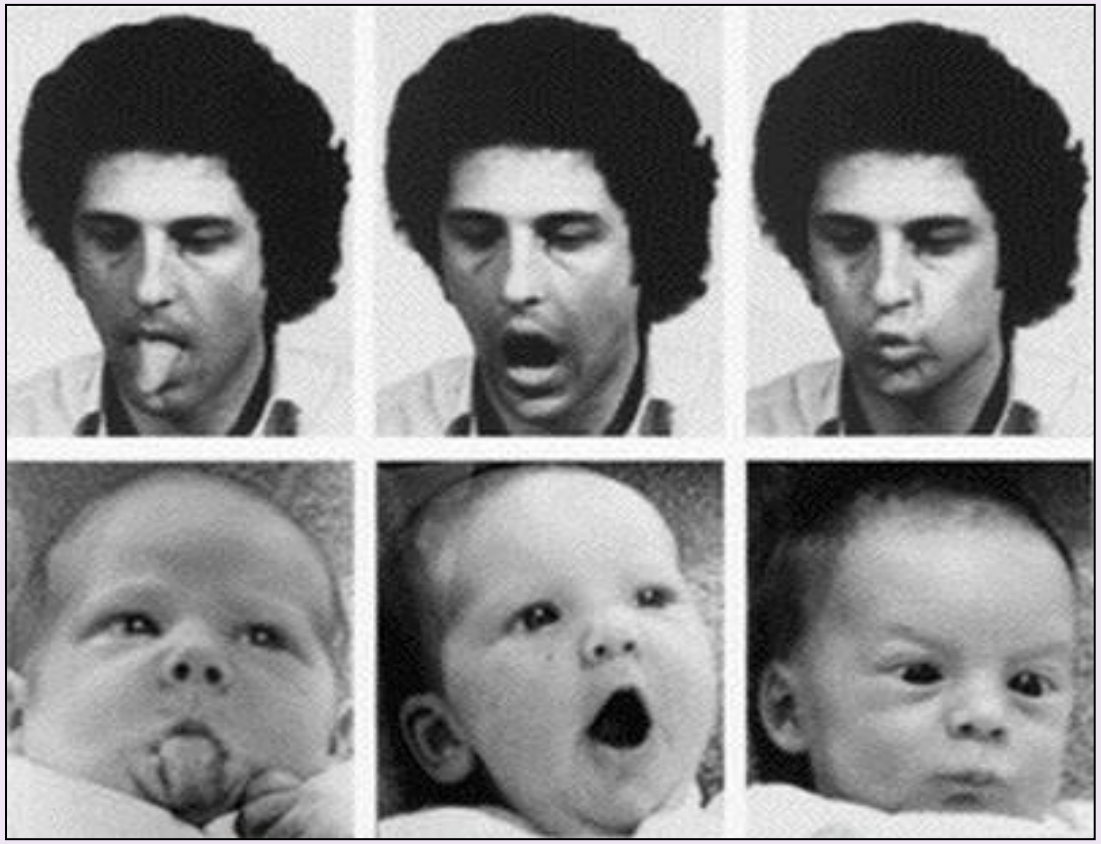
Adapted from: Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers June 2010 – American Academy of Child and Adolescent Psychiatry

Babies are Born Ready to Attach

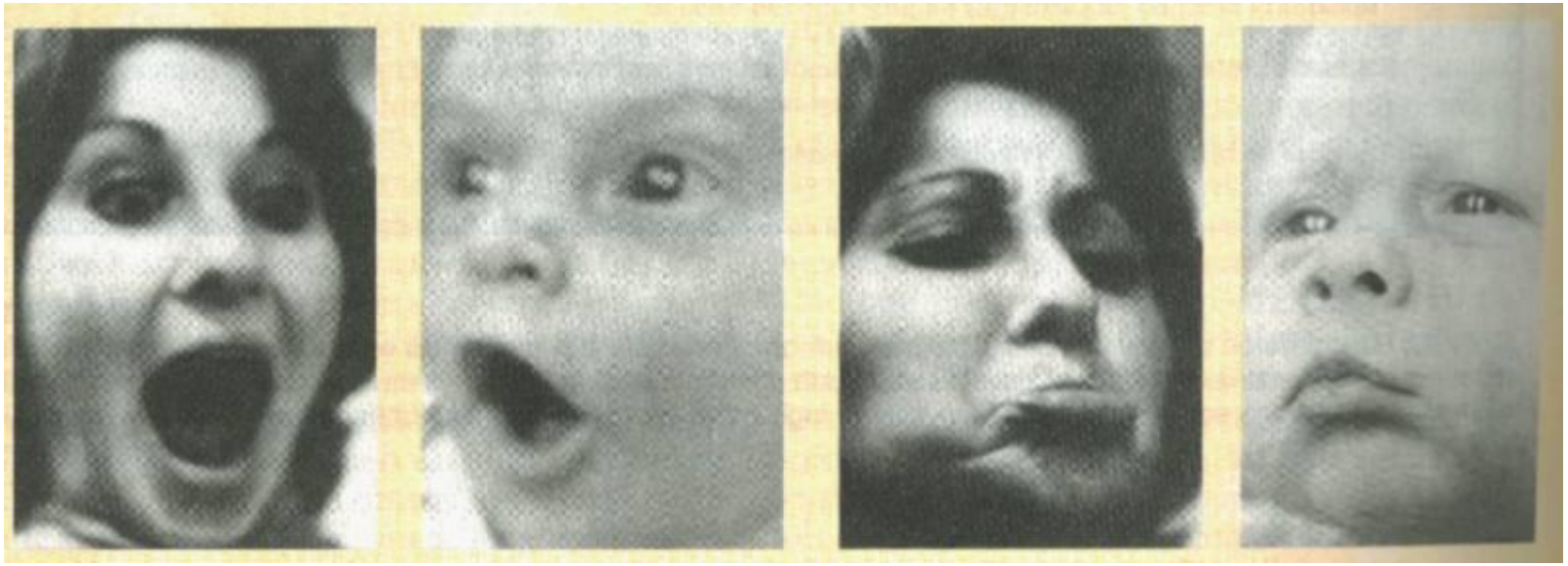
- Babies can distinguish smells of their mother's breast milk vs. other women's breast milk.
- They communicate through cry or coo to get their needs met.
- En Face Gaze- Baby's primary interest in looking at faces, particularly mother's.

Babies are Born Ready to Attach

- Newborn babies have an early ability to imitate faces (Neonatal Imitation).
- It is thought to be a way for infants to begin the very first forms of face-to-face communication. This aids in bonding and getting needs met.



Dr. Beatrice Beebe
Mother- Infant interactions



Serve and Return

https://www.youtube.com/watch?v=E7IlnTG7wzk

Serve and Return

BABY BRAIN FACTS

Baby brains are “denser” than adolescent or adult brains.

A baby’s brain has over 100 billion neurons.

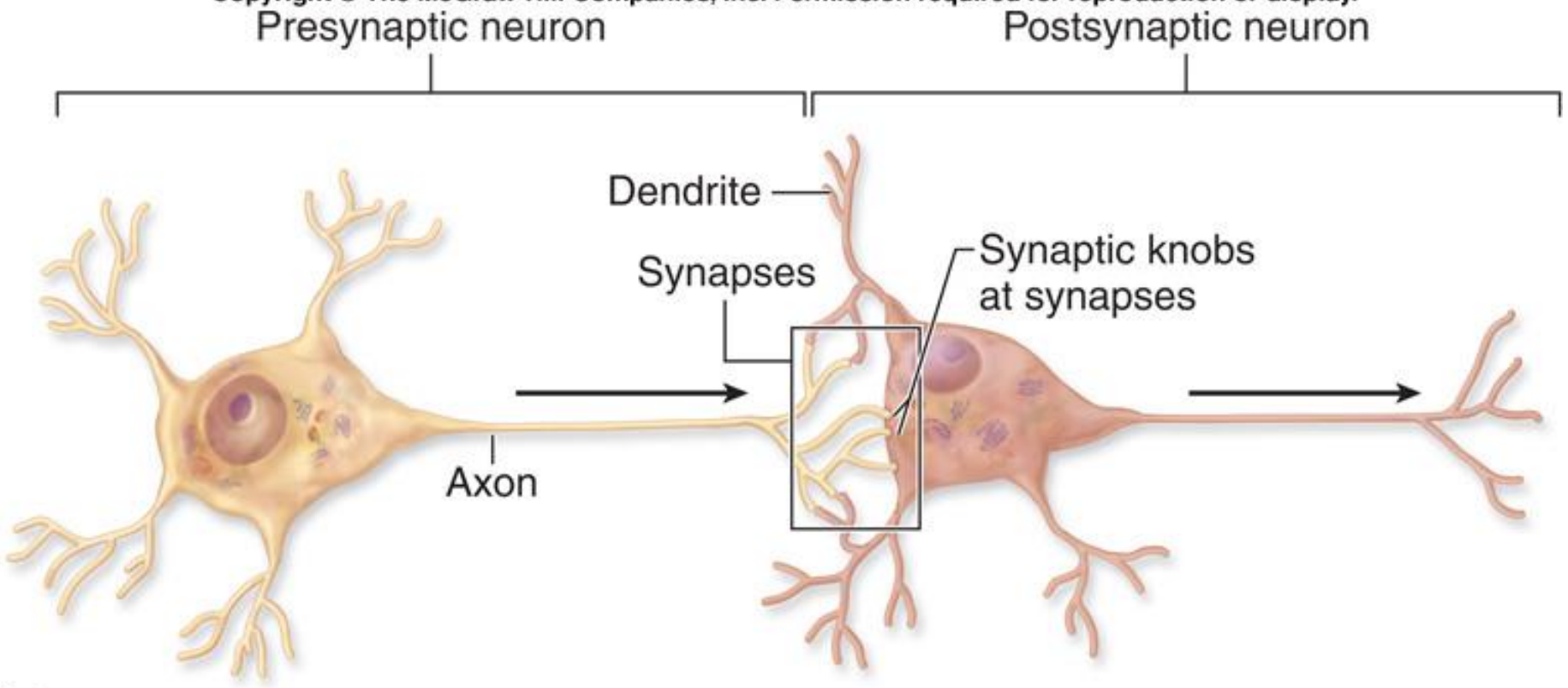
Brain growth is most rapid over the first 3 years of life.

By age one, the brain is 50% of adult size, 80% by age 3, 90% by age 5.

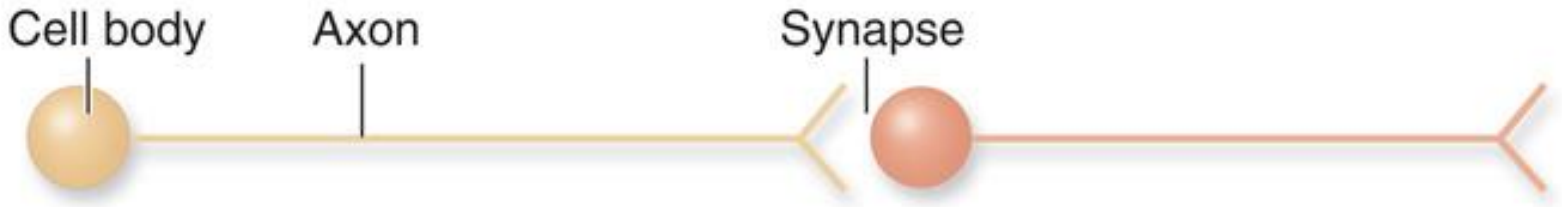
CONNECTION–Neural Exuberance

Neural Exuberance:

- Period in infancy through early childhood when cell communication is most rapid.
- Neurons form connections – synapses.
- By age 2, the cerebral cortex has over 100 trillion synapses.



(a) Synapse



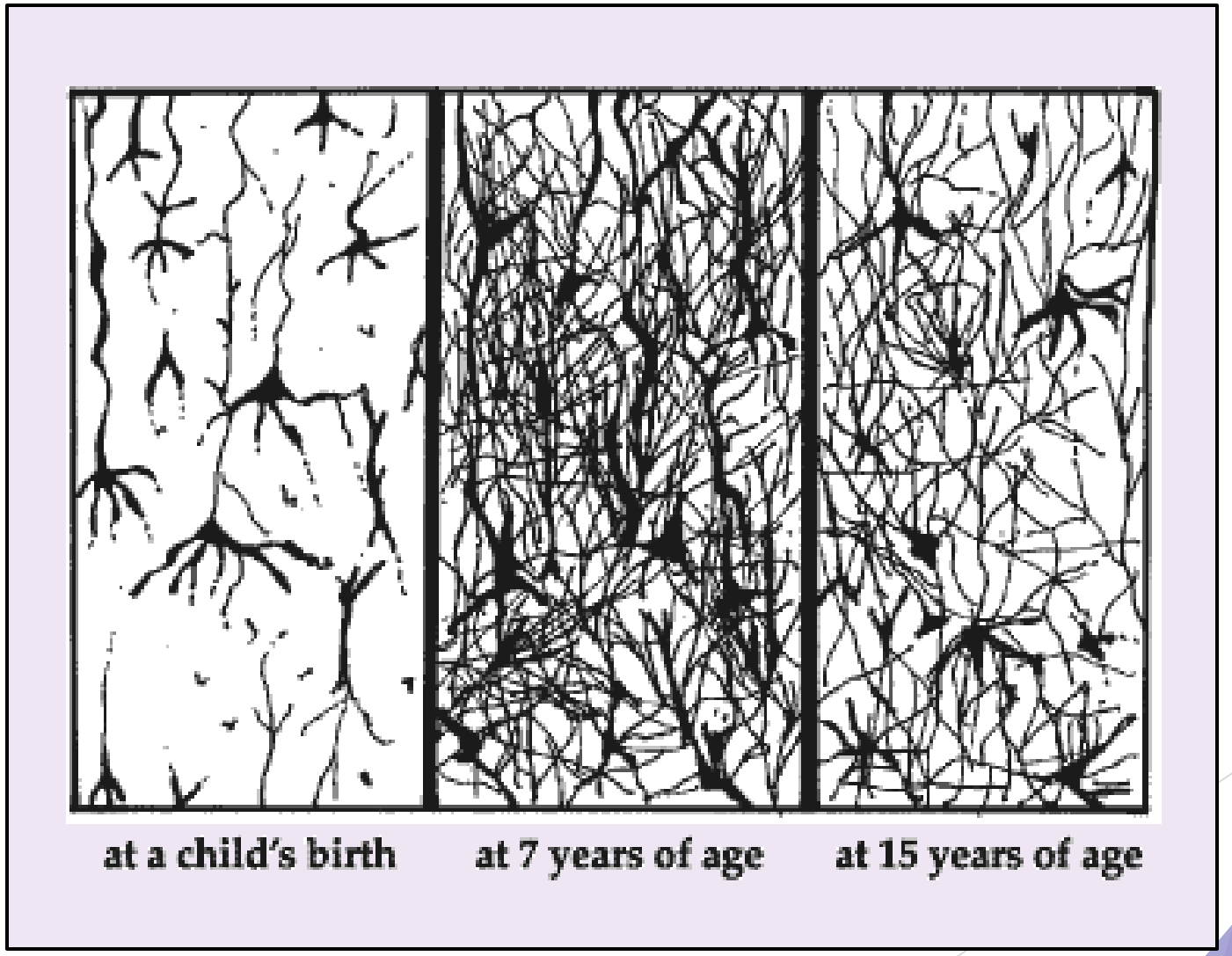
(b) Simplified representation of a synapse

CORRECTION - Pruning

Pruning

- Elimination of synapses that are not used.
- Pruning results in more efficient brain functioning.
- By early adolescence there are fewer connections, but they are “stronger.”

