

Early recognition of infant mental health concerns

Parents and children both benefit from early identification of infant mental health concerns and referral to appropriate services.

ABSTRACT: Early recognition of infant mental health concerns is a critical first step toward ensuring optimal outcomes for very young children at risk for social, emotional, and behavioral disorders. The family physician is in a crucial position to detect these concerns and to initiate steps to link the family with relevant resources. Accessing treatment and support remains a challenge in many communities, but awareness about the importance of early intervention is increasing and services are gradually being developed to ensure more equitable access. The Alan Cashmore Centre provides one example of a community-based approach to addressing risk in very young children and their families.

Zero to Three, the National Centre for Infants, Toddlers, and Families, defines infant mental health as a continuum, ranging from a state affected by social and emotional problems and disorders to complete social and emotional wellness—an ability to form satisfying relationships with others and to play, communicate, learn, and experience the full spectrum of human emotions. Infant mental health develops in the context of family, community, and cultural expectations for very young children.¹

When looking at infant mental health, the infant, the caregiver(s), and the relationship are all involved. When screening for infant mental health difficulties, it is important to consider behaviors (**Table 1**)² and risk factors (**Table 2**).³

Clinical scenario 1

A couple comes into your examining room with their 5-month-old daughter. You notice that the baby sits quietly in the car seat throughout the appointment. She initiates no eye contact with her parents and the parents do not engage with her. She doesn't vocalize or smile, even when you try to engage with her. Her parents do not express concern about this. They say "she's a good baby, cries very little and likes to entertain herself." They are pleased that she seems to enjoy the TV and report she likes watching cer-

tain shows. They mention that they try not to pick her up too much because they don't want to "spoil her." There are no concerns about her physical health and she appears to be growing well. The father is an architect and the mother is on maternity leave from full-time employment as a computer analyst. Is there a further role for you as a physician?

This scenario suggests that there may be infant mental health concerns. At this early stage, the risk factors can be missed, especially when contact with the family is brief and infrequent and the parents do not report concerns. The family physician is in a crucial position to detect early signs of infant mental health problems. The physician is also in a good position to help because the physician's perspective is often held in high regard by the patient. The mother has likely come to rely on and trust in the physician through the pregnancy and delivery.

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The physician may be one of the only professionals involved in the child's early months. In addition to listening to what the parents are saying, the physician can take a few minutes to notice the baby's social and emotional behaviors and the parent-child interactions.

Table 1. Behaviors and interactions to consider when assessing infant mental health.

<p>Parent behavior</p> <ul style="list-style-type: none"> • Quality of physical relationship (holding, face-to-face contact, eye contact, proximity, positioning) • General mood and affect • Expressed attitude about the baby (positive or negative) <p>Infant behavior</p> <ul style="list-style-type: none"> • Predominant mood • Eye contact with parent and others • Social initiative and responsiveness • Attachment-seeking behaviors (seeking proximity and contact with parent, particularly when stressed) • Ability to be comforted or soothed • Developmental progression • Sleep and feeding regulation • Quality and amount of vocalizations • Evidence of curiosity • Range of emotions demonstrated <p>Parent-child interaction²</p> <ul style="list-style-type: none"> • Behavioral quality of the interaction—parent's sensitivity and responsiveness to infant cues • Emotional tone of the dyad—feeling conveyed by this relationship (e.g., tense, withdrawn, sad) • Parent's interpretation of the child's behaviour—comments made by parent about child (e.g., a mother says "he's trying to make me angry" in reference to her 3-month-old)

Clinical scenario 2

You have been following this particular patient prenatally and postnatally. She is married to an involved partner, a working professional. Both parents appear to have had successful work histories. The mother has been under the care of an adult psychiatrist for more than 3 years for treatment of anxiety. The baby is 3 months old and appears to be meeting developmental milestones, although the mother says she continues to feel stressed and is not enjoying her baby yet.

When a mother describes lack of enjoyment in her baby, it is important to gather more information about her current life circumstances and relevant history. In this case, the physician learns that there is ongoing couple's conflict, including verbal fighting, a history of parental mental illness, and

Table 2. Risk factors for infant mental health difficulties.³

<ul style="list-style-type: none"> • Parents with a history of childhood deprivation/abuse • Parents with a history of mental health issues (including depression and anxiety) • Parents raised in a family with parental mental illness • Parents with a history of relational problems in general • Parents with a history of substance/alcohol abuse • Adolescent parents • Unplanned/unwanted pregnancy • Difficult or traumatic birth experience • Conflict/family violence • Limited family/social support • Poor prenatal care • Infant regulation difficulties (sleep, feeding, under- or over-response to stimulation)

lack of social or family supports. Identification of these risk factors does not mean infant mental health concerns are inevitable, but they do signal a need for heightened attunement to the infant's social and emotional development.

