

Tasmanian Infant Mental Health Conference  
Tasmanian Early Years Foundation  
8 - 9 November 2011

The baby's right to be heard: Who should  
engage with the troubled infant and her  
parents?

Associate Prof Campbell Paul,  
*Mental Health Service, Royal Children's Hospital,  
University of Melbourne and the Murdoch Children's  
Research Institute*

News of Baby *by Elizabeth Riddell*

Welcome, baby, to the world of swords  
And deadlier words.  
We offer you a rough bed, and tears at  
morning,  
And soon a playground  
Bounded by ice and stones,  
A buttonhole of thorns,  
A kiss on war's corner.

We promise you, baby,  
The stumble of fear in the heart,  
The lurch of fear in the bones.

Painted upon your mother's cheek  
already  
I see the dark effusion of your blood,  
Bending already beside her patient chair  
the bandaged ghosts.  
Welcome, baby, no dread thing will be  
omitted.  
We are your eager hosts.



# Understanding babies and their needs *means looking at ourselves*

Moore

Titan

In the past, how did we see  
the *social and emotional*, and  
physical rights of infants?  
*Does this inform the present?*

**Cascades Female Factory, Hobart  
1828-1856**

Women sent to the factory when  
pregnant  
Some ? 2000+ women

Then infant went to nursery, orphanage  
when weaned for their mothers, as  
mothers returned to work as domestics in  
homes, farms, etc

**Infants : Very high mortality**

What was the impact upon the infants'  
development and attachment ?

There was a Quaker influence, Elizabeth  
Fry

Later an asylum

Lying-in Hospital for single mothers

Truganini was buried here before being  
exhumed

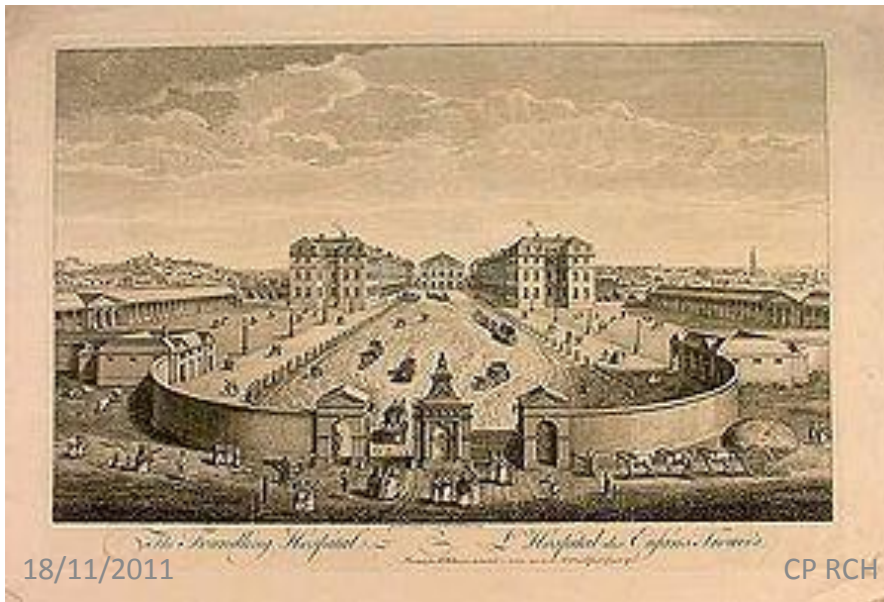
# A more “humane” abandonment of infants in London in the 19<sup>th</sup> century

**The Foundling Hospital was erected in Bloomsbury 1742-1745**

**Parents who are unable to feed and care for their own children placed in the care of the Foundling Hospital.**

**Supported by: GF Handel and W Hogarth amongst others**

**Thomas Coram, former ships captain**



# Spitz

## ***“Grief: a Peril in Infancy” 1947***

- Documented severe neglect and despair of infants and toddlers from after WWI’
- *Emotional Deficiency Diseases*
- Had one intervention showing the importance of a consistent carer, providing an attachment relationship in a children's orphanage
- *Reduced very high infant mortality*
- Still an issue..for *institutionalised and neglected infants*
- <http://www.archive.org/movies/thumbnails.php?identifier=PsychogenicD>

# Infants and profound withdrawal

## Rene Spitz:

- Analytic depression (loss of carer) 'Hospitalism' 1945
  - apprehension, sadness, weepiness
  - lack of contact, rejection of environment, withdrawal
  - retardation of development, retardation of reaction to stimuli, slowness of movement, dejection, stupor
  - loss of appetite, refusal to eat, weight loss
  - insomnia