Cells that fire together, wire together.



PLASTICITY

- Capability of the brain to change structure and function in response to experience.
- Can be influenced by both positive and negative experiences.
- Infant/Toddler brains are more capable of this but the process occurs throughout life.
- Sensitive periods, time spans when parts of the brain depend on certain kinds of experiences to develop normally.

Barriers to Attachment

- High risk families
  - Poverty
    - Newly arriving immigrant families
    - Adolescent or single parents
    - Homelessness
    - Chronically ill children or caregivers
    - Substance abuse, Mental Illness
    - CYF involvement/ Foster care
    - History of trauma, neglect or abuse (physical, sexual, emotional)

** These factors do not lead to attachment problems in all cases, they can complicate the attachment process.**

Barriers to Attachment

- Other Risks
  - Postpartum Depression
  - NICU stay
  - Inability to breastfeed
  - Early tests during pregnancy (testing for “risk” of genetic conditions - not always accurate)
  - Developmental delay or disorder of the baby or parent
  - Multiples
  - Parent’s past history with CYF, Foster Care, or Adoption System.
  - Baby as a transference object

Developmental Delays or diagnosis in some cases can inhibit the attachment process:

- Sensory aversion to touch, sound, etc. (Autism diagnosis)
- Feeding difficulties.
- Caregiver feelings of guilt and grief.
- Sharing time with therapists and doctors.

What is Healthy Social and Emotional Development?

Confidence

Curiosity

Intentionality

Self-Control

Relatedness

Capacity to Communicate

Cooperativeness

Heart Start: The Emotional Foundations of School Readiness

published by ZERO TO THREE 1992

Birth- 5 Child Development

- **Birth – 1 Month of Age**

Child can make basic distinctions in vision, hearing, smelling, taste, touch and temperature. Child has pain perception. **Prefers to visually fixate on faces.**

Adjusting to life outside of the womb. Crying is normal. Child needs to feel calm, safe and have a routine.

2-3 Months

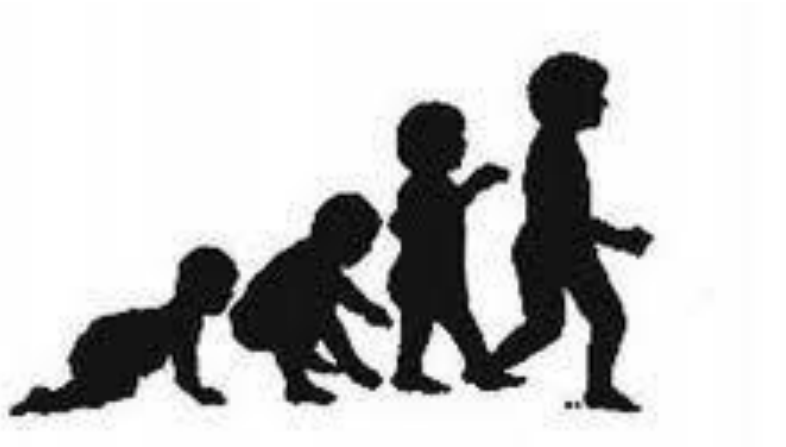
- Control of eye muscles, lifts head when on stomach, localizes sounds, recognizes mother visually and other familiar people.
- ***Expresses a variety of feeling through smiles, frowns, body movements and coos.**
- Settling into a routine. Comforted by being fed and cuddled.

4-6 Months

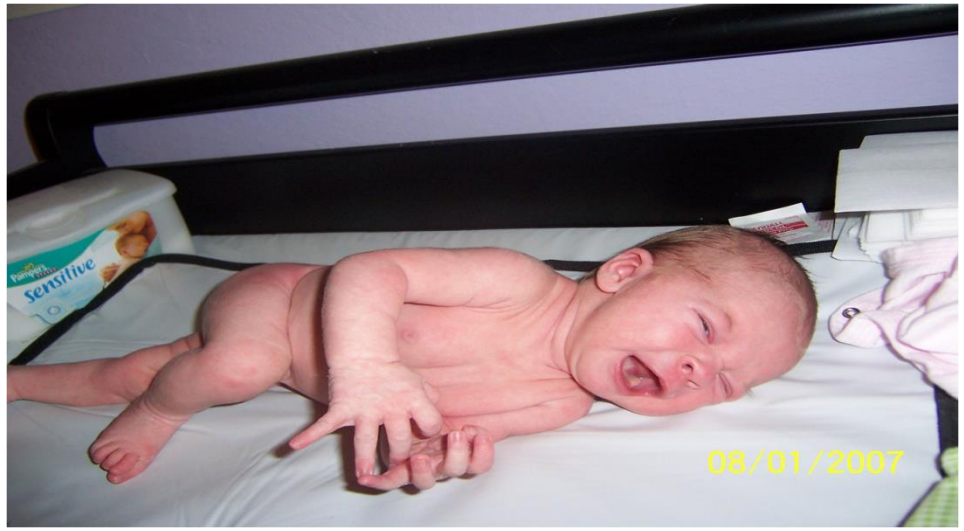
- Control of head and arm movements, purposeful grasping, rolling over, babbling.
- ***Beginning to show fear around unknown people (Critical Period)**
- Able to laugh and make happy sounds.
- ***Calmed when picked up and upon hearing a familiar voice**

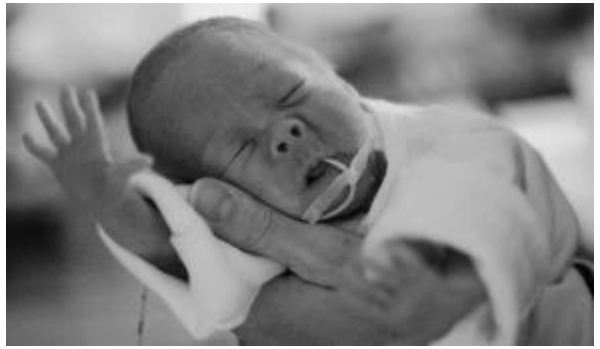
Why Cues are Important

- Cues help caregivers to understand their babies needs to avoid frustration on their part and on the baby's
- Cues help caregivers understand how they can help their child
- Baby's decrease their stress level when cues are properly read

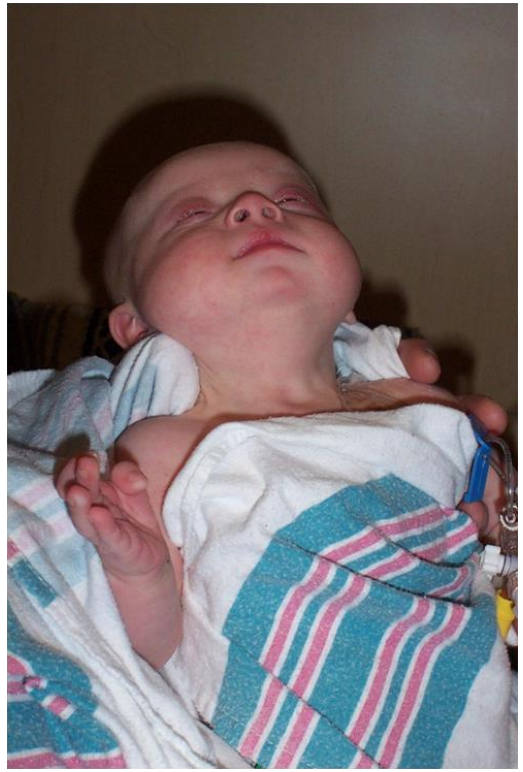


Distress/ discomfort/ “Help me out”





Distress Cues



RAW VIDEO: Emotional dad on slain wife, kidnapped child

7-9 Months

- Child has control of trunk and hands. Sits without support, crawls, control of legs and feet, supported standing.
- ***Strong emotional attachment to Mother (Primary caregiver) and may protest separation from that caregiver.**
- Shows self soothing behaviors with a familiar toy or by thumb sucking.
- Shows increased expressions of fear, anger and sadness
- Interest in Peek-A-Boo

10-18 Months

- Child may say 2-10+ words, imitates sounds, responds to simple commands. Creeps up stairs, walking, begins to understand turn taking.
- ***Fear of strangers along with increased curiosity and exploration, dependent behavior, resistant to naps and some foods. Tantrum behaviors (end of Trust vs. Mistrust, beginning of Autonomy vs. Shame and Doubt).**
- Needs reassurance from parents/ primary caregiver

*****CRITICAL PERIOD!*****

18 Months-2years

- Runs, kicks a ball, capable of bowel and bladder control, more than 200 words. Upset when told “No”
- Needs caregivers to teach right from wrong. Easily distracted due to short attention span
- ***Pretend Play**
- ***Likes routine and changes are upsetting. Shows sympathy. Decreased fear of strangers.**
- ***Able to hold a picture of a loved one in mind- helps with separation**

2-3 Years

- Object Permanence is solid by this point.
- Use of short sentences, stuttering may occur briefly. Sense of humor and may play tricks. Gives orders.
- ***Play is the main activity and is important in the development of identity and confidence.**
- *** Continues to be self centered and may feel responsible for what happens.**

(Moving into Initiative Vs. Guilt)

3-4 Years

- Self sufficient in many routines, sharing and cooperative play.
- ***Explicit memory available- involves recollection of previous experiences**
- May have imaginary friends
- Interest in genitals (potty training)
- Ability to bargain but not to reason, less frustrated and angry with limits.
- ***Continued Fear of parental abandonment.**

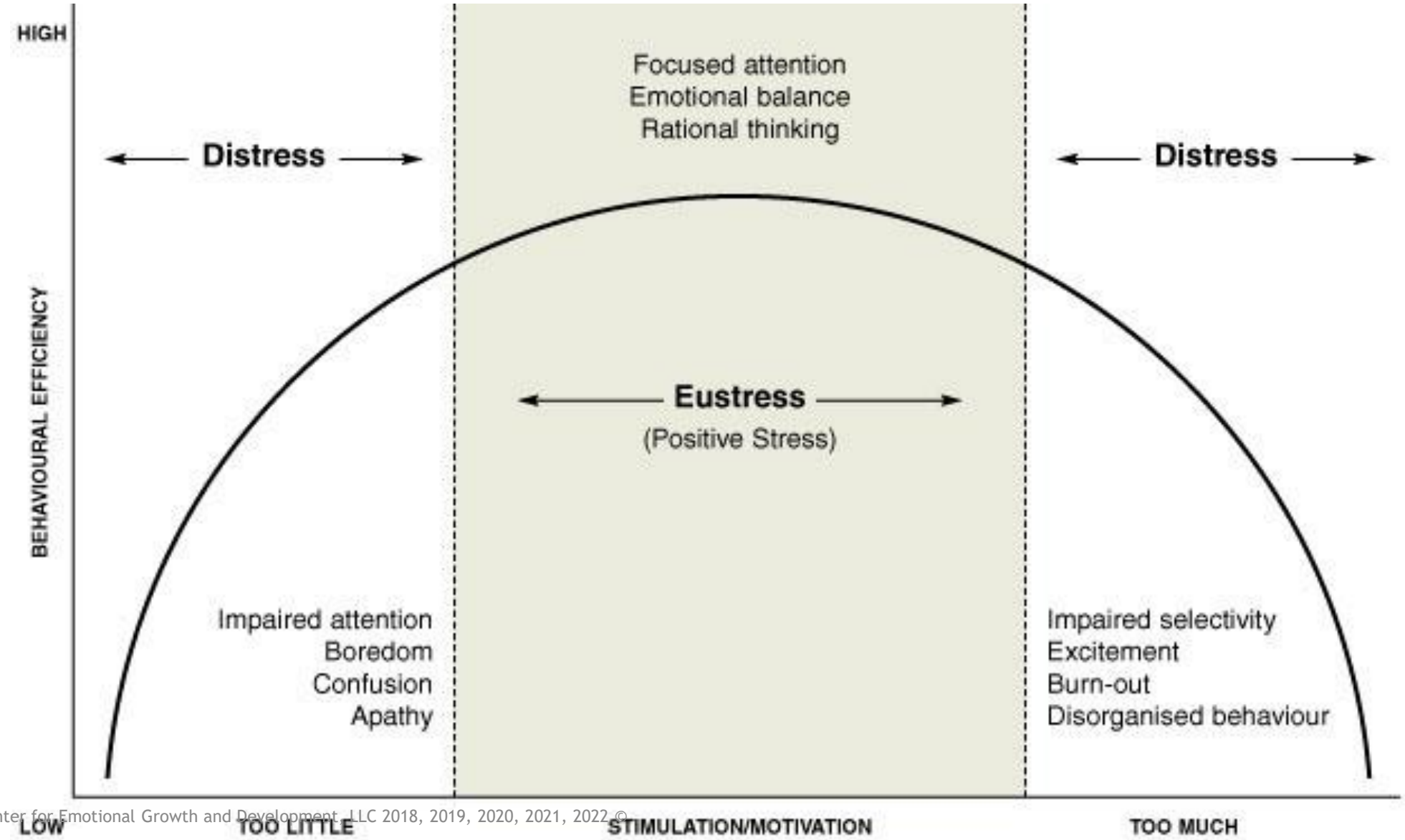
4-5 Years

- Mature Motor Control, dresses self, has mastered basic Grammar, likes to “show off”
- ***Can relate to a story**
- ***Sense of past/ Future developing**
- Can be serious and realistic at times. Demonstrates anger physically or verbally (slamming doors, stomping feet, “your not my friend”).
- ***Protective and kind towards parent, younger child or Pet.**
- ***May worry that something may happen while the child is not there and parents would not be available to them when needed.**

Infants as Moral Creatures?