Three months later you see this family again. There are sleep and feeding problems. The baby's weight has fallen from the 50th percentile to the 20th. Previous gains in social responsiveness and vocalizing have been lost. The baby's affect is flat. The interaction suggests an absence of pleasure. The mother's physical handling of the baby is awkward and tense.

The infant in this scenario now appears to be showing some social and emotional difficulties. What might be going on in the family? If a physician wonders whether interactions between parent and child may be of concern, further exploration is warranted. Showing interest in the mother's feelings about her baby and her new role as parent will provide an opening for her to reveal struggles she may be experiencing. Undetected parental mental health concerns, particularly in the context of social isolation, are significant risk factors for the infant's social and emotional development, including the development of a secure attachment with the parent.

Community referrals

If a physician becomes aware of worrisome behaviors and risk factors, as in clinical scenarios 1 and 2, it is important to consider a referral to a community professional who can address broader infant mental health concerns. For example, in clinical scenario 2, it would be appropriate to explore options such as marital therapy, adult psychiatry for both parents, and parenting education.

Currently, not all communities have equal access to infant mental health services. In most communities

throughout BC, specialized treatment services for high-risk infant populations (age 0–5) are limited. Physicians identifying concerns in the early stages of a child’s development can be challenged to find resources within their communities. The community health nurse is the one resource consistently available throughout BC. The nurse can play a pivotal role in identifying early concerns, collaborating with the physician, and linking with available resources.

In Vancouver, one specialized resource is the Alan Cashmore Centre, a multidisciplinary early childhood mental health service offered through Vancouver Community Mental Health Services. Assessment and treatment services focus on the child’s social and emotional development in the context of family relationships. Referrals to the Alan Cashmore Centre are made by both professionals and parents. The child must be under age 5, the parent must be able to identify some treatment goals, and the child must be exhibiting social, emotional, or behavioral difficulties.

When parental mental illness is of concern, professionals tend to refer to adult psychiatry. However, the mental health needs of the infant are often overlooked. Early referrals are encouraged so that the social and emotional needs of the infant can be addressed and a healthy parent-child relationship can be promoted.

Infant mental health assessment

Often, a physician will not be approached about problems until a child is in preschool, when difficulties with socialization and regulation become more evident.

Clinical scenario 3

A patient comes to you with concerns about her 3¹/₂-year-old daughter. The

mother reports a variety of difficulties that have become worse since the child started preschool 6 months previously. The child has little tolerance for frustration, hits herself and others, has difficulty with any kind of transition, and cannot manage within a group. The child wants to make social contacts, but seems to lack the communication skills to be successful with her peers. For example, she runs up to hug children and knocks them over, or she plays with such single-minded focus that she appears to be unaware of the environment around her. She has no problems with free play, but anything requiring sustained focus and structure is a struggle and the end result is disruptive behavior. The preschool is reporting significant behavior management concerns. The mother says she has been concerned for a couple of years, even though this is the first time she is mentioning these problems.

Clinical scenario 4

A single mother reports growing concern about her 4-year-old son, who she describes as “defiant, uncooperative, physically aggressive, and unfazed by any kind of consequence.” The mother says the child is “running the show” in the home. She reports having had ongoing difficulties with limit-setting since he was a toddler and is concerned that his behavior is becoming more dangerous (e.g., locking himself in the bathroom, locking her out of the house). She cannot take him out shopping or visiting because she is unable to manage him in public. She reports feeling increasingly angry with him and has slapped him in anger on a couple of occasions. The child attends preschool and there have been no reports of similar concerns within this setting.

In clinical scenarios 3 and 4, a comprehensive assessment conducted by a child and family therapist, a child psy-

chiatrist, or both would be completed over the course of three or four sessions. These sessions might occur in the home, at the centre, or in both places. A detailed history of the pregnancy and the child’s development would be reviewed. A detailed family history would be taken, with particular attention being paid to experiences of loss, trauma, abuse, neglect, or maltreatment of the parents as children themselves. The assessment phase would include direct observation of the child and the child interacting with the parents. The child would also be observed in his or her child care setting. Other family and environmental factors, past and present, would be explored in an effort to determine what might be affecting the overall emotional tone and functioning of the family. Particular attention would be paid to individual and family strengths as well as to stressors.

Assessment of the parent-child relationship looks somewhat different from assessment of either parent or infant alone. Attention is paid to the parent’s early attachment relationships as these are relevant to the individual’s own parenting and relationship style. Toward this end, the Adult Attachment Interview (AAI) might be used. This structured interview, developed by George Kaplan and Mary Main at the University of California in 1985, identifies experiences of loss or trauma that the parent has experienced as a young child. This history is important to identify because it is strongly linked with disorganized attachment in the child (*disorganized attachment* is discussed on page 117). Disorganized attachment is particularly important to identify early on as it is the strongest predictor for later childhood mental health disorders.⁴

The AAI give parents an opportunity to reflect on their childhood memories, experiences, and rela-

tionships with their own parents. This interview can give both the therapist and the parent insight into how attachment and parenting styles can be replicated with the next generation, even when parents are trying to provide a different experience for their own children.