# Dyadic Depression

## - *Presenting Problem*

- 13 month old girl.....Jane
- severe failure to thrive below 3 percentile
- admitted to paediatric hospital for 4 weeks
- all investigations normal, except for slightly reduced iron levels
- **on admission lethargic, withdrawn, passive, developmental regression / delay**
- **continued poor oral intake**
- **intensive nursing with primary care nursing team**
- **diet consisted of:**
  - » **breast milk ?... volume**
  - » **cow milk**
  - » **some vegetables**

# Mother's history and progress:

- *History of severe depression during late pregnancy and post partum months*
- *withdrawn, quiet “like in a black hole”*
- *no treatment*
- *supported by peers in communal house*
- *The best was there but seemed to be as a **plug** not for nutrition. She was quiet.*
- *subsequently psychotherapy when infant 10 months old, but the baby was not seen , although present*
- In the context of infant-family therapy, with both mother and father present, we could see that baby was seeking engagement, to be with her parents
- Jane responded to intervention from a small group nurses
- The family felt contained in hospital context while a new relationship was established for Jane with both her mother and her father
- Gradual improvement in eating, communicating, capacity to play an overall development.
- Jane had ongoing mild speech and developmental delay into her school years, although her mood improvement was dramatic and sustained.

## possible **infant and toddler presenting problems**

- Post traumatic Stress Disorder
- Disorders of Affect, Adjustment Disorder
- Regulation Disorders of Sensory Processing
- Sleep Behaviour Disorder
- Feeding Behaviour Disorder
- Attachment disorders
- Disorders of Relating and Communicating
- Relationship disorders such as
  - Over-involved, Under-involved, Anxious/Tense, Angry/Hostile, Mixed Relationship Disorder, Abuse Relationships (physical, verbal, sexual) (AXIS II Classifications) (DC: 0-3R, 2004)
- Other Disorder

Using diagnostic criteria **DC: 0 -3R multi-axial classification system of disorders**, or ICD-10, or DSM-IV-TR

# Babies and toddlers do have mental health problems

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

*Briggs-Gowan and Carter(2008)*

- **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 six commencing primary school:
- *The early detected problems were largely ones which endured into primary school*

**ICD 10 diagnoses axis I, II and III (N : 211)**  
**In Children 1½ years old**  
*Copenhagen Child Cohort 2000*

**Axis I Psychiatric Syndrome**

- Developmental Disorders 2.8%
- Hyperactivity/Attention Deficit Disorder 2.4%
- Disorders of Conduct & Emotions 4.3%
- Reactive Attachment Disorder 0.9%
- Eating Disorder 2.8%
- Sleeping Disorder 1.4%
- Adjustment Disorder 3%
- Other 0.5%
- **All disorders: 16.1%**

**Axis II Specific Developmental Disorder**

Developmental Disorder 1.9%

**Axis III Intellectual Level**

Psychomotor Retardation 1.4%

*‘The prevalence of mental health problems in children 1½ years of age – the Copenhagen Child Cohort 2000 ‘*

Skovgaard et al Journal of Child Psychology and Psychiatry 48:1 (2007), pp 62–70

# Mental Health Disorders in Early Childhood

Egger & Angold 2006

Egger & Angold 2006	age 2 to 5 years	age 8 to 17 years
Any diagnosis	16%	26%
Serious emotional disorder	12%	13%
Anxiety Disorder	9%	8%
Disruptive behaviour disorder	8%	6%
ADHD	4%	3%
Depression	2%	3%

## John Bowlby, James and Joyce Robertson

- Young children and hospitalisation
- Distress after parents visit: visiting restricted as it interfered with care of children
- Exposure of the child's severe distress and withdrawal caused major controversy
- Later change in focus on psychological **needs of the child in hospital**

## Attachment and separation: Impact on the 'ordinary' child

Laura, 2y 5m old , spends 10 days in hospital

Correlates with the **Strange Situation Procedure (SSP)**

**James and Joyce Robertson** introduce the medical and nursing world to the impact of even relatively short term separation for a child from caregivers  
Eventually , this lead to major changes in hospital care of children

**Bowlby**  
**Anna Freud**  
**Winnicott**

had already noted the impact upon very young children of disrupted attachment during and after WWII

Eg evacuation to war nurseries out of London

**M Rutter** discussed his personal experience in Finland at ESCAP Congress

## A TWO YEAR-OLD GOES TO HOSPITAL

by JAMES ROBERTSON

A Scientific Film (1952)

web site for [Robertson Films](#)



A Two Year-Old Goes To Hospital

**Classic film showing the suffering of a little girl in hospital separated from her mother**

. A vivid study of the problem of admitting to hospital a child who is too young to be effectively prepared for the experience or to be made contented in the absence of her mother. *This film has been designated "of national and historic importance" and a copy is being preserved in the National Archives.*