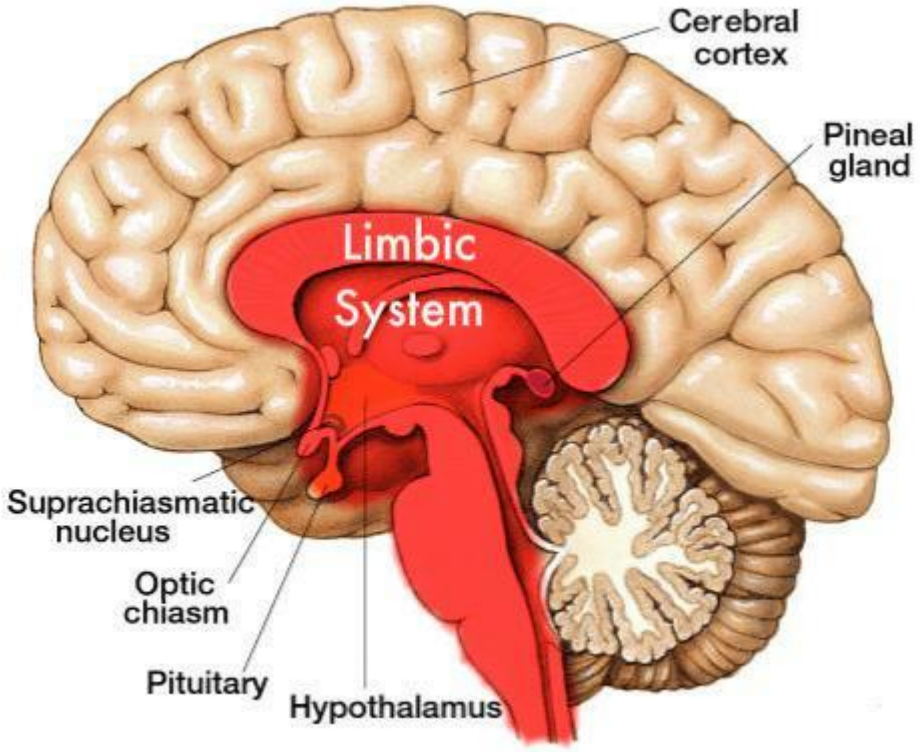
Time for a Break!

Trauma and Stress



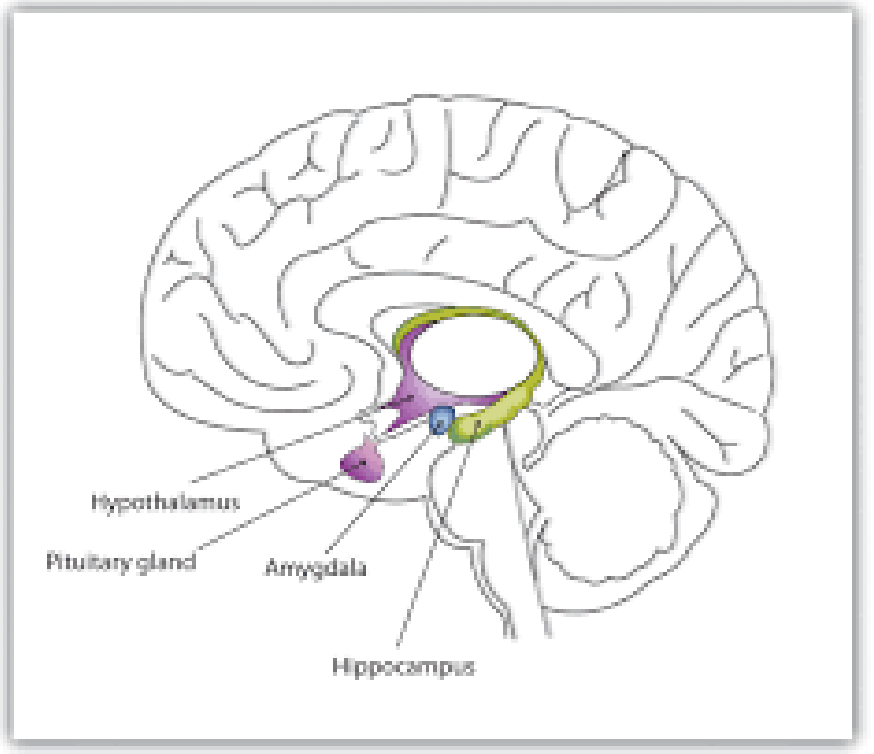
The Stress Response

- The infant's body responds to stress by mobilizing energy resources to deal with an immediate threat and shifting resources away from future needs such as growth and repair.
- Triggered by action of the autonomic nervous system (ANS) and the hypothalamic-pituitary-adrenocortical system (HPA) which is releases cortisol.



Limbic System

- Emotional experience, expression, regulation
- Motivation
- Physiological regulation
- Memory
- The Stress Response



What is Traumatic Stress?

When a potentially traumatic circumstance, experience, or event becomes **too difficult for children and their families to cope with.**

- Elicit feelings of terror, powerlessness and out-of-control physiological arousal.
- Include re-experiencing the event, avoidance, hyper-arousal and persistent difficult thoughts and emotions.
- May have a profound effect on his/her perception of self, others, the world and future.
- Generally, for young children traumatic events can become a full sensory experience.

-nctsn.org

What is Trauma?

"When a child feels **intensely threatened** by an event he or she is involved in or witnesses, we call that event a trauma."

- *nctsn.org*

Trauma is: Unexpected- resulting in distress, Uncontrollable- results in feelings of helplessness, Sensory experience- physical and emotional triggers.

Factors Surrounding Trauma

The impact traumatic events has on a person is dependent upon the person.

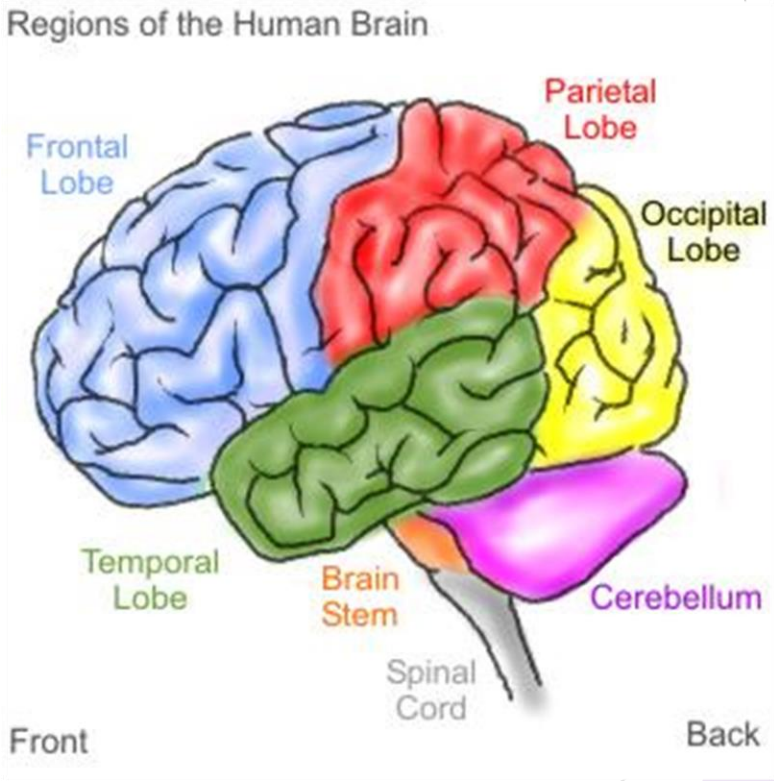
- Other Factors Include:
  - Frequency
  - Duration
  - Age of insult
  - Individual coping skills
  - Resources/ support available

Trauma

- Traumatized Children will often at base line be in a state of low level fear
  - Much higher heart rate
  - Hyperarousal and dissociation responses
  - Cortisol (stress hormone) levels are consistently higher even at resting state than non-traumatized children.

What Happens with a “Trauma Brain”?

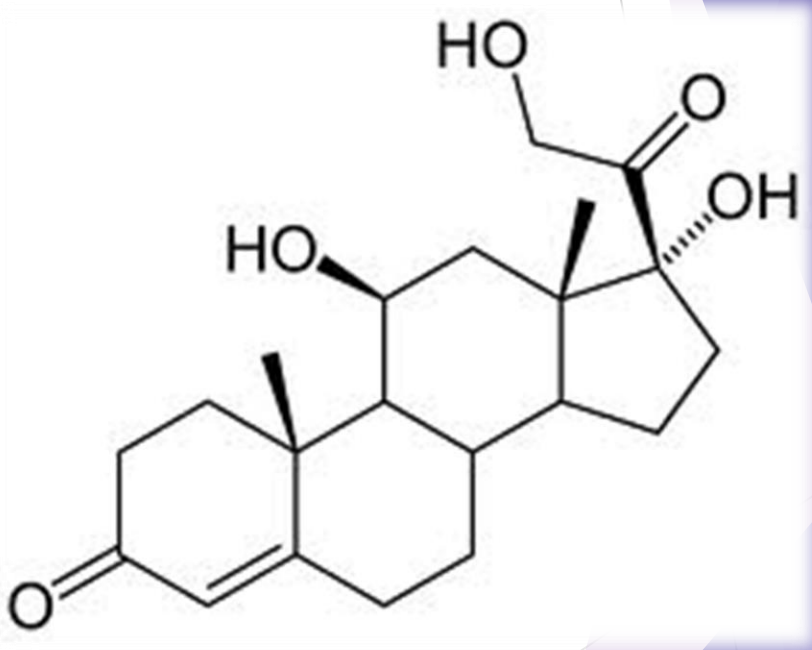
- Deficient development on the left side of the brain affecting memory and a possible lead to depression
- Difficulty integrating the functioning of left and right side brain functions
- Brain becomes “wired” to experience fear, anxiety and stress



“Trauma Brain” Reactions

- Adrenaline and Cortisol begin to act against each other during times of stress- one is released to calm the other- Cortisol cannot overcome adrenaline.
- Limbic System is always activated – emotions
- Frontal lobe- reasoning (both areas of the brain quit talking to each other – this “disconnect” can look like ADHD)

