# ZERO TO THREE®

July 2011 Volume 31 No. 6

Journal of ZERO TO THREE: National Center for Infants, Toddlers, and Families

## Stories From the Field

Identifying the Early Signs of Autism

Helping a Grieving Toddler

Addressing Infant–Parent Mental Health in Pediatric Physical Therapy

Healing From Post Partum Depression

# THIS ISSUE AND WHY IT MATTERS

*Stories are powerful because they reach us somewhere deep inside. In stories, the abstract and the incomprehensible can become concrete and meaningful, the theoretical can become practical, the scientific can become more human.* Jackie Winfield (2010, p. 31)

Stories have the ability to help us make meaning out of our experiences, inspire us to do our best, and allow us to learn from our mistakes. The stories in this issue of *Zero to Three* bring to life the intimate, complex, and delicate work of helping very young children and families in times of crisis and growth.* The authors share the real life challenges of putting theory, research, and training into practice, and the rich rewards of making a difference in the lives of very young children and their families.

The articles in this issue span a wide range of problems: from anxiety, grief, and developmental delay, to the array of neurodevelopmental concerns stemming from Fetal Alcohol Spectrum Disorder. The authors also share their experiences related to working with issues of family violence, poverty, and mental illness. The stories reveal the complexity of meeting the needs of infants and toddlers, and of helping parents and caregivers provide optimal support for their children at the same time they are facing their own challenges. A common theme that emerges in most of these cases is that it takes a coordinated team of multidisciplinary professionals to achieve the best outcomes for children and families, particularly when family circumstances are complicated.

While the authors illustrate different approaches in their clinical work, they all remind us that the underlying foundation for successful intervention lies in the quality of the relationships among those involved. All professionals, even those in roles that traditionally do not include mental health as part of their discipline, can benefit from understanding the value of facilitating strong, supportive relationships between providers and families, between parents and children, and between the professionals working on their behalf. For example, in one of the articles in this issue, a physical therapist describes how she transformed her approach by infusing principles of parent and child mental health into her work and how this shift made the difference in her ability to provide effective physical therapy services. In another article, the author describes how collaboration and interdisciplinary teamwork among professionals from various agencies with different plans and objectives was essential to prevent a family from being overwhelmed by the intervention and dropping out of the services.

I hope you find that all the stories in this issue provide inspiration and demonstrate the value of the life-changing work that is being done by professionals who work with infants and toddlers and their families. Please share your thoughts by visiting *Zero to Three* on Facebook and leaving a message at www.facebook.com/zerotothreejournal.

Stefanie Powers, Editor
spowers@zerotothree.org

Winfield, J. (2010). Once upon a time … telling out stories. *Child and Youth Care Work, 28*( 1), p. 31.

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* Note: To protect the privacy of the children and families, all names and other identifying information have been changed. The photographs are for illustration only and do not depict the families involved.

ZERO TO THREE®
National Center for Infants, Toddlers, and Families

Founded in 1980

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*July 2011 Volume 31 No. 6*

## STORIES FROM THE FIELD

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## ALSO IN THIS ISSUE:

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**www.zerotothree.org/journal**

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# Letters

## Helping All Children Succeed

***Editor's Note:*** *The following letter refers to an article originally published in the November 2009* Zero to Three *Journal which was included in a recent edition of the* ZERO TO THREE Insider *electronic newsletter. Learn more on our Web site, www.zerotothree.org.*

As a long time public health nurse in a rural community I am grateful for the article on Poverty, Trauma, and Infant Mental Health. I agree that we should train all those who come in contact with young children and their families about these issues.

Others who need to be trained about these affects are educators of K–12 students. Recently one of my sisters-in-law, who is a 4th grade teacher, was commended by her principal for a very simple act: she was the first teacher in the lives of two 4th graders who had NOT referred to them as "bad" kids. She recognized their angry behavior as possibly due to a troubled family setting and made small efforts to help them find success inside the classroom and in an after-school program. She made them begin to feel good about themselves.