# The Mother Baby Relationship

Donald Winnicott

- The '**Good enough mother**'...she contains his anxieties
- Allows for the baby to feel omnipotent at first....to let him feel **HE** created things..the world..
- Then she gradually,predictably allows him to become **dis-illusioned...**
- The baby moves from a position of total dependence to relative independence

# The **mirror** role of the mother

after Winnicott

- ‘What does the baby see when he looks at his mother’s face?’
- ..he sees himself
- The expression on the mother’s face reflects what she sees in her baby
- When the mother is *depressed*, her face is a mirror to be *looked at*, not into.’

# Still Face paradigm: Ed Tronick and Lynne Murray)

# What is attachment?

- Bowlby(1969):
- *a strong disposition to seek proximity to, and contact with, a specific figure and to do so in certain situations, notably when frightened tired or ill.*
  - **Attachment behavioural system**
    - *operates in tandem with*
  - **Exploratory behavioural system**
- *If the child feels **secure** in the presence of an attachment figure, then the child's motivation to venture out and **explore** increases*
- *If the child becomes frightened or stressed, motivation to explore reduces and **seeks proximity***

# Response to separation

- **protest**
  - clinging, crying, screaming
  - anxious searching.
- **despair**
  - listless & no interest in surroundings, refuses food,
  - occasional tears ie preoccupied with mother but hopeless
- **detachment** *over time*
  - self centred,
  - invested > objects than relationships, may interact

# Attachment: Bowlby

- The dyadic experiences of attachment lead to a representational **internal working model** of relationships, such that the dyadic feature becomes a personal quality

Rutter 2009

The **dyadic attachment behaviour** was able to be operationalised , and measured, by Mary Ainsworth with a **strange situation procedure (SSP)**

# attachment behaviour....

- ‘made up of a number of component instinctual responses which are at first relatively independent of each other.
- These mature at different times during first year of life and develop at different rates
- they serve the **function of binding the child to the mother** and
- contribute to the **reciprocal dynamic** of binding mother to child
- ...**sucking, clinging and following** (not letting mother out of sight or earshot) in which **baby is principal active partner** and **crying and smiling** in which his behaviour serves to **activate maternal behaviour.**”

# *Operationalising: Strange Situation*

## **Procedure: Mary Ainsworth**

**each episode lasts 3 minutes**

1. Introduction
2. Baby alone in playroom with mother
3. Stranger enters the room
4. Mother leaves the room
5. Mother returns. Stranger slips out of room
6. Mother leaves -- baby alone
7. Stranger returns & tries to comfort the baby
8. Mother returns

# Classification of attachment dyads: SSP

from Zeanah, Berlin and Boris 2011

Infant -parent dyad classification	Reunion behaviour	Prevalence (low-risk samples)
secure	Infant Expresses distress; active comfort seeking; resolves distress, resume exploring	65%
avoidant	Minimal response to separation, may be reduced exploration; ignore/actively avoid caregiver on reunion	20%
resistant	Intense distress at separation, attempts to get comfort limited, awkward or interrupted; incomplete resolution of distress on the union; resists caregiver attempts	10%
disorganised	Anomalous reactions: mix of rapid, incoherent sequence proximity/avoidance-seeking, resistance, fearful of the parent (e.g. Trying to leave, prefer stranger, intensely fearful response) [? Dissociative moments]	15%

# Disorganised Attachment Dyad

## D classification

- child displays **‘contradictory and unintegrated behaviours towards caregivers when comfort is needed’**..confused and unintegrated approach/avoidance responses to others. Confused, disoriented mind states and interrupted misdirected behavioural responses in S S
- **Evident by 12mo in 15% (US)**
- Associated with Hostile/Helpless carer behaviours
- Frightened/frightening
- *Lyons Ruth, Hesse*

## Still Face Procedure at 3-6 mo

- Can show a Differential response of **Organized vs. Disorganised** attachment dyads:
- *The amount of time of **baby looking away** from mother who has resumed gaze; increases with ‘D classification’*
- *See Gergeley, Fonagy, Koos et al, 2004*

# Problems of Attachment

- 1. Reactive attachment disorders:** severe developmental trauma
- 2. Disrupted attachments,** with a range of outcomes for infant: depression, anxiety, hostility, feeding problems : Relationship based problems
- 3. Dyadic attachment classification :** insecure, disorganised ay be associated with other problems

# Attachment Disorders

*'The attachment system serves to ensure survival of offspring by promoting mutual proximity of infant and caregiver, protection from danger'* (Stafford and Zeanah, 2006)