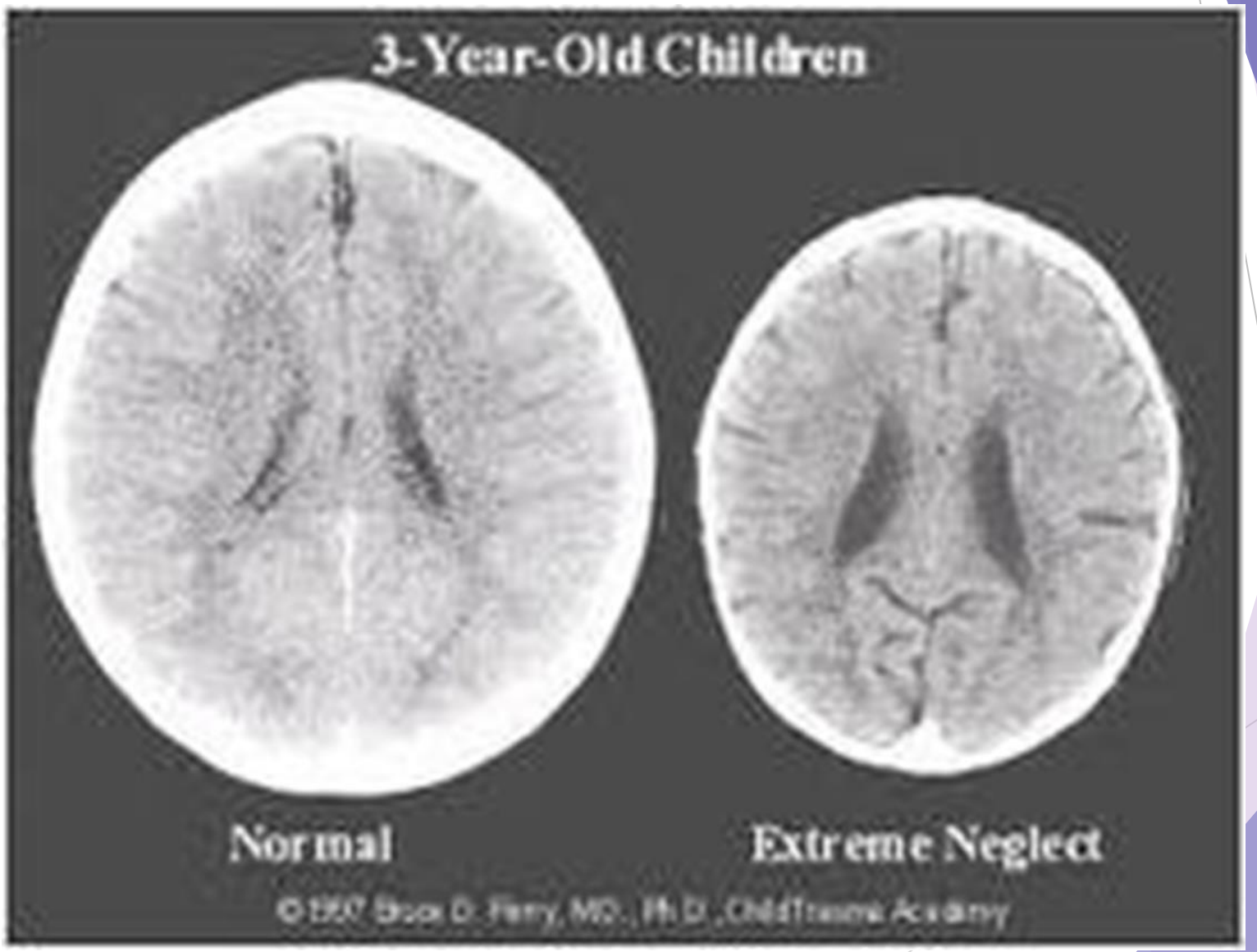
Cortisol



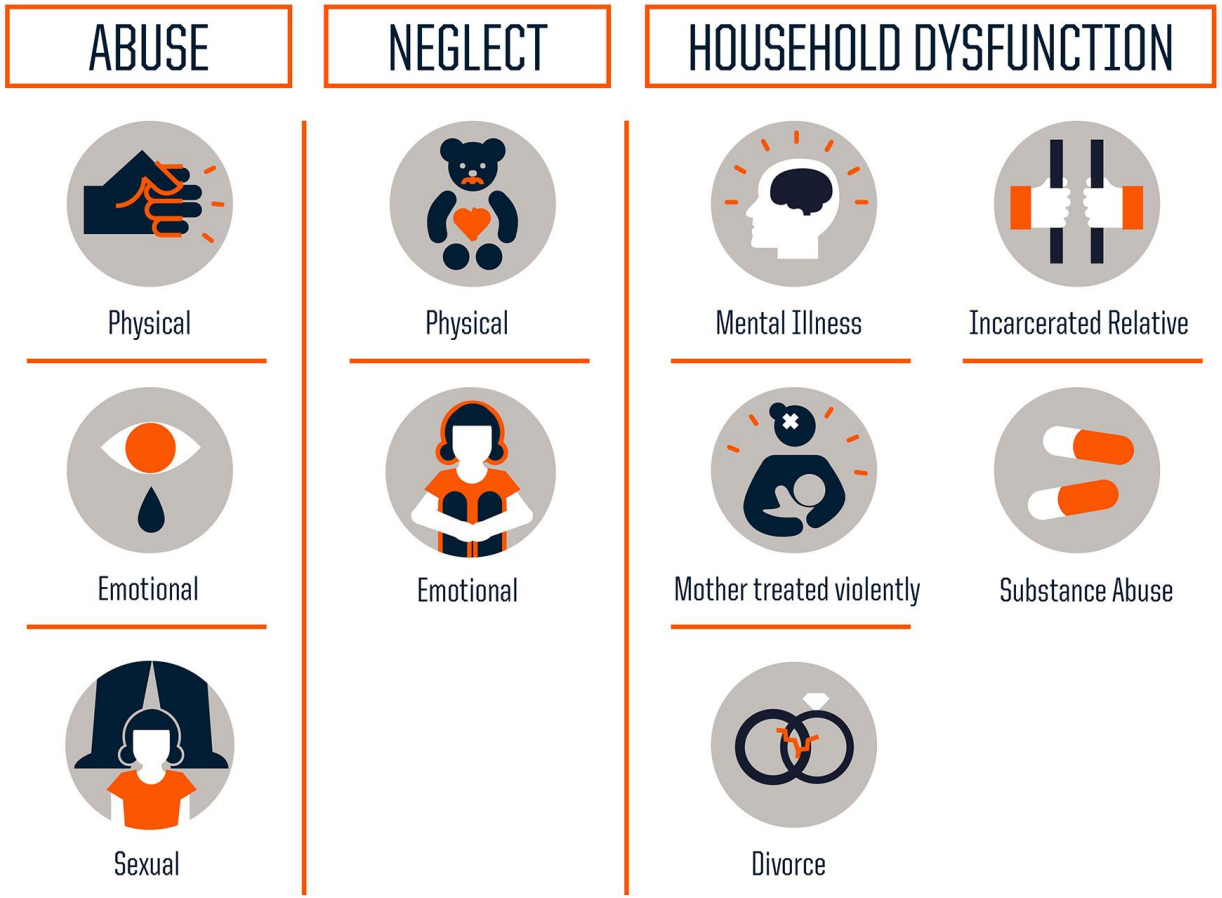
These brain changes can be attributed to:

- ✓ Clumsiness
- ✓ developmental delays
- ✓ Difficulty concentrating and retaining information
- ✓ Smaller physical size
- ✓ Hyperactivity
- ✓ Impulsiveness
- ✓ Difficulty integrating sensory experiences

Toxic Stress

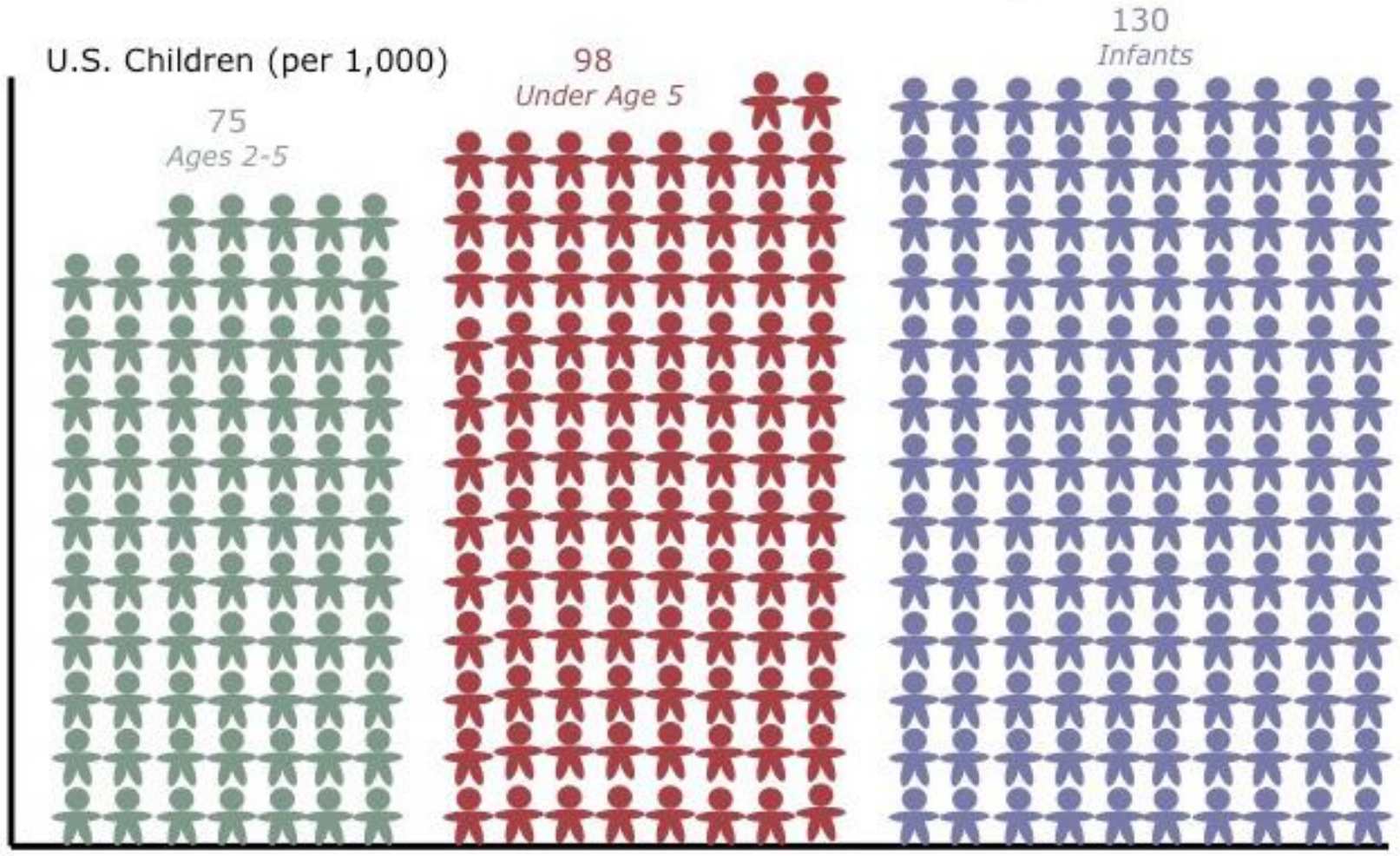


“ACES”
Adverse Childhood Experiences



NATIONAL FORUM ON EARLY CHILDHOOD PROGRAM EVALUATION

Sources of Toxic Stress in Young Children

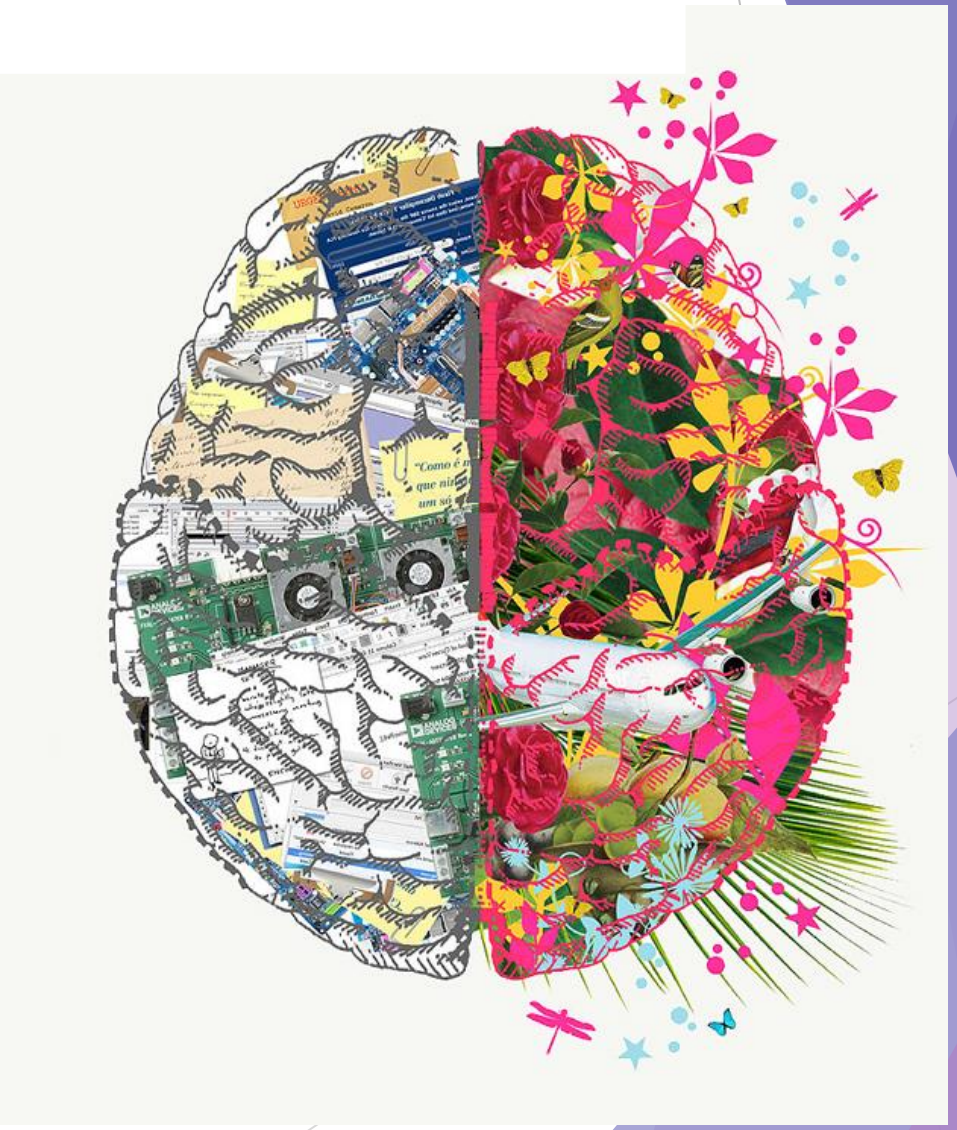


DREAM TEAM!!

The first 3 years of life is predominately a right brain function.

Attachment theory is, in essence, a regulatory theory…involving the primary caregiver's psychological regulation of the infants maturing limbic system.

– Alan N. Shore, 2001



Regulation – Self Regulation

Ability to:

- Sense and react to changes in the environment.
- Manage stress and seek stability (Homeostasis).
- Experience and communicate positive and negative affects (Emotions).

Co-Regulation

https://www.youtube.com/watch?v=ZomlnmKRDu8

Toddler Behavior Regulation

Important Things to Remember About Behavior

- Behavior is Communicative
  - *Behavior is the EXCLUSIVE communication for disruption until roughly the age of 3.*
- Self-Protective
- Often decreased with Empathy

"It is more important to be with, not to know."

- Anne Gearity, University of Minnesota

How could this teacher have communicated to support this child?

Important Things to Remember about Behavior

1. Most of the time it is not about you – Try not to take behavior personally
2. Behaviors WILL Happen
2. Developmental processes are playing a huge roll!

Signal Before Speaking

No one can follow a direction they have never heard

Children who have experienced Trauma Have: **Confusing Interactions with Adults and Peers**

- They expect adults to be harsh or unavailable, and they provoke the reactions they expect.
- They assume their needs will be ignored so they rarely seek or accept adult help.
- They make outrageous and unrealistic demands.
- Requests that ask for compliance usually turn into power struggles.
- Ordinary social expectations threaten them so they wreck social experiences.
- Their play is aggressive or repetitive. They lack imagination and creativity.

- Washburn Center Developmental Repair Training Manual

Children who have experienced Trauma Have: **Emotional Reactivity**

- Their feelings are easily triggered but confused by physical sensations that are called arousal.
- When sad, disappointed or surprised, they react with anger and aggression.
- They show low frustration tolerance so new learning is hard.
- They become easily humiliated by ordinary tasks.
- They react to others emotions with aggressive acts that quickly become out of control.

- Washburn Center Developmental Repair Training Manual

Children who have experienced Trauma Have: **Distorted Perceptions**

- They perceive danger much of the time, and assume they could be hurt.
- They carry grudges and retaliate when they have been hurt, even if the hurt is accidental.
- They misread social cues and often assume retaliatory aggression has occurred when none was intended.
- They don't remember what happened in the past, and they can't think about or explain their own experiences.
- They remember bad times and often distort good times with worries.

- Washburn Center Developmental Repair Training Manual

Children who have experienced Trauma Have: **Inadequate Skills**

- Because they have poor language skills, or don't rely on words, they resort to actions like hitting, kicking, spitting, and swearing.
- Their problem-solving skills are poor, and their solutions usually make things worse.
- They anticipate difficulties, but rarely seem to learn from new experiences.

- Washburn Center Developmental Repair Training Manual

Change “Children” to “Adults”

Confusing Interactions, Emotional Reactivity, Distorted Perceptions, Inadequate Skills.

Paper Plate Babies

Love isn't a state of perfect caring. It is an active noun like "struggle." To love someone is to strive to accept that person exactly the way he or she is, right here and now.

-Fred Rogers

Parental Mental Health and Unfortunate Trends

“Difficult Regulatory Partners”

One-third, or 33 percent, of adults report changes in sleeping habits, 32 percent report headaches and 27 percent report an inability to concentrate due to stress. Not only that, 47 percent of adults report losing patience with or yelling at their partner, and 46 percent report similar behavior with their children because of stress.