I respect educators for the most part. Unfortunately there is often little consideration by educators or the educational system that all children come from family settings. Those settings are usually NOT "picture perfect". Poverty, mental illness, and domestic and sexual abuse have a much greater impact on the ability of children to learn than we would like to think and it doesn't end when kids go to kindergarten. We need to consider every child as precious, even when they are beyond pre-school.

Thanks for the great work you do!

*Nancy Crawford, RN*
*Yavapai County (Arizona) Community Health Services*

## Strengths in Early Intervention

In response to Dr. Robin McWilliam's recent article "The Top 10 Mistakes in Early Intervention" in the *Zero to Three* Journal published in March 2011, the doctoral students in the Early Intervention Program at the University of Oregon have developed a list of the Top 10 current practices in the field. Dr. McWilliam had systematically summarized 10 strategies that needed to be reconsidered, and provided practical suggestions. Nevertheless, as upcoming leaders in the field, we felt the need to also remind the field of the strengths and effectiveness of current practices, and to identify possible future directions.

Our goal is to focus more on the effective practices that we see working and offer this list as a learning opportunity for interventionists and professionals in the field, encouraging programs to re-examine and reflect on their current practices. The Top 10 practices are created based on an ecological and transactional perspective, and are organized as a dynamic system, beginning when children and families first enter the early intervention system.

Our Top 10 current practices are listed below:

1. Respond sensitively to family's unique cultural (e.g., ethnic, linguistic, religious, and socioeconomic) characteristics and preferences.
2. Adopt a family-centered and family-friendly approach for practices. Families and children are the central part of the intervention system. The needs of both children and their families are considered in a transactional perspective, and caregivers are included as strategic partners.
3. Utilize a transdisciplinary model to provide collaborative and coordinated care across professionals (e.g., speech language pathologist, occupational therapist, or physical therapist) that serve the family. Professionals share their expertise with other team members to better support the child and family for their well-beings.
4. Use formal and informal assessment methods to identify the educational and developmental interests and needs of children and families. Assessment is a dynamic and ongoing process.
5. Based on the assessment results, develop Individualized Family Service Plan (IFSP) and Individualized Education Plan (IEP) goals that are observable and measureable. Goals target functional skills, are simple enough for multiple people to embed, are generalizable to various settings, and add quality to a child's life.
6. Use developmentally appropriate intervention strategies based on play and functional activities that are able to be embedded into the family daily routines.
7. Provide ongoing coaching and timely constructive feedback to improve learning effects. Interventionists, caregivers, and classroom teachers benefit from the modeling of specific teaching or parenting strategies.
8. Determine the scope of resources, concerns, and priorities of the parents. Interventionists can then refer families to community resources (e.g., knowledge of specific agencies, cost, contact information) based on their needs.
9. Utilize constant monitoring and data collection to guide the decision making process, redefine practices, and reorient services. Programs demonstrate effectiveness and accountability through reporting annual child outcomes.
10. Utilize reflective practice and strive to keep current on professional development by attending quality trainings/workshops/conferences, joining relevant professional associations, and reading literature regarding evidence-based practices.

Based on the aforementioned Top 10 practices, we proposed the following five future directions for enlightening future work in the field. These directions are ongoing, but we would like to stress their importance to elicit future research and the translation of research findings into practices. The five directions are:

1. Teacher preparation: High-quality professionals are in need.
2. Early screening and identification to provide universal or more intensive service.
3. Provide prenatal or pre-conception services.
4. Provide resources and educational services to the at-risk population.
5. Technology (creative, innovative, and inspirational tools).

*Jane Squires*
*Professor of Special Education*
*University of Oregon*

**Send your feedback** to the Editor of the *Zero to Three* Journal. Email Stefanie Powers at spowers@zerotothree.org, call 202-857-2641, or fax 202-638-0851. Include your name, affiliation, city, and state. Letters may be edited for length and clarity.