- Children with disorders of attachment will demonstrate problems or deviations with behaviours associated with ensuring **proximity and safety**.
- Persists over a period of at least six months and involving different caregivers

# Attachment disorders?

- Classification of dyadic attachment behaviours
  - Assessment using *the strange situation, still face, adult attachment interview, parent development interview, working model of the child interview, and other methods*
  - **Not pathological**, but **insecure** classification may be indicative of greater risk of significant childhood psychopathology
  - **Disorganised dyadic classification , more likely associated with disorders** ( & 65% of institutionalised children demonstrate D behav)

# Attachment disorders/behavioural patterns

Carl Heinz Brisch 2002

- **Non-attached attachment disorder**
  - No attachment behaviour towards anyone
- **Undifferentiated attachment behaviour**
  - Friendly to everyone, social promiscuity
- **Exaggerated attachment behaviour**
  - Excessive clinging
- **Inhibitive attachment behaviour**
  - Excessive compliance, minimal reaction to separation
- **Aggressive attachment behaviour**
  - Physical or verbal aggression in the context of separation
- **Attachment behaviour with role reversal**
  - childhood parentification
- **Psychosomatic symptoms**
  - inadequate growth, hospitalism

# Reactive Attachment Disorders

- *Aberrant social behaviours (attachment), appearing in early childhood across different social contexts, as a consequence of pathogenic care: **severe abuse, institutionalisation***
- Onset before
- *Prevalence*: not known, but maybe very common in the context of **child maltreatment and neglect**,
- *Course*: *significant improvement if early intervention (? < six months)* some problems persist despite early change of caregiver (*risk for later personality disorder developments*)
- **Better outcome for inhibited type**
- 40% atypical insecure pattern years after adoption
- Treatment : Not known (EB) but should be long term care
- *'Holding' therapies contraindicated*

# Reactive Attachment Disorders

## ICD10 and DSM IV

### Emotionally withdrawn/ inhibited

- Absence of tendency to initiate or respond to social interactions
- Inhibited, hypervigilant ambivalent reactions
- Low positive affect
- Outbursts of irritability or fear
- Rarely seeks or responds to comfort
- Less common after foster care

### Indiscriminately social/disinhibited

- Demonstrates overly familiar behavior and reduced or absent reticence around unfamiliar adults.
- Rarely or minimally checks back with adult caregiver after venturing away even in unfamiliar settings.
- Willing to go off with an unfamiliar adult with minimal or no hesitation.

# Reactive attachment disorders

## Co-morbidity

- Mental retardation  
cognitive delays
- Speech and developmental  
delays
- Infant depression
- ***Quasi-autistic syndromes***  
(Rutter et al 1999)

## Differential diagnosis

- Autism spectrum disorders (?  
co-morbidity also)
- Infant depression
- Post traumatic stress disorder  
(complex trauma)
- Attention deficit/hyperactivity  
disorder
- Oppositional defiant and  
conduct disorders

# Autism spectrum disorders and dyadic attachment classification

- *Children with autism may* have a similar range of Strange Situation Procedure attachment behaviour classifications
- Oppenheim

# *Amelia*: nearly 2 yo in China, orphanage

Multiple carers, neglect  
Abandonment in the presence  
of people  
Pain as neonate?  
Feeding trauma  
Feeding refusal

Memory of early trauma?  
*Plastics*

- *Newborn found abandoned in plastic by the railway line*
- Raised in orphanage shearing a cot with a baby with severe cerebral palsy
- Visual impairment undiagnosed
- Force fed, later gastrostomy fed
- Absent vocalisation
- Avoidant engagement with anyone
- Volunteer carer adopts Amelia after 18 months

# Amelia: aged 8y3m: Progress

- Four years living with her adoptive family
- Major improvements in most areas: inquisitive
- Feeding well
- speech distorted , not clear, at a 2 to 3 year level:  
*enjoys communicating words gestures and signs; 2-4 word phrases, including affect “I scared”*
- Easily overwhelmed by stimuli
- When frustrated she may hit head
- major planning problems and cognition
- Responsive to family, difficult with peers
- attending normal school with full-time aide
- *Brain mapping: Child Trauma Academy Bruce Perry*

# Quasi Autism Syndrome Rutter

- Seen in some children with severe deprivation from orphanages
- ?? Can be seen in very young children in other situations of severe emotional deprivation in the community
- Other major development problems secondary to severe parental distress, depression: living with an absent parent
- Eg ***Damien 18m old severe feeding refusal, and pervasive developmental delay: speech, motor, emotional, which responds to 2 week intensive tube weaning and therapy program: development suddenly explodes***