The Working Model of the Child

opmentally based system for diagnosing mental health and developmental disorders in infants and toddlers. As the infant/toddler version of the *DSM-IV-TR*, it utilizes a similar five-axis system to classify concerns presenting not only within the infant but within the parent-child relationship as well. A copy of this classification system is

time are all used in this context. Parent(s) and infant are seen together and the work takes a dyadic focus. The primary goals are to promote positive parenting behaviors, reduce negative parenting behaviors, increase sensitive attunement to infant cues, and promote a secure attachment in the infant. Sessions can be conducted both in the family's home or in a therapy room with age-appropriate toys available. Discussion of the parent's observations and experience of the child is intended to create empathy and sensitivity to the child. Psychoeducation is integral to the work and is included throughout. Generally, these treatment models range from 5 to 12 sessions. Examples of dyadic models include *Watch, Wait, and Wonder*,⁶ Interaction Guidance,⁷ Modified Interaction Guidance,⁸ and Parent Child Interaction Therapy.⁹

A copy of DC: 0-3R is an essential reference for physicians who see children under 4 in their practices.

Interview is another tool often used during the assessment phase. The interview, developed by Charles Zeanah and colleagues at Brown University in 1986, is designed to reveal the parents' perceptions, feelings, motives, and interpretations of their children and the parent-child relationship. The series of questions focus on exploring the meaning of the child's behaviors, especially from the parent's point of view. According to Landy, "Whether a parent's perception of her child is positive and realistic or negative and distorted, this significantly influences how she interacts with and parents her child."⁵

The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R)*² is an invaluable reference for assessment and treatment planning. First published in 1994, it was the first devel-

an essential reference for physicians who see children under 4 in their practices.

Infant mental health interventions

In addressing infant mental health concerns, the parent-child relationship is often the focus of intervention. Current research is addressing the efficacy of certain interventions and new, modified forms of interventions are emerging. Usually treatment involves some combination of relational interventions and parent-infant psychotherapy, as described below, and referral to other professionals and agencies.

Relational interventions

These interventions focus on the parent-child interactions in the moment. Videotaping, coaching, modeling, video feedback, and infant-led floor

Parent-infant psychotherapy

A component of the work involves exploring a parent's relational history—particularly how this influences his or her feelings about and responses to the infant. Sessions are also held with parent and infant together. The presence of the infant serves as an incentive for discussion and provides the therapist and mother with an opportunity to observe and understand the parent-infant dynamics. A focus is maintained on the baby through the provision of developmental information and advocating for the infant.⁶ Selma Fraiberg, the originator of parent-infant psychotherapy, coined the now familiar term "ghosts in the nursery,"¹⁰ which refers to the enduring and unrecognized influences from the past that negatively affect current feelings and behavior as it relates to the relationship with the baby. Fraiberg describes the nature of this work most succinctly: "We move back and forth, between present and past, parent and

baby, but we always return to the baby.”¹⁰ This approach assumes that the change in the infant will come about as a result of changes in the parent.⁶ It is most effective with parents who have a good deal of insight and have some interest in exploring historical issues. *Watch, Wait, and Wonder* is an example of this kind of approach.⁶

Other professional resources

Advocacy for services and collaboration with involved professionals are vital when addressing infant mental health concerns. Case management involves ongoing assessment of family needs and linking with relevant professional and community resources designed to reduce parenting and family stress. Additional resources might include those provided by community health nurses, adult mental health, Ministry of Child and Family Development (MCFD), housing, occupational therapy, child care agencies, parent groups, and infant development consultants.

Conclusions

The field of infant mental health is relatively new. There is much to be learned about the most effective prevention and treatment approaches. It is important to ensure services are equitably available and accessible across the province. Heightened awareness of infant mental health is needed at all levels of care.

The needs and capacities of the infant—particularly within the context of the relationship with the primary caregiver—has become an area of significant research, yielding much new information. It is now well established that optimal health for infants can have a lifelong impact on their emotional well-being. Continued research will result in increased capacity to learn more about what kinds of

interventions help build security in a child and which do not. There is much to be done in the field and much enthusiasm for it.

Many families struggle with significant and entrenched challenges that often persist throughout childhood. Family physicians can ensure that the needs of the child are addressed in the critical early years. The physician is truly the frontline infant mental health practitioner and is in a unique position to recognize signs of difficulties early on. Given the relationship of trust that most physicians have developed with their patients, they have a key role to play in early identification of problems and in supporting families to access the services they need. Appropriate referral can help individuals be better parents and can have an enormous impact on the long-term mental health outcomes for our children and youth.

Competing interests

None declared.

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