American Psychological Association's Stress in America survey,

The Role of Stress and Depression in Early Intervention and Support Services

- High Rate (>40%)
- Multiple Stressors in both EI and Tracking:
  - Grief and adaptation related to receiving diagnosis or result of delay.
  - Stress, both acute and over time, of multiple birth and/or NICU experience.
  - Stress of appointments and therapies centered around child.
  - Economic stress of delay and disability.
  - CYF and foster care amplifies risk of difficult attachment and depression.

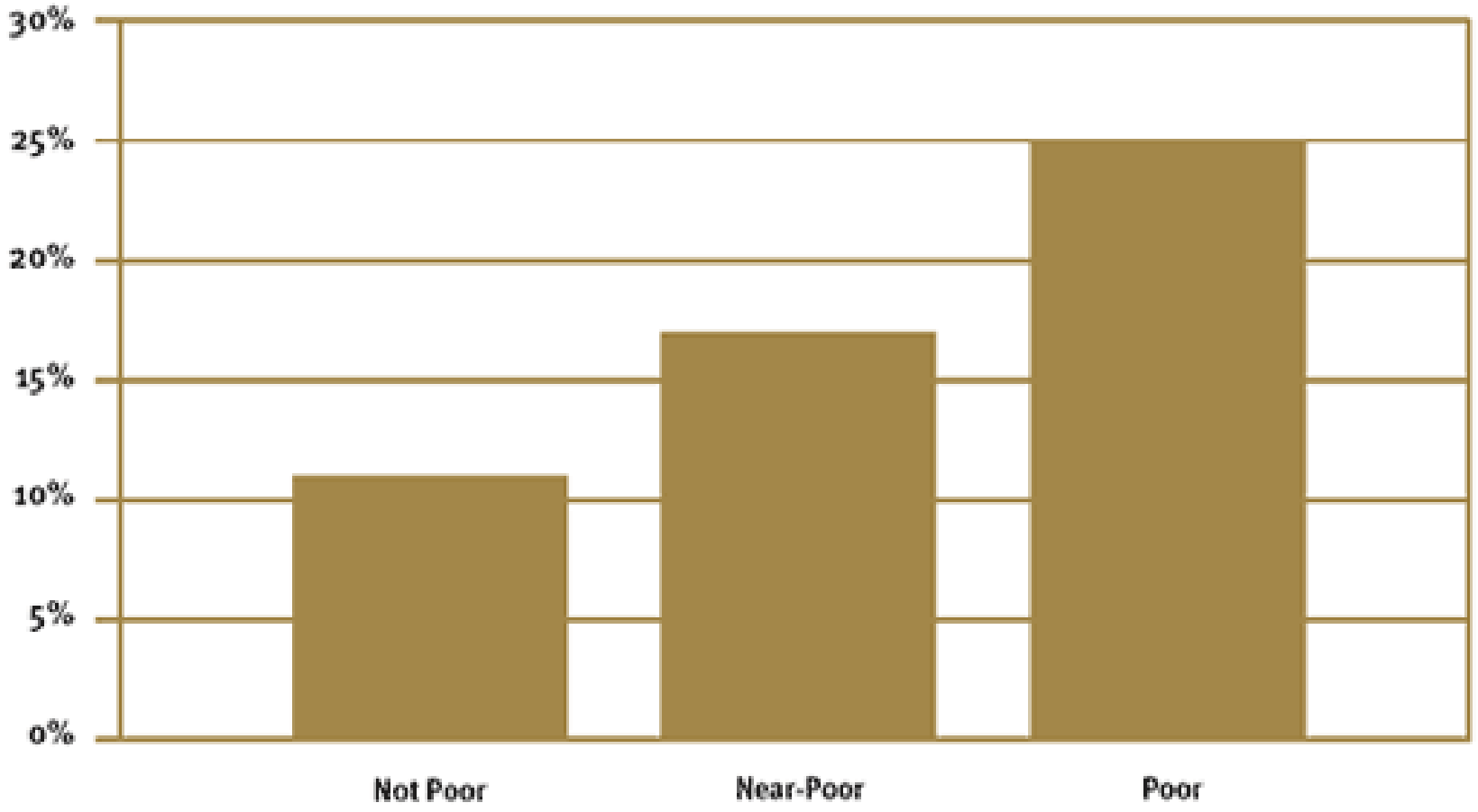
Major depression

- One of the **most common** mental disorders in the United States. For some individuals, major depression can result in severe impairments that interfere with or limit one's ability to carry out major life activities.
- A period of **two weeks or longer** during which there is either depressed mood or loss of interest or pleasure, and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, self-image or recurrent thoughts of death or suicide.
- Unlike the definition in the DSM-IV, no exclusions were made for a major depressive episode caused by medical illness, bereavement, or substance use disorders.

Depression and Women

- Experience depression more often than men
- Biological, life cycle, and hormonal factors that are unique to women may be linked to women's higher depression rate.
- Typically have symptoms of
  - Sadness
  - Worthlessness
  - Guilt

Maternal Depression Affects Children in Low-Income Families Disproportionately



Percent of mothers with a 9-month-old infant who are moderately or severely depressed

Harvard Center for the Developing Child

Risk Factors for Parental Mental Health Issues

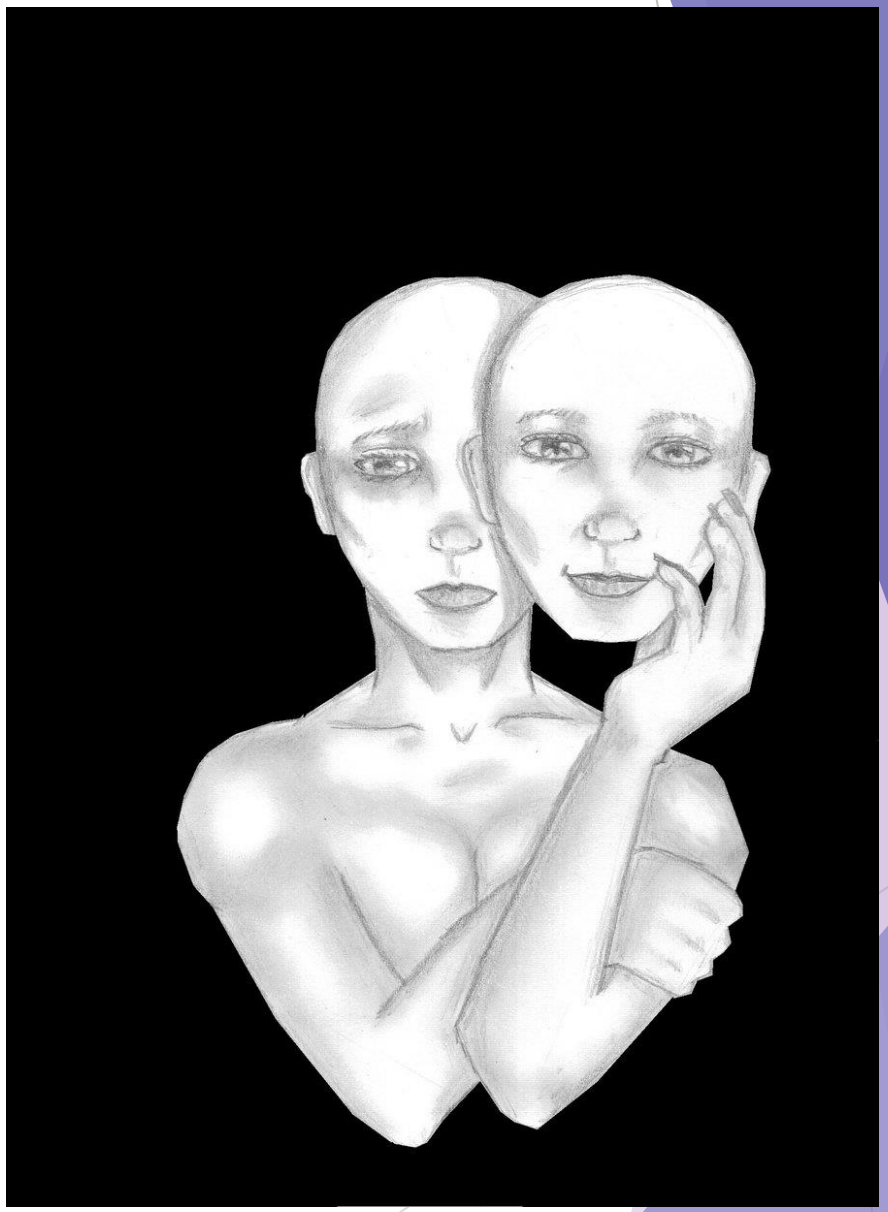
- Loneliness
- Lack of social support
- Recent stressful life experiences
- Family history of Mental Illness
- Marital or relationship problems
- Identifying as 2 or more races
- Financial strain
- Early childhood trauma or abuse
- Alcohol or drug abuse
- Unemployment or underemployment
- Health problems or chronic pain

Depression Incidence by the Numbers

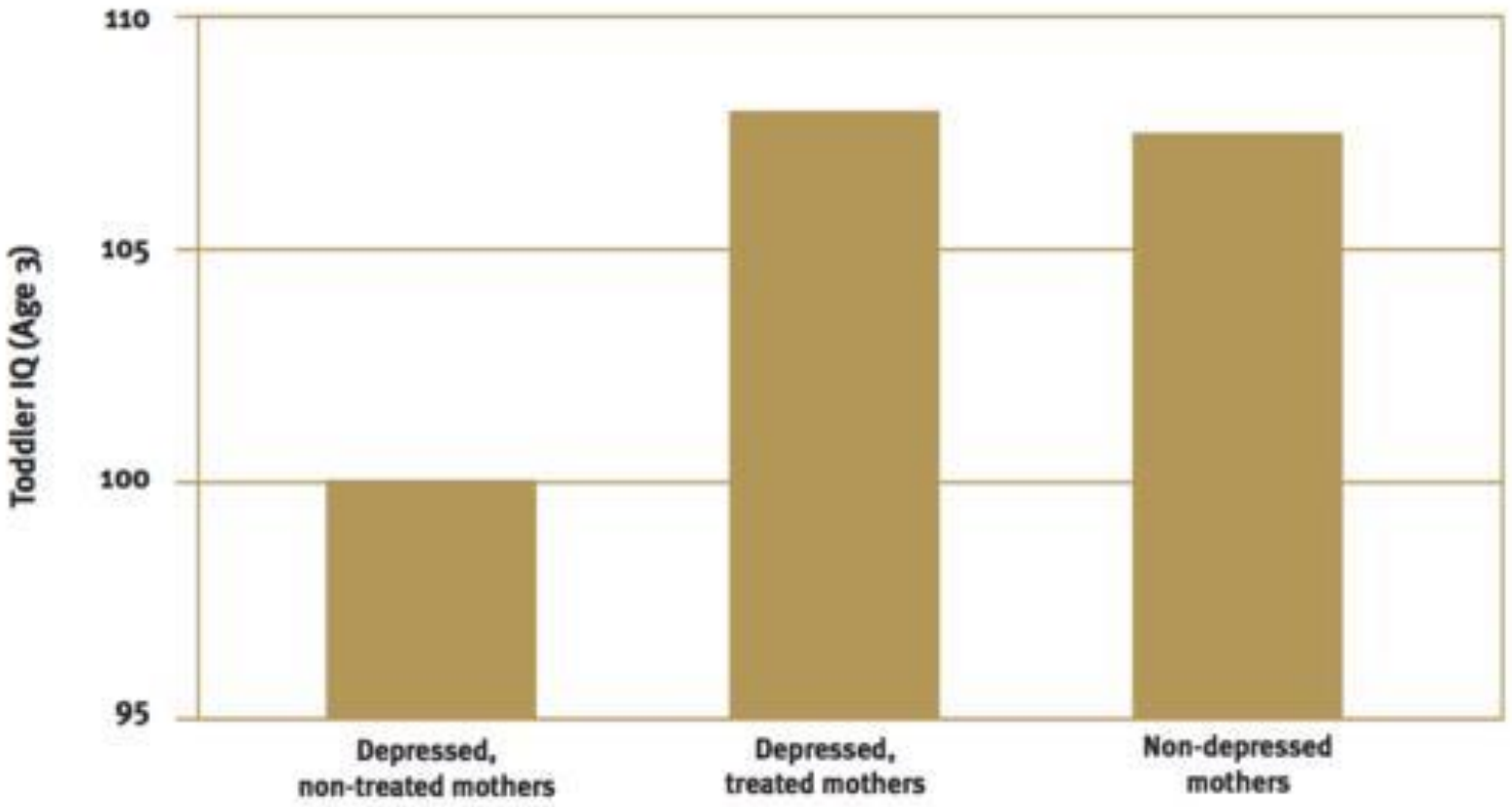
- Depression Alone- 10%
- “Baby or Maternity Blues”- 50-80%
- Postpartum Depression- 13%
- Postpartum Psychosis- 1-2 per 1,000 deliveries
- Posttraumatic Stress Disorder related to childbirth- 3-6%
- 75% of adults diagnosed with major depression have at least one other mental health diagnosis

Depression Treatment

- An estimated 44% received combined care by a health professional and medication treatment.
- Treatment with medication alone was least common (6%).
- Approximately 37% of adults with major depressive episode did not receive treatment.



Toddler-Parent Therapy Improves Cognitive Development



Mothers with a major depressive disorder were randomly selected to participate in Toddler-Parent Psychotherapy as a preventive intervention for their children, age 20 months at entry to program. Children's scores on Bayley Mental Developmenet index did not differ at age of entry, but significant differences appeared in IQ tests given at age 3.

Source: Cicchetti, Rogosch, and Toth (2000).

How Caregiver Depression Effects Attachment

- Caregiver may be insensitive/ unresponsive to a baby's communication cues or provides inconsistent response to the cues.
- May be unable to recognize the cues.
  - Over/under stimulating the child.
- Caregiver talks about the child in negative terms or rejects the child.
- Often appears angry or irritated with the child.
- Expresses emotions in a fearful or intense way (looking overwhelmed).
- Inappropriate expectations for the child's age.

Ed Tronik- Still Face Paradigm

Edward Z. Tronick, MD,

Caregiver Depression and its Effect on Attachment

Researchers in Israel found that **the babies of depressed mothers scored the poorest on all outcomes of social engagement, fear regulation, and physiological stress reactivity** after 9 months. **The infants showed the lowest levels of social engagement during interactions with their mothers**, **were unable to self-regulate** during situations that introduced novelty, **fussed and cried more often**, and their physiological stress response showed both higher baseline levels and a more pronounced stress reactivity.