# Is Something Wrong With My Baby?

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**SERENA WIEDER**
*Profectum Foundation, Mendham, New Jersey*

Julie came into the world smoothly and bright eyed, to her parents' delight. Her father, Jeff, wondered why she did not cry, but her Apgar scores (a measurement of the health of a newborn immediately following birth) were fine. Her mother, Sarah, held her tenderly to her breast, joyous and relieved she was here, safe and sound. Julie sucked slowly but an hour with the nursing specialist gave Sarah some helpful tips and the new family went home the next day, with Sarah and Jeff eager to be parents for the first time. The bassinet was ready and grandparents hovered and helped. Julie did not seem to mind the fuss at all. Sarah nursed her every 2 hours, at times stirring Julie to suck, but she was easy to change and bathe and was smiling before long. She gained weight slowly but this did not concern the pediatrician, who was pleased to hear she was sleeping for longer stretches and had confident parents. Sarah and Jeff checked for Julie's developmental milestones every week, having read the "what your baby should be doing" books, but at 3 months wondered why she was not cooing and following them more than fleetingly. It was great she slept 5-6 hours at night and was an easy "pick up and go" baby so they could meet with friends, go out to eat, and did not have to worry about playing music or the vacuum too loudly, but she was so quiet. Sarah realized Julie perked up when she danced with her, and Julie would look and smile. Jeff liked to swing Julie in the air and tickle her, and she would giggle. Her parents told each other they were so lucky, comparing Julie to their friend's fussy babies.

Julie did not like tummy time and was not rolling over but preferred to lie on her back, looking at mobiles and smiling at her parents looking down from time to time. Again they noticed she vocalized only when dancing and it took active roughhousing to arouse her laughter and pleasure. Sarah, a school librarian, preferred snuggling and reading books to Julie, and Jeff, a teacher, got bored after a few minutes of swinging, put Julie down without her protest, and went back to grading papers. Julie did look at them intermittently and seemed to recognize their voices at a distance, but did not call them with her sounds. Up close Julie would avert her gaze and hardly referenced them. Finally, at 8 months, her parents delighted when she reached and banged a toy to make sounds. They were thrilled when she showed stranger anxiety, happy to reassure her. Even the start of sleep problems when teething meant she was like other babies. Perhaps this was why she wasn't babbling.

Sarah found herself worrying about her beautiful little baby, so easy and so undemanding, but perhaps too much so. Jeff kept telling her not to worry so much. His mother said Julie was just like him as a baby and Sarah's mother kept saying she worried too much, all babies were different. Sarah was not so sure. It was April and the public announcements for Autism Awareness Month

**Abstract**
**Parents are often the first to recognize early signs of developmental challenges, launching the family into an unanticipated journey that sometimes resolves quickly but sometimes does not. Development depends on nurturing relationships that provide the necessary experiences to allow the child to develop. Equally important are the relationships that nurture the parents who are derailed from their dreams and who need to find the inner and outer resources to do what is necessary on this now uncertain path. Join Sarah and Jeff on a journey to discover their developmental pathways with their lovely Julia. Not knowing what the early signs will mean, they capture their child's engagement and their relationship becomes the foundation for the future.**

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Dedicated to the memory of Stanley Greenspan, a founder of ZERO TO THREE and ICDL, whose brilliance and dedication to children and families enhanced so many lives as he taught us to understand development and the vital force of relationships to change the world.

Photo: ©iStockphoto.com/Maya Kovacheva

**Development has to develop, is not taught, and depends on experience.**

were everywhere, every day. Sarah decided her baby had autism and ran to the pediatrician. Jeff protested and so did the pediatrician, but she listened and finally agreed Julie might be somewhat under-reactive and slower to move. She did not think it was autism nor could it be diagnosed so early. Sarah insisted on a referral.

## What Is Wrong?

Sarah and Jeff waited anxiously to see me. Sarah's thoughts raced from wanting reassurance everything was okay to wanting to be told something was wrong and what to do about it. Too much reading on autism had overwhelmed her, and even Jeff's loving reassurances could not allay her fears. Julie was looking at the bright Big Bird and Cookie Monster chairs in the waiting room and noticed the door open. I had spoken with Sarah on the phone and I suggested we start just by playing with Julie and that she and Jeff do what they usually do so that I could get to know her. Sarah put Julie on her favorite blanket on the floor and showed her a teddy bear toy that pops up. All Julie had to do was touch the rolling cylinder in front. Sarah showed her again and again saying, "Look Julie, look!" her voice growing increasingly anxious, and finally put her hand on Julie's hand to do it again but Julie did not join her and stiffened. Sarah tried again. Sarah looked up. "Do you see what I mean?"