# Richard and his mother

- *Mother's EPDS score: 15*
- *"he won't look at me, it is a struggle to get eye contact, he just looks away into space, his eyes roll away." he doesn't ask anything of me*
- *When he cries I can't stand and I have to leave him in his room and go outside.*
- *However he has a normal PEDS score*
- *Richard's ADBB score: 18 (cut point= 4)*

# 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, Matthey

# Infant Withdrawal: ADBBB 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

# Richard 6mo

## Observed behaviour (ADBB)

1. empty facial expression
2. Poor eye contact: empty stare
3. Body stiff, hands closed
4. Self stim: sucks on lip
5. Sparse vocalisation
6. Delayed response to stimulation
7. Difficult to engaged
8. Low attractiveness

*Comments: can warm up with effort, tires? emotionally*

Score: 18 cutpoint=4

## Progress

- 2 weeks later : 'he's not crying'
- Feeding better gained 330gm Taking solids
- No vomiting, Settled at child care
- Play interaction improved
- Mother began antidepressant medication , but 'depressed' again at week 4

# Modified Alarm Distress Baby Scale

(Matthey et al., 2005)

Is a *screening* tool to assess infant withdrawal behaviours:

- 2-24+ months
- based on the ADBB (Guedeney & Fermanian, 2001)
- identifies **need for further investigation** eg of socio-emotional distress, physical illness, developmental disorders

# Maternal depression

- depression may:-
- Effects mother's capacity to care well for her baby
- reduced breastfeeding, difficulties in managing crying, distress
- Preoccupied with her own feelings..missing baby's cues
- may lack contingency: changes in *motherese*..

# Maternal depression and infant toddler development

- *99 families in inner city industrial area..35 mothers depressed*
- *Immigrant mothers: poor English, little family support*
- *Native born mothers: unhappy unstable insecure childhoods*
- ***Behavioural problems more common in those infants and toddlers of depressed mothers***
- *important study looking at women from NESBackground*
- **DEPRESSION IN MOTHERS IN A MULTI-ETHNIC URBAN INDUSTRIAL MUNICIPALITY IN MELBOURNE: AETIOLOGICAL FACTORS AND EFFECTS ON INFANTS AND PRESCHOOL CHILDREN**
- Williams H & Carmichael A
- *J. Child Psychol. Psychiat. Vol. 26, No. 2, pp. 277-288, 1985*

# Mechanisms maternal depression & child outcome: Lynne Murray (2003)

1. **Lack of contingency**..infant has trouble connecting his behaviour and the environment
2. **Insensitive/unresponsive** parent behaviour:hard for baby to sustain attention/interest
3. **Hostility/intrusive behaviour** causes infant distress/disorganisation
4. Reduced parental **imitation** of infant expressions
5. Ongoing dysfunctional cycles of relating long term conflict

# 'Speech' of the Depressed Baby

- Babies can be depressed..withdrawn
- inactivity
- crying
- inexpressiveness
- lack of cuddliness
- poor eye contact
- indifference to separation

# Why is Infant Depression so important?

- Human brain development is experience dependant
- The baby is really a TWO brain setup
- The lack of an attuned other affects brain development directly
- However human has capacity for adaptation of our genetic inheritance (evolution)

# *Depression* may affect child development

- even if the mothers' depression resolved by 2 months, children by 5 years old show more self-negativity and less sense of agency..differences continue into adolescence
- SI lowered IQ and some cognitive difficulties.
- By one year old infant of depressed mother significantly more likely to be *insecurely attached* to their mothers than securely attached .

Lynne Murray (1997)

- *Sroufe (2000) suggests resistant & avoidant attachment is related to depression as adolescents or adults*

# A Global Interactional Assessment Scale :

Lynne Murray ,Winnicott Research Unit, Reading UK

- Mother infant interaction ;view both (mirror ,video) *baby 2 and 4 months old*
- Optimal interaction opportunity :warm, awake ,fed, alert
- Talk and play with your baby ..

# Development of affect regulation

A symbolic representational system of affective states develops as a consequence of:

- Close interactions between infant and caregiver via process of **contingent *marked* mirroring**
- **The caregiver reflects his intentions accurately, and does not overwhelm him**
- Assist in the development of affect regulation, selective attention, secure attachment
- See also: interaction structures of **disruption and repair** (Tronick et al): not *exact* matching. In play only 30% of time relatively matched. other is minor mismatch

# Mothers' brain responses to infant expression of affect is associated with *working model of attachment*

- Looking at own babies happy (or crying) face: Mothers with **secure adult attachment** pattern have preferential activation of nucleus accumbens and medial prefrontal cortex
- Looking at own babies crying: *mothers with insecure/dismissing attachment pattern have activation of the insula* .. Which may indicate triggering sad..? Traumatic autobiographical memories
- Strathearn