- *Journal of American Academy of Child and Adolescent Psychiatry Vol. 48, Issue 12 (2009)*

Impact on Delivery of Services

- Widely recognized that mental illness, particularly depression, interferes with the effective delivery of home visitation services.
- Symptoms of depression (poor concentration, fatigue, poor memory) interfere with learning and challenge home visiting professionals who are not always comfortable addressing depression.
- Professionals are not always prepared to divert attention from the goal of a child-centered service.

– Ammerman, R., et. al., 2002, and Ammerman, R., Putnam, F.W., et al., 2005

Anxiety

- The presence of excessive worry about a variety of topics, events, or activities. Worry occurs more often than not for at least 6 months and is clearly excessive.
- The worry is experienced as very challenging to control. The worry in both adults and children may easily shift from one topic to another.
- The anxiety and worry are accompanied with at least three of the following physical or cognitive symptoms (In children, only one symptom is necessary for a diagnosis of GAD):
- Edginess or restlessness
- Tiring easily; more fatigued than usual

- Impaired concentration or feeling as though the mind goes blank
- Irritability (which may or may not be observable to others)
- Increased muscle aches or soreness
- Difficulty sleeping (due to trouble falling asleep or staying asleep, restlessness at night, or unsatisfying sleep)

8 WAYS A CHILD'S ANXIETY SHOWS UP AS SOMETHING ELSE

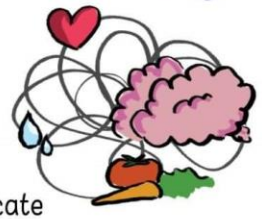
1. Anger

The perception of danger, stress or opposition is enough to trigger the fight or flight response leaving your child angry and without a way to communicate why.

2. Difficulty Sleeping

In children, having difficulty falling asleep or staying asleep is one of the hallmark characteristics of anxiety.

3. Defiance



Unable to communicate what is really going on, it is easy to interpret the child's defiance as a lack of discipline instead of an attempt to control a situation where they feel anxious and helpless.

4. Chandeliering

Chandeliering is when a seemingly calm person suddenly flies off the handle for no reason. They have pushed hurt and anxiety so deep for so long that a seemingly innocent comment or event suddenly sends them straight through the chandelier.

5. Lack of Focus

Children with anxiety are often so caught up in their own thoughts that they do not pay attention to what is going on around them.

6. Avoidance

Children who are trying to avoid a particular person, place or task often end up experiencing more of whatever it is they are avoiding.

7. Negativity

People with anxiety tend to experience negative thoughts at a much greater intensity than positive ones.

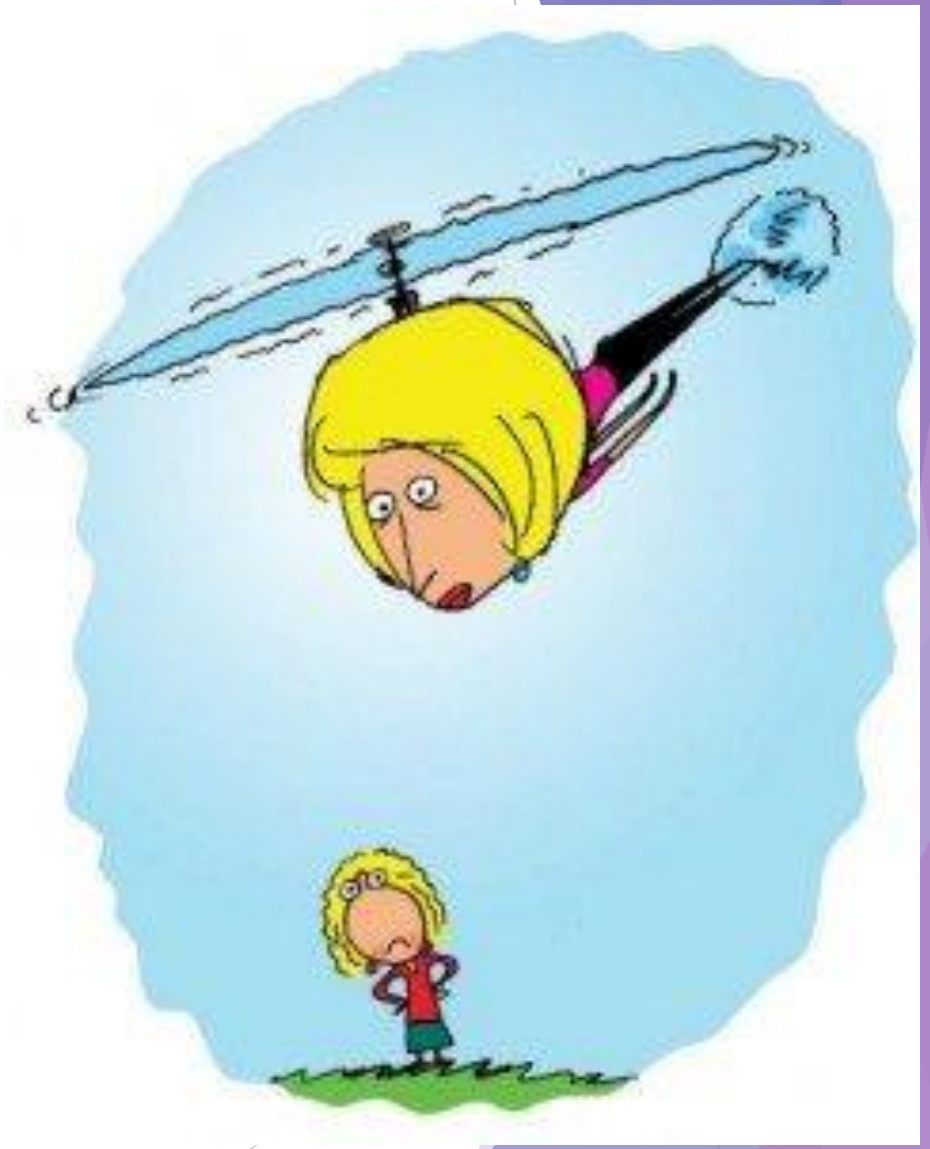
8. Overplanning

Overplanning and defiance go hand in hand in their root cause. Where anxiety can cause some children to try to take back control through defiant behavior, it can cause others to overplan for situations where planning is minimal or unnecessary.

gozen.com

Research suggests that **anxious parents are less likely to grant their children autonomy and more likely to demonstrate lower levels of sensitivity.** Other research found a **significant association between maternal mental illness and permissive parenting (lack of parenting confidence,** lack of follow through) as well as verbal hostility.

- Bridges to recovery



The more severe the parents' psychological problems, the earlier the children's behavioral disorders emerge

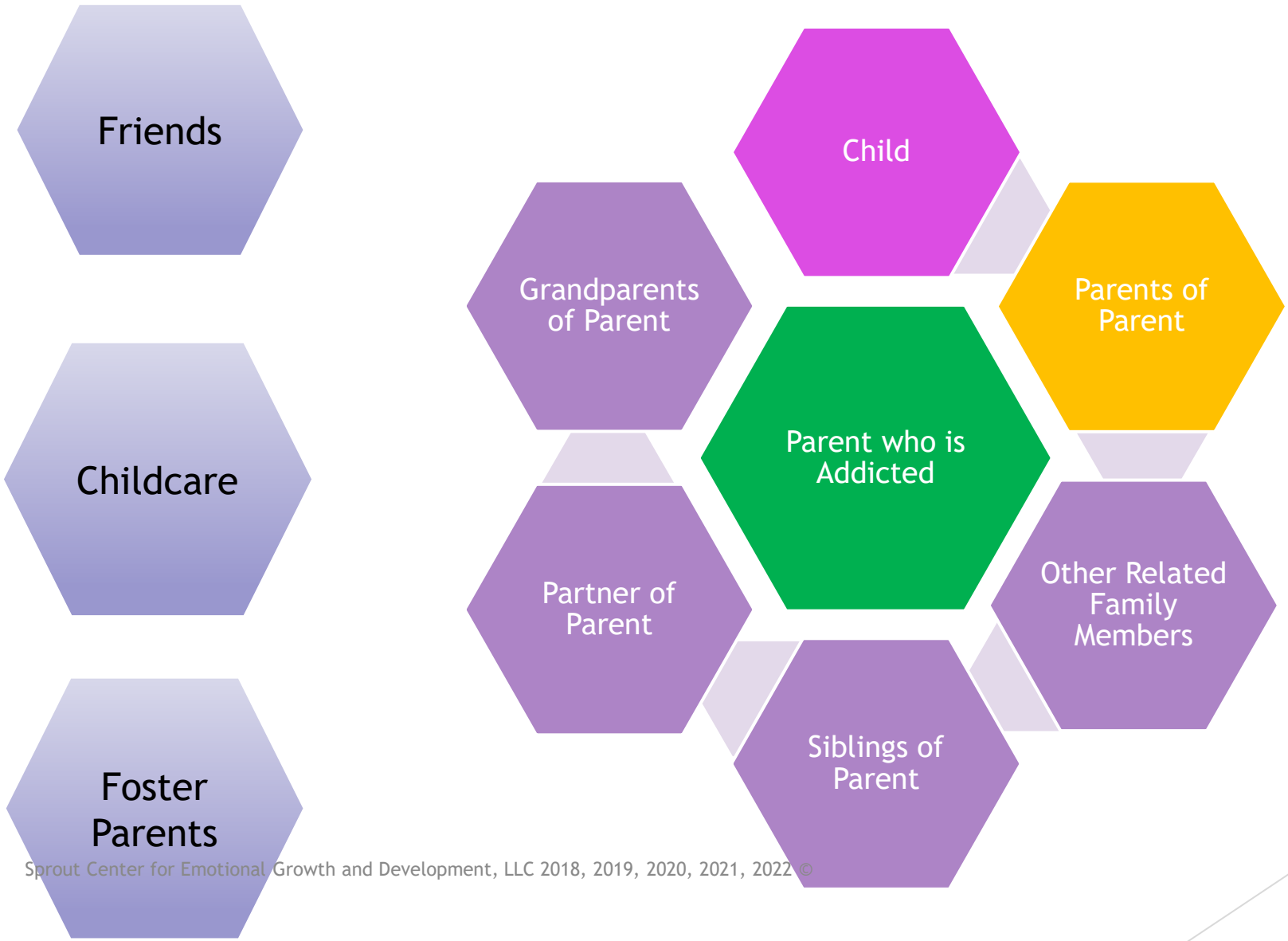
. Narayanan MK, Naerde A. Associations between maternal and paternal depressive symptoms and early child behavior problems: Testing a mutually adjusted prospective longitudinal model. Journal of affective disorders. 2016;196:181–9. doi: 10.1016/j.jad.2016.02.020