I nodded and said soothingly, "Perhaps this is too new. Take your time and try something more familiar."

Sarah pulled out a favorite book and snuggled Julie in her lap. Julie looked at the pictures and Sarah read, enjoying the rhythm of the words from beginning to end. She could not see Julie's face easily but felt her little body relax and so did she.

"What else does she enjoy?" I asked, noticing Jeff was eager to show that Julie could respond more joyfully and swung her in the air singing, "Here we go Loopty Lu." Julie alerted and smiled, looking down, and even cooed as her father got more vigorous but then it suddenly got to be too much and she squirmed in his arms and turned away.

"What is wrong with my child, what is wrong?" Sarah moaned. It was not clear what would be helpful in the moment. Certainly not reassurances that negated her observations and feelings. I told Sarah and Jeff I understood their concerns and that we would figure it out together. I said that it was fortunate they had not waited and that as we discovered Julie's unique characteristics, their love and interaction would support her development. I asked Sarah to play with Julie again, but this time to be the "toy" and use herself rather than an object. Julie was lying on her back and as Sarah bent over her smiling and trying to catch her gaze, Julie reached out for her mother's necklace now swinging above her. Sarah was encouraged to talk slowly to Julie as she moved gently and Julie held on with a slight tug. Sarah started to sing and the two got into a lovely swaying rhythm. Sarah started to feel connected as Julie held on. I suggested she also move back and forth vertically to catch Julie's gaze and to maintain the rhythm and singing. In just moments the two were looking at each other and Sarah's voice beckoned her lovely daughter who started to smile and coo. "Just stay with it!" I whispered as I saw a love affair reigniting but this time on a two-way street. I encouraged Sarah to move a little more to either side in a peekaboo way. Julie turned her head to seek her and soon anticipated the next move. Sarah was so pleased, she grabbed her scarf and put it over her head calling, "Where's Mama? Where's Julie?" This extended their interaction a few more minutes until Sarah looked at Jeff and me with tears welling. Jeff wanted to try too, asking himself if he could slow down enough. When asked what was different for her, Sarah realized she was always leading and had stopped expecting Julie to respond, afraid she would not. She was so fast at everything so she did not know what to make of Julie's passivity and often just left her alone. Meanwhile, Jeff was speeding up and resorting to his tickle games. I suggested he first entice Julie and wiggle his fingers in front of her until he caught her gaze and then move in slowly, "Here comes the tickle bug, Julie!" She looked and smiled as her arms and legs started to quiver in anticipation. Then came giggles.

These moments of joint attention and shared pleasure became the platform to now talk about Julie. By supporting even a few moments of connection, her parents' fears started to abate, and they could step away from feeling they were at fault or that something terrible was wrong. We talked about Julie's profile and how she responded to different sensations, what she preferred, and how she needed time to organize a response. "But why was she such an under-reactive baby?" they wondered. I asked if she reminded them of any other babies they knew. The stories started to spill out, revealing the extent of the anxiety the parents were feeling. Our time was almost up and I recommended we meet weekly for an extended evaluation we would do together. Meanwhile, it was important for the parents to have little play sessions—similar to the one they'd had that day—with Julie six to eight times a day, focusing on simple interactions, waiting for her signals, and experimenting with keeping her engaged. A few suggestions based on their experience together in the last hour now made sense.

After they left, I wondered about my questions. Was Julie just an under-reactive, slow to warm up child who needed more appropriate input to register the world around her? Was she also sensitive to too much input, getting overloaded and shutting down? What a hard line to walk! Was Sarah so anxious and getting depressed not knowing what was wrong with her baby, who was so unlike what she expected? Was Jeff too protective but worried too? It had seemed she was such a "good" baby and their friends envied all the hours she could sleep without needing to be calmed down. Did Julie respond differently to sounds and words than to what she saw or to when she moved? And although Julie's milestones in each sensory area were not quite "delayed" given the range, there was something worrisome in her poor intent and initiative. Perhaps wooing and strengthening her joint attention and engagement would bring these out. Perhaps better understanding of their child and themselves would help these frightened parents. Perhaps Julie would need therapy. I marveled at how times were changing as parents were now raising questions about their child's development but were also quick to arrive at wrong conclusions. Did Julie have autism, and what did that really mean? Our work together would help us know.