# Parental Reflective Function

## Fonagy, Slade(2005) et al

Based on parental interview, the AAI or PDI (parent development interview) or working model of the child interview Assess mother's:

- representations of the infant,
- her relationships with the infant
- how she sees herself as a mother
- **Parental RF** is predictive of the quality of the infant attachment at later stages of development
- higher levels of maternal reflective functioning indicative of secure infant care giver attachment status

# Work with baby and mother

- Babies can change quickly: their brains and minds are rapidly developing
- Don't ascribe problems to 'a bad baby' or just temperament
- Can use **ADBB scale** as measure of infant withdrawal
- Use **EPDS** as screen for mother depression

# ***Hidden trauma*** in Infancy

- If the caregiver is not available to regulate the infants physiological response to arousal/stress, both internal and external
- the caregivers' unavailability means there can be *interactive dysregulation* which influences the infants' stress tolerance .. The neuro-endocrine stress response system may then be out of control
- This may not be as obvious as with trauma in the older child
- Karlen Lyons-Ruth

# Infant *disorganized* attachment behaviours

- Infant **disorganized attachment behaviour** is related to frightened or frightening behaviour of the attachment figure (parent)
- The source of comfort or safety is the same as the source of fear
- This leads to conflict behaviors
- With simultaneous *activation and inhibition* of infants attachment behaviours
  
- Main and Hesse 1990

# 'Disorganized' infant behaviours

Lyons-Ruth

- Strong contradictory behaviour patterns. attachment followed by avoidance , freezing ,dazed look
- Simultaneous contradictory behaviours .. Comes towards but then turns away,.. Cries as seeks a hug...
- Incomplete or interrupted sequences of behaviour.. Suddenly stops or changes
- Stereotypies.. Over and again ..stumbles for no apparent reason
- Freezing, stilling slowed movements
- Show fear of parent: hunched shoulders ,fearful face expression.. Strange, distorted facial expressions
- Disorganized .. Wanders about,confused,multiple changes in mood

# ***Anybody's child* : severe disorders of mother-to-infant bonding**

CHANNI KUMAR 1997

## **A severe, disorders of maternal affection and behaviour**

an early process of mother-to-infant bonding seriously wrong

at least one episode of postnatal mental illness described as unexpected and often catastrophic failure to love one or more of their babies

women reported *absent affection, sometimes hate, rejection, neglect or impulses to harm*

feelings often began immediately or very shortly after the birth

specific to one child; such characteristics are best encapsulated by the term 'maternal bonding disorder'

no direct evidence of predisposing maternal personality traits or previous experiences

Postnatal mental illness and recalled severe pain during labour *associated*.

The nature of the link between postnatal mental illness and disorders of maternal bonding remains *unclear*.

# *Attachment Disorder mimicking Pervasive Developmental Disorder in Korea*

25 Korean children **aged 2 to 4 ys**

- High achieving families, no family psychiatric illness
- Serious disturbance of relationships: ***Poor interaction with others, absent or poor eye contact, unresponsive to name, restricted affective expression, solitary play, poverty of speech, repetitive play, aggression and irritability, head-banging***

***Apathetic, constricted, depressed***

- 64% classified as *D insecure/disorganised*
- None demonstrated *secure attachment classification*
- **Children responded dramatically to the research evaluators, and subsequent therapeutic interventions**

Shin et al, IMHJ (1999)

# Korean syndrome of Attachment Disturbance & caregiving environment

- Moderate to Severe maternal depression: listless and isolated
- Mothers appeared distant and emotionally unavailable to infants
- Separation from parents (4)
- Mothers reported difficulty forming multiple caregivers emotional bond, MGM not available
- Cultural issues: suppression of emotional expression, channelled into somatic modalities pain and anxiety withdrawal
- High academic pressure upon the children (**infants taught by English video 11/25**)
- Intergenerational trauma: Impact of Korean War especially upon women