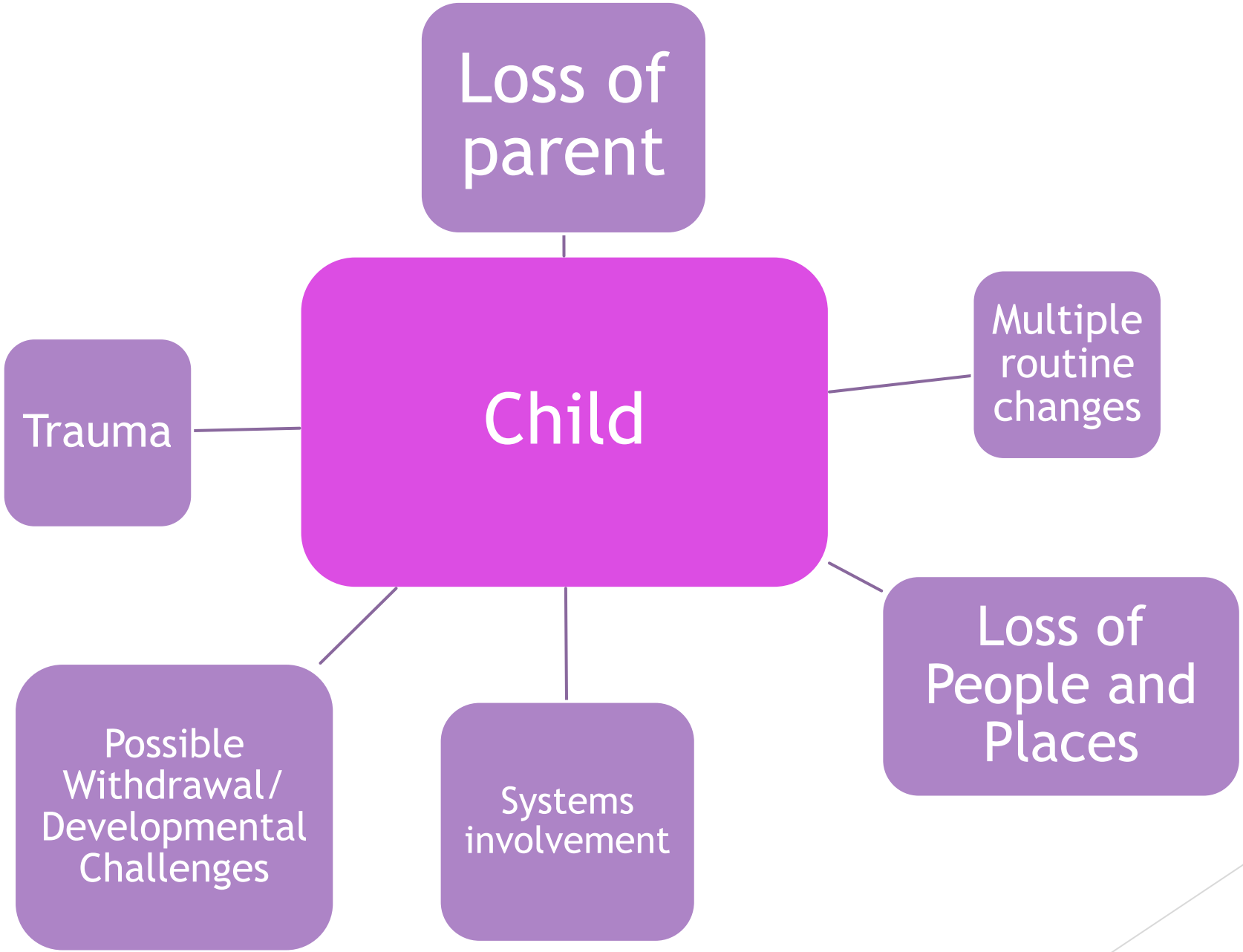
Substance Misuse Disorder

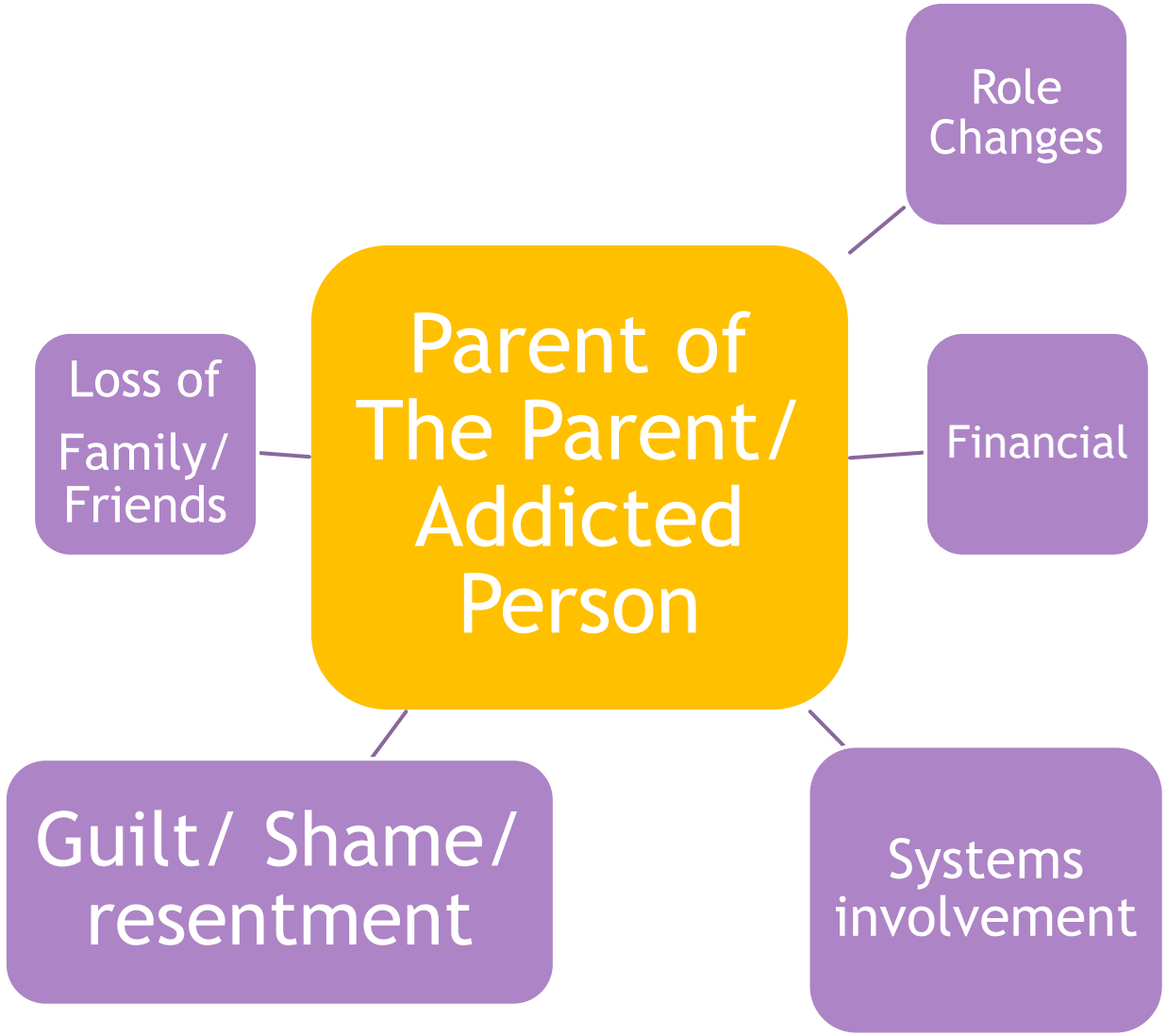
Opioid and NAS Statistics

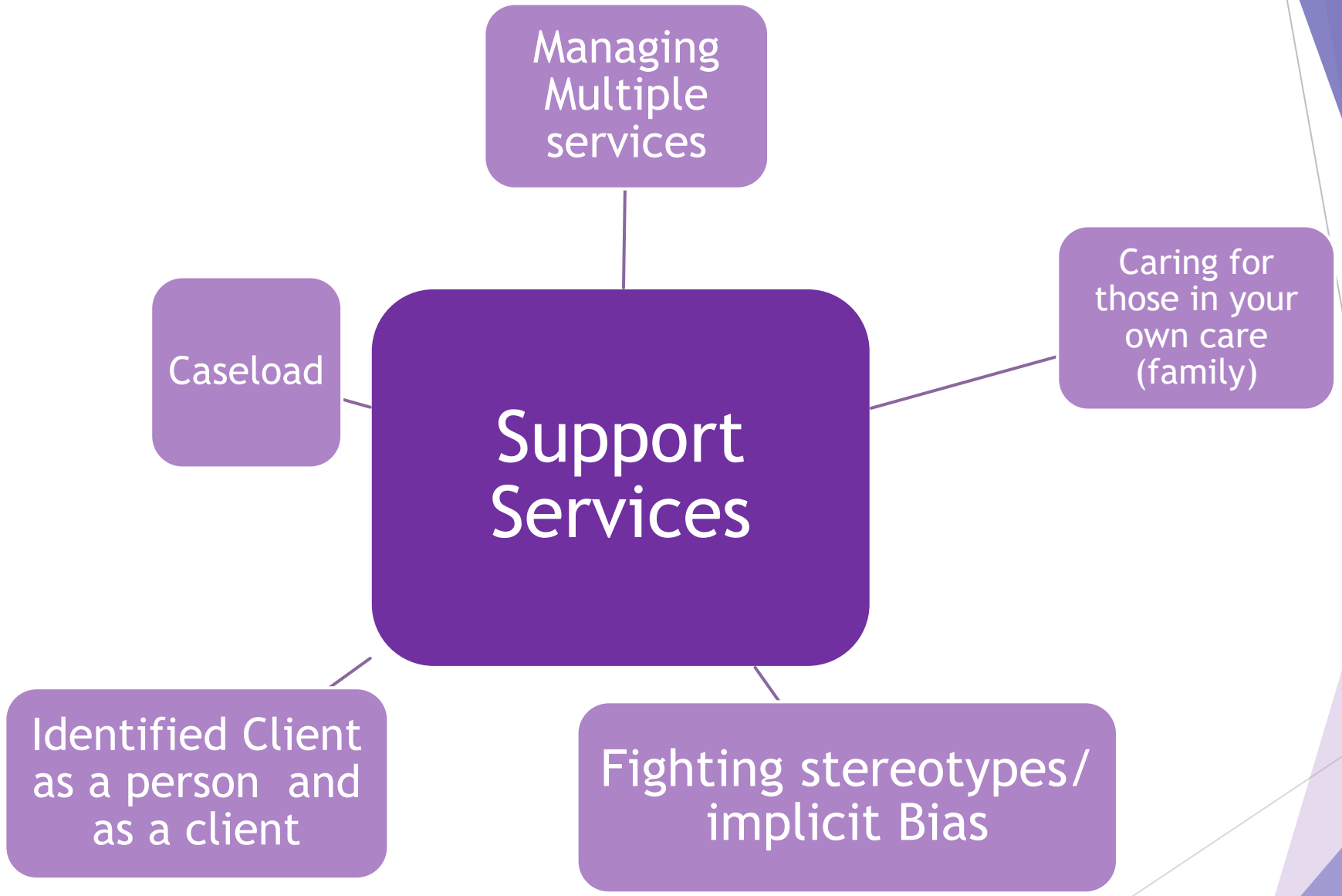
- 1 Baby born every 15 minutes is born with opiate dependence- NPR
- From 2015-2018 number of children in foster care jumped 11 percent
  - Nearly 437,000 Children – Adoption & Foster care analysis reporting
- Parental Substance use cited as a factor in 36% of all foster placements (2017 APA).
- Delaware's average is 20.9 per 1,000 births

Who are we working with?









Multiple Trauma Exposure

- Home Changes
- Potential viewing of incapacitated/overdosing parents
- Law enforcement involvement
- View of overdose
- Limited Supervision
- Missed Education

Shaking of Trust

The message of **“Don’t talk about it”** is written all over opioid use.

Children who are receiving the “Don’t Talk About It Message” show behaviors of:

Shutting down and not talking or babbling/ “baby talk”

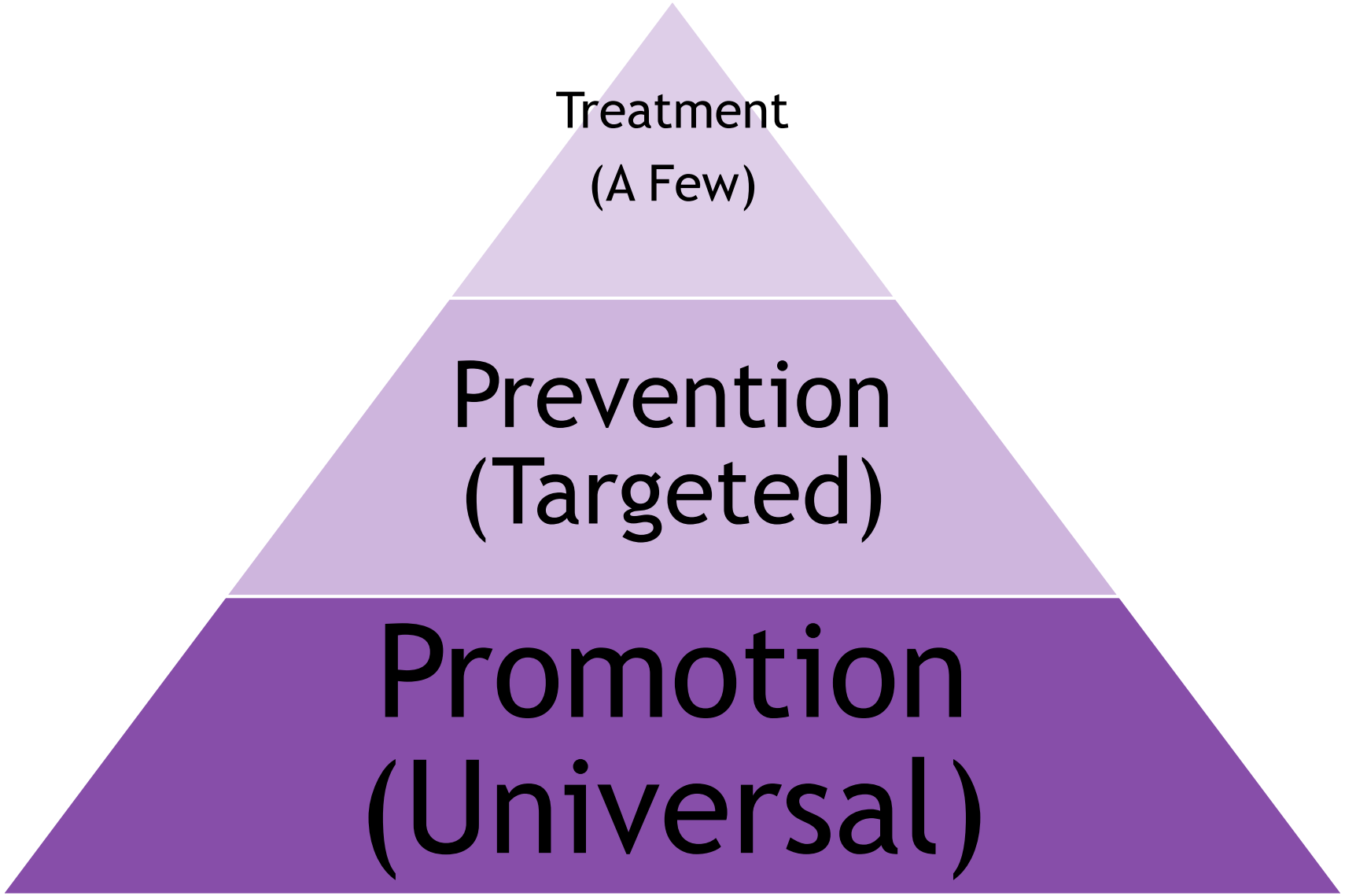
Avoiding questions about family members

Suddenly becoming silly or angry

Changing the subject

“little lies”

Supporting Families and Using our skills



What Parents look for

- 1. Personal Attributes of the Therapist/ Home visitor
- 2. Practical or Concrete Assistance
- 3. Noticing the child and listening to the parent in an effort to understand
- 4. Talking with the parent about the baby, offering developmental guidance and information specific to each child and family member.

Infant Mental Health Home Visiting Strategies
From the Parent's Point of View
Deborah Weatherston 2010

What Parents look for

- 5. Offering positive reinforcement and encouraging parents
- 6. Offering emotional responsiveness and support to parents experiencing intense conflict, unresolved losses, and traumatic experiences past and present. That interfere with the loving care of their children and awaken the expression of complex emotions
- 7. Offering a context in which parents think about themselves and their children.

Infant Mental Health Home Visiting Strategies
From the Parent's Point of View
Deborah Weatherston 2010

Personal Characteristics and Attributes

Understanding
Compassionate
Knowledgeable
Perceptive
Patient
Attentive
Humorous
Comfortable
Nonjudgmental
Available
Flexible
Supportive
Reliable
Trustworthy
Helpful
empathetic

Relationships and the Home Visit: Who is the Therapist/Home Visitor?

- Family may have mixed feelings.*
- Family wants information that therapist/HV brings.*
- Therapist/HV must manage role as perceived "authority figure" with some families.**
- Therapist/HV must be aware of his or her own feelings and perspectives.*
- Therapist/HV must manage boundaries.

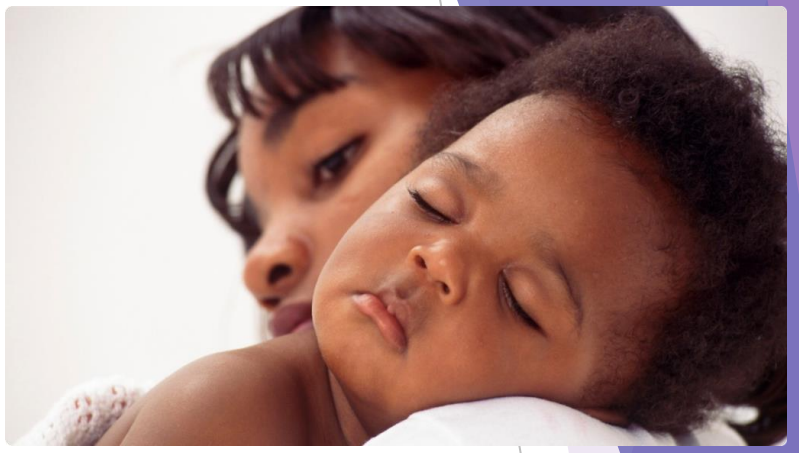
* ***Mental Health in Early Intervention: Unity in Principle and Practice***, Foley, G. 2006

** ***Family and Relationship-Based Principles and Practices***, Pawl and Milburn 2006

Who is The Child?