## Check the Checklist

Sarah and Jeff arrived early for the next visit looking a bit grim but eager to tell me they had tried to play. Julie sat quietly in her carriage. Sarah quickly blurted out they wanted to know the "truth" and had completed an autism checklist she found online in a research article. I knew we would have to look at it together. I thought of how we professionals plead for early diagnosis because early intervention matters. Julie was only 9 months old. Could we change the course of a disorder if we intervened early enough? I found myself wishing I could tell Sarah and Jeff that we just had to play more and that Julie would be fine. I was uncertain about Julie's diagnosis and where it might lead, but I was certain about the need to support these worried parents and help them believe in their baby. They needed a relationship in which I could join them on a journey where time and work would define the course of development and that anticipated the tension and sleepless nights when every day's feelings would depend on whether Julie responded to their efforts or not.

This visit did not start with play but with looking at their checklists, their urgency palpable. It turned out they had three! One for autism, one for sensory processing disorder, and one for toddlers. I asked Sarah and Jeff which items they felt were relevant to Julie and mapped them out to create a profile of their perceptions of Julie. Before long they were telling me Julie was too young to diagnose but asked if she was at risk. As they answered their own questions we could look at what we knew and what we did not know. We discussed that development has to develop, is not taught, and depends on experience. So what experiences did Julie need? We looked at the map of concerns and relative strengths that had emerged from the questionnaires. There were many scattered items, and the picture was no less confused.

## Journey of Discovery

I THEN SHARED the Developmental Individual-Difference, Relationship-Based (DIR®) framework (Greenspan, & Wieder, 1998, 2006; Robinson, 2011; Wieder & Greenspan, 2001, 2003) to guide their understanding of Julie's functional emotional developmental capacities, individual differences in regulation and sensory motor processing, and interactions with relationships and environment (see box The DIR® Model: Foundations for Development). I assured them this framework would help us monitor her progress. I knew Sarah would read everything she could about DIR as soon as she got home! It was the way she helped herself in this vacuum of not knowing what was wrong or what would happen next. Just then Julie woke up and looked around. I said, "I think someone is looking for you."

Sarah bent over the carriage and looked at her beautiful little girl's face, quietly saying, "Good morning JuJu, time to get up sweetheart," and smiling. I sensed she wanted Julie to reach to her outstretched arms and quickly suggested she massage Julie's arms and legs while she continued to woo her. She added, "I got your right leg Julie, and your left leg, and your right arm and your left arm," and then Sarah held her two arms and gently pulled, helping Julie locate her body. Julie became more alert and focused on her mama's face and smiled. A few minutes more of this cycle and this time Julie reached out with her arms towards her mother. Tears came down Sarah's cheek as she lifted her little girl and started to dance with her. When she stopped for a moment, Julie lurched her body and even made a sound. As Sarah picked up her signal, she moved again and danced to a song she had made up that week. Jeff and I looked on not wanting to break this trance. When Sarah finally looked up and smiled, I thought to myself she should add this item to her checklists. Sarah and Jeff took turns interacting with Julie for the remainder of the session. They had done their homework and could enjoy her fleetingly, letting their defense down!

"What worked here?" I asked, seizing the moments of hope, and thus began their journey of discovery. We thought about how to engage Julie throughout her waking hours, when dressing, eating, bathing, and on the floor playing. Jeff remarked on how important his pacing was and not being so afraid of holding her more tightly. Sarah said she saw him avoiding sudden jerky moves now. They were understanding the principles. Both were calling her JuJu.

As they left, however, Sarah asked, "Can we really help her? She is not autistic is she? I know, I know, we have to wait!"

"We are not waiting Sarah. We will provide the interactive experiences Julie needs and she is responding!"