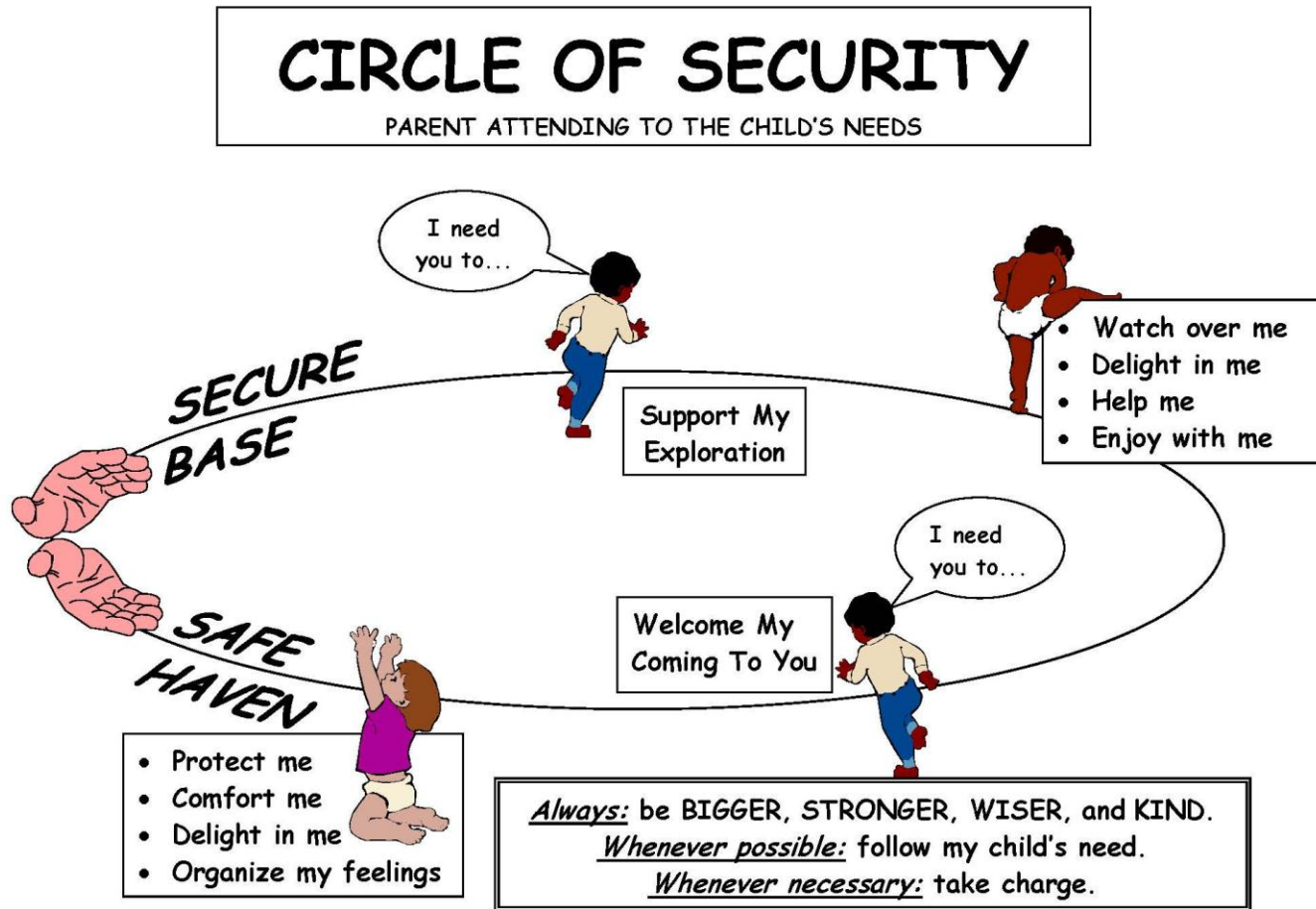
# Interventions for attachment disorders

*Interventions can be provided at many portals of entry (Stern)*

- Interagency collaborative programmes
  - **take two** Victoria; Community infant program, Boulder
- Infant parent **psychotherapy**
- Child Parent Psychotherapy (*insight oriented psychotherapy, developmental guidance, emotional and concrete support: Lieberman, Chicchetti, RCT, SanFrancisco*)
- Interactional guidance (McDonough, 2004)
- Environmental change, Foster care
- *Circle of Security program (Cooper)*
- *The Mothers and Toddlers Program (Yale)*
- RCH infant parent therapy model of IVn
- Family therapy

***Contraindicated therapies include “re-birthing,” holding therapy’, rage reduction therapy, attachment therapy***

# Circle of Security Model c



© 1998 Cooper, Hoffman, Marvin, & Powell  
circleofsecurity.org

# Child parent psychotherapy: Relationship-based approach

- Insight Directed Psychotherapy
  - Unstructured Developmental Guidance
  - Emotional Support
  - Concrete Assistance
1. *Mental health problems need to be addressed in the context of the child's primary relationships.*
  2. *Mental health risk factors operate in the context of transaction between child and social environment.*
  3. *Child rearing practices, deeply held often unconscious **cultural** values*
  4. *'Corrective attachment experience'*

Alicia Lieberman, based on Fraiberg's work.