- Central focus of services
- Impact of temperament: How does caregiver describe child?
- What kind of cues can this child use?
- Ability to effectively use cues can change with the disability/delay:
  - Preemies
  - Fussy babies
  - Blindness/deafness
  - Autism
  - Communication delay
  - Feeding problems
  - Intellectual disability
  - Behavioral issues
  - Parent's needs

Who is The Caregiver?



- Caregiver has a unique perspective that is necessarily different than ours.
- Caregiver always has other family members that impact her/him as well as the child.
- Caregivers need to be seen as valuing their children, despite their circumstance.
- No matter where they are on their road to recovery from depression, grief, or addiction, they are traveling. We know that because they opened the door to us.

Revisiting the Home Visit: Looking Through a Relationships-Based Lens

Weaving into all phases of a home visit:

- Careful listening and reflective comments.
- Respectful "wondering together." *
- Joint observation and problem solving.
- Positive perceptions (noticing strengths).
- Listening for the past.

** Cohen et al, "Watch, Wait, and Wonder", 1999*

Shark Music

Parents are like shuttles on a loom. They join the threads of the past with threads of the future and leave their own bright patterns as they go.

- Fred Rogers

How can we help to decrease the "Shark Music"?

Speaking for the baby

Safe base

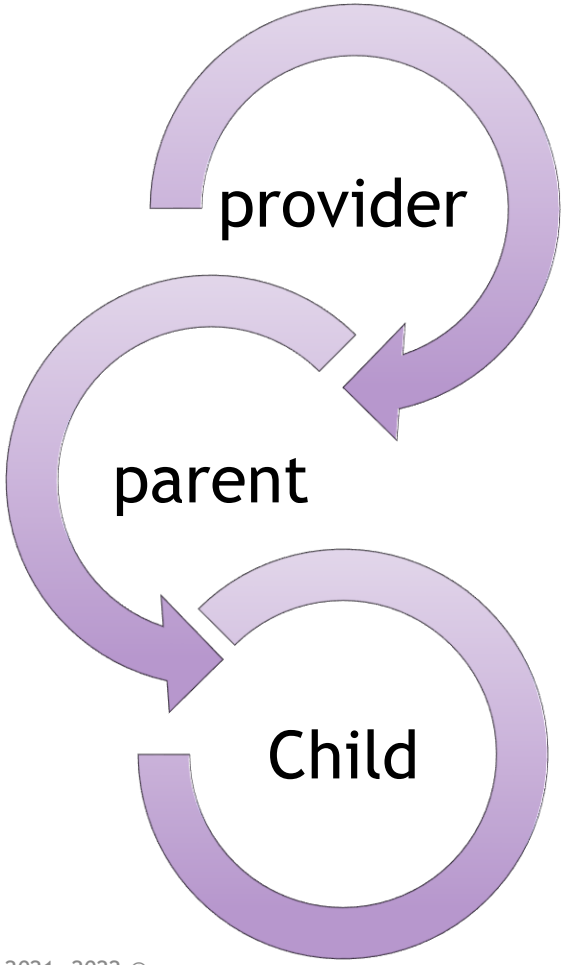
Parallel process

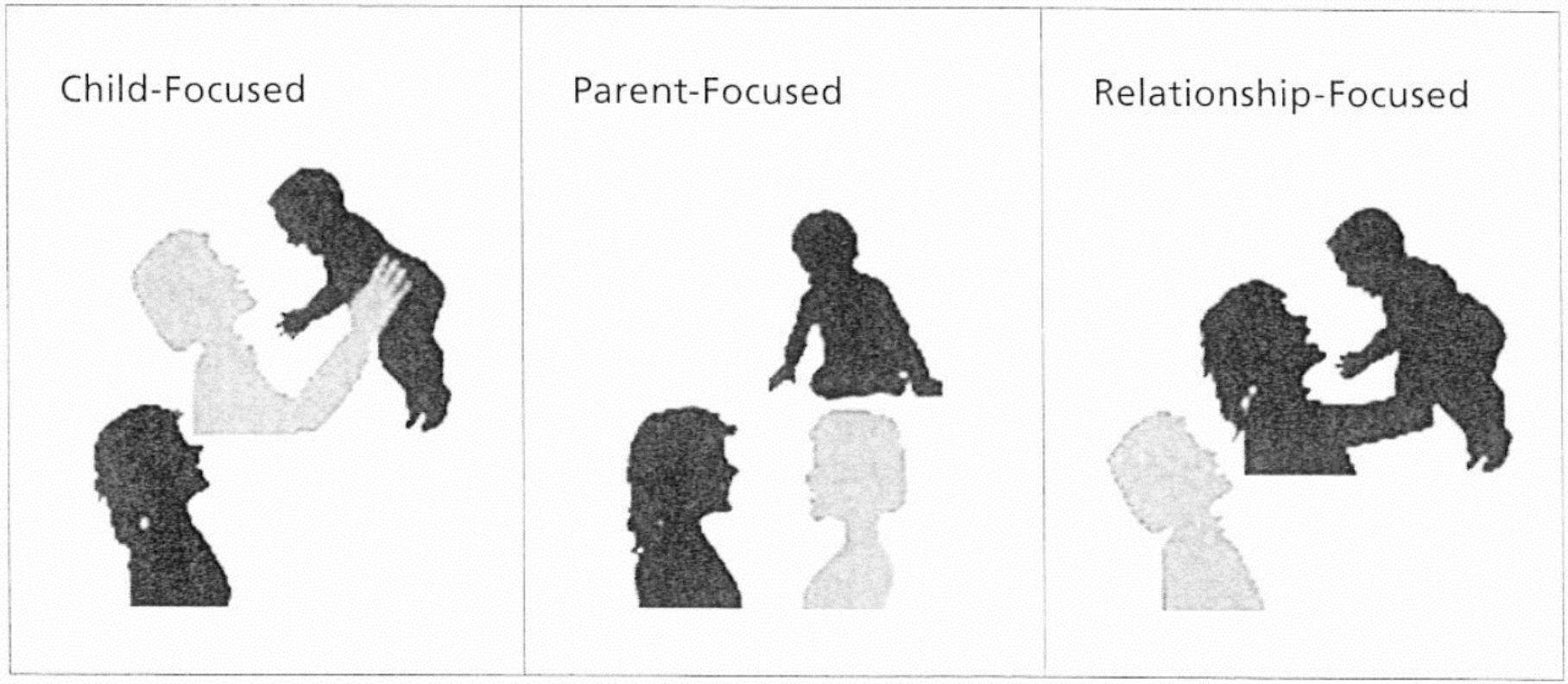
Recognizing ghosts and angels

Wait, Watch Wonder

Reflective Supervision and Practice

Parallel Process

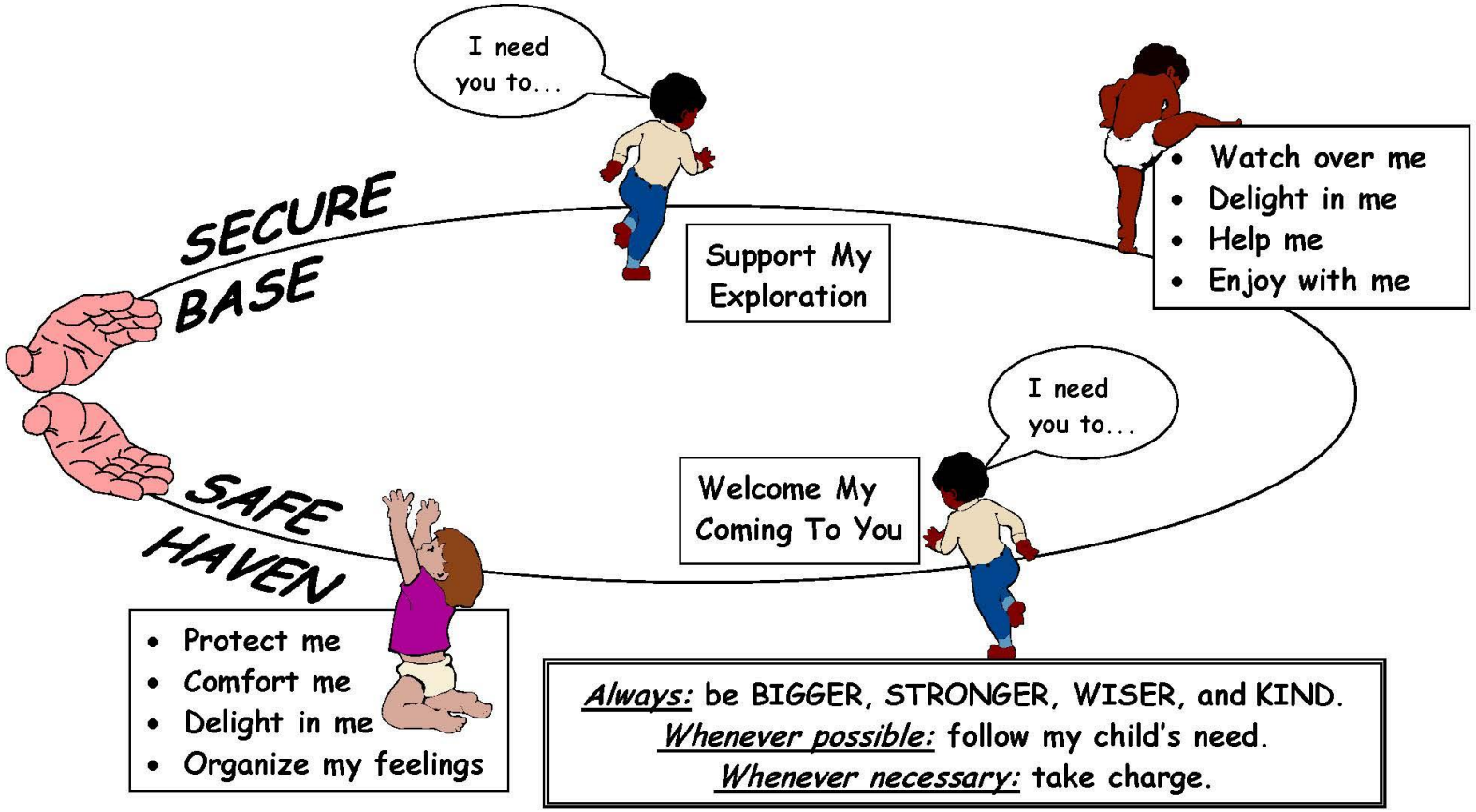




Kelly, Zuckerman, Sandoval & Buehlman, 2003.

CIRCLE OF SECURITY

PARENT ATTENDING TO THE CHILD'S NEEDS



Challenges of Therapeutic Interventions in the Home Environment

- Forfeits one of the key aspects of office-based therapy: the consumer indicates his engagement in the therapeutic process by her/his physical presence.
- "Emotional availability" can change role of therapist/HV into a substitute, fantasy family member. – Boundaries!
- Can be difficult to balance focus with caregiver and infant/toddler in a chaotic, distracting, and sometimes disturbing environment.

(Birch, Marian, ***Finding Hope in Despair: Clinical Studies in Infant Mental Health, 2008)***

Paradigm Shift
(based on Deborah Weatherston, IMH Journal, 2007)

From

- Working with the individual parent or infant
- Working in the clinic or center
- Talking and telling

To

- Working in the context of the relationship of the parent and infant
- Working in the home or other natural environment
- Observing, listening, and reflecting

Shifting

From

- Observing either risks or strengths
- Discipline-specific approach
- Focus only on external social and economic realities

To

- Observing both risks and strengths
- Inter- or trans-disciplinary team approach
- Focus on internal psychological processes in addition to external realities

Careful Listening and Reflective Comments

- **Affirm** when things are difficult (“That sounds really hard to me”) without labeling caregiver’s experience.
- **Acknowledge ambivalence** when you hear it. “You aren’t sure if these visits are a good idea.”
- **Acknowledge depression** and loss when you hear it.
- **Follow caregiver’s lead**: Your thoughtful attention may be the first opportunity they have had to be “heard”. This is not usually the time to offer “solutions” or try to cheer the caregiver up if problems are being talked about.

Wondering, and Working Together

- **Open ended questions**: “What happened when you were a toddler that got into something?”
- **Talking for child**: “Mama is laughing when I press the buttons on the remote but her words sound angry”
- **Sharing developmental information without being directive**: “You’re right, she is really good at understanding your words, I can tell you and she are on the same wavelength!” (positive comment on relationship) “We know that all children this age are learning to learning how to stop themselves.” (Normalizing) ”She will be better at it when she is a little older! What would help her with pushing buttons on the remote until then?” (Open-ended question)
- **Engage caregiver** with the perspective of helping child to learn. “She is interested in your attention and needs your help. By taking the remote away and showing her a paper to crinkle up, you helped her make a choice she isn’t ready to make on her own. You showed her what she could do instead!”

Let’s Practice

Reflective Supervision and Practice

The Story of the O's

by Chandra Ghosh Ippen, Ph.D.

Illustrations by Erich Ippen

Piplo productions

Free download available at Piploproductions.com

Relationships-Based Practice: Wrap Up

- A habit of **observing and listening carefully**
- A willingness to work hard **at supporting and strengthening meaningful relationships**
- A respect for **consistency and continuity with families**, as well as flexibility toward the challenges of depression
- An ability to **invite caregivers to tell us what they saw, felt, heard, or experienced**
- An ability to **establish trust, safety, and security** in our presence
- An ability **to meet families where they are** on their road to adaptation and recovery from any and all life challenges.

- Adapted from "The Infant Mental Health Specialist" Deborah Weatherston, Zero to Three Publications

Often when you think you're at the end of something, you're at the beginning of something else.

- Fred Rogers

Erin Troup, LPC, NCC, CT, IMH-E® (IV Clinical)

412-882-8471

www.sproutcenterconsult.com

SPROUT
CENTER FOR EMOTIONAL GROWTH AND DEVELOPMENT, LLC