# Parental Reflective Function

Fonagy, Target, Slade ,others

- *“the mother’s capacity to mentalize about her own child relates both to adult attachment and infant attachment classifications.* ( research by Slade)
- high levels of mentalization of the child in the mothers’ narratives were associated with secure infant – mother attachment.”
- “PDI-RF measure was indeed an indicator of the mother’s propensity to focus on the child’s unique subjectivity, carefully separated from her own wishes, needs, beliefs and desires..” Fonagy & Target
- Further deeper observational assessment of dyad using ‘AMBIANCE’ Lyons Ruth

# Traumatized mothers can change their minds about their toddlers Schechter et al 2006

- Infant parent psychotherapy with video feedback, controlled exposure to the child's distress and simultaneous stimulation of ***parental reflective function***
- 32 mothers exposed to **interpersonal violence** and their child, aged 8-50 mo
- **Clinician Assisted Video-feedback Exposure Sessions (x2)** on child separation distress
- Change in **maternal perception of the child**, as she faces **prev avoided mental states of helplessness and loss of protection**
- Asked ***'Tell me what is going on there? What is going on in your child's mind? What were you feeling then? What was your child feeling...'***

# Interventions for severe attachment disorders

Stafford and Zeanah

- **Assess parental fitness ? Foster care**
    - Problems of assessment, New Orleans program
  - Provide new **attachment figure** in the absence of a consistent one (Dozier)
    - family case conference
    - Therapeutic foster care (Hughes)
    - *Mind mapping* and treatment, Bruce Perry
- Avoid disruptions in caregiver relationships

# Interventions for **Severe Reactive Attachment disorders**

- Intervention with a child removed from institution:
  - Bucharest early intervention Project: rct to local newly trained Foster parents Zeanah et al
  - 
  - Rutter: children adopted into the UK; describes an autism-like syndrome
- Intervention within the institutions:
  - St Petersburg :placing infants together: peer interaction/ 'attachment'
  - South America Orphanage IMHJ 2010

# Consequences of **Severe Attachment Disorders**

- **Current suffering**
- Vulnerability later to Borderline states & personality disorder: *association with insecure, preoccupied and fearful attachment styles 'disorganised'* Agrawal 2004, Levy 2005
- Impact upon **parenting capacity** and subsequent generation of infants
  - Lyons-Ruth

# CHILDREN'S RESPONSE TO PROFOUND INSTITUTIONAL PRIVATION Rutter et al (2001)

## *165 Romanian chn*

- Adopted <42 mo
- Followed up to 6 yrs old
  - 7 domains of function assessed
- Attachment problems
- Inattention/overactivity
- **'quasi autistic' features**
  
- Only 20% showed 'normal' functioning  
but if **adopted < 6 mo, then 70% normal** with no increased incidence of
  - Emotional difficulties
  - Poor peer relationships
  - Conduct disorder

# Severe attachment disorders as a world wide public health & human rights issue

- The infant's right to a secure base: an attachment carer
- thousands of children abandoned, to orphanages .. growing up without primary adult caregiver
- Physical health interdependent with relationship and emotional health

# Engaging the baby:

Dr Ann Morgan, Melbourne (2010)

- important to **engage the baby**, we can do that with a **game**: for example playing with the therapist's bracelet
- Try to make the baby feel present as an **equal partner in the interaction**
- To help both the mother and the **child feel part of the threesome**, both in the therapy situation and later at home with the father
- this allows the ***third*** in the group to **be an observer**: each of the therapist, the mother and the baby in turn can observe the others interacting
- This can allow for essential periods of the **baby being actively in the mother's mind**, given that much the care provided within the relationship is reflexive



# ‘Moments of meeting’

- ‘Participants interact in a way that creates a new implicit *intersubjective* understanding of their relationship and permits a **new way-of-being-with-the other**’
- Created on the spot, coming from the therapist’s own sensibility and experience, *beyond technique and theory...*
- Followed by an ‘open space’ ...and a new ‘intersubjective context’
- Stern et al ,The Boston Change Process Study Group 2010

# Engagement with the baby: techniques

- The therapist uses her own self, **her own body** to engage the baby with:
- Gaze
- Voice
- Touch
- Spoken Word
- Use of toys
- Occasionally physical holding
- The construction of these in sequences of responsive interaction
- Must experience taking risks with the baby..take chances, as does a parent
- The process of *rupture and repair*.. Tronick, Beebe
- The therapist may seem silly or 'sloppy' as discussed by Stern

# Who should engage with the distressed infant and family?

- All of us
- Work to ensure the infant and toddler have access to a safe secure ongoing attachment relationship
- Cross-disciplinary and inter-agency collaborations..**engaging parents and infants and toddlers themselves as partners**