After they left I pondered Julie's use of the checklists and reading everything she could find in her attempt to cope for better and for worse. She would not need help finding information. She would need help in letting it go and trusting her relationship with her child as she and Jeff enticed Julie forward. Julie had to discover her arms and legs could support her and she could move from side to side and turn over, her dad beckoning with funny faces. Sarah would discover how to hold Julie so she could reach out and touch her mama's mouth or nose to silly sounds. It would be easy to add a swing and fun at bath time where Julie would get the extra vestibular (a sense of balance, movement, and spatial orientation) and proprioceptive (the sense of the relationship between parts of the body) support she needed. My mind raced with all kinds of suggestions I could make but I stopped. Sarah

### THE DIR® MODEL: FOUNDATIONS FOR DEVELOPMENT

The **D**evelopmental, **I**ndividual-Difference, **R**elationship-based (***DIR®/Floortime™***) Model is a framework that helps clinicians, parents, and educators conduct a comprehensive assessment and develop an intervention program tailored to the unique challenges and strengths of children with Autism Spectrum Disorders and other developmental challenges. The objectives of the *DIR®/Floortime™* Model are to build healthy foundations for social, emotional, and intellectual capacities rather than focusing on skills and isolated behaviors.

- The **D *(Developmental)*** part of the Model describes the building blocks of this foundation. Understanding where the child is developmentally is critical to planning a treatment program. The Six Developmental Milestones describe the developmental milestones that every child must master for healthy emotional and intellectual growth. This includes helping children to develop capacities to attend and remain calm and regulated, engage and relate to others, initiate and respond to all types of communication beginning with emotional and social affect based gestures, engage in shared social problem-solving and intentional behavior involving a continuous flow of interactions in a row, use ideas to communicate needs and think and play creatively, and build bridges between ideas in logical ways which lead to higher level capacities to think in multicausal, grey area and reflective ways. These developmental capacities are essential for spontaneous and empathic relationships as well as the mastery of academic skills.
- The **I *(Individual differences)*** part of the Model describes the unique biologically based ways each child takes in, regulates, responds to, and comprehends sensations such as sound, touch, and the planning and sequencing of actions and ideas. Some children, for example, are very hyper responsive to touch and sound, while others are under-reactive, and still others seek out these sensations. **Biological Challenges** describes the various processing issues that make up a child's individual differences and that may be interfering with his ability to grow and learn
- The **R *(Relationship-based)*** part of the Model describes the learning relationships with caregivers, educators, therapists, peers, and others who tailor their affect based interactions to the child's individual differences and developmental capacities to enable progress in mastering the essential foundations.

Source: www.icdl.com

Photo: ©iStockphoto.com/Benjamin Lin

**Development progresses with relationships that can tolerate and support a range of emotions and challenges.**

and Jeff did not need another checklist of do's and don'ts. Julie's delays were evident, and she would benefit from early intervention. But first we had to establish a foundation for relating and communicative intent. Over the coming weeks we focused on how to find the optimal level of arousal and joint attention in order to increase engagement. As their pleasure increased, Sarah and Jeff learned to read Julie's subtle cues and waited for her to initiate her desire through small gestures. Every small move generated hope, and they slowly began to believe in their child who now responded to her name and anticipated their interactions. Sarah came in reporting the games and opportunities she created for interactions using her voice, looks, and movement when she cared for Julie. Jeff reported he waited for her cues when they played sensory-motor games, knowing she loved the robust movement but just a little too much or too fast did her in. They also reported they did not spend time with friends who had babies Julie's age these days, their worries creeping into their voices. While Julie was sleeping they asked questions and talked about their families and a cousin who had autism. When both parents could not come, they talked about their spouse and their wish to protect each other from their worries, but also longing for the fun they used to have together and started to communicate this more to each other.

### *Learn More*

**First Signs**
*www.firstsigns.org/concerns/flags.htm*

**Interdisciplinary Council on Developmental and Learning Disorders**
*www.icdl.com*

**Autism Speaks**
*www.autismspeaks.org*

**Sensory Processing Disorders Foundation**
*www.spdfoundation.net*

Within just a few months a gleam in Julie's eye was evident. She responded to her name and reached out, though she could not point or wave yet. Her first birthday, celebrated at 13 months, was kept small with only close family, and she licked the icing with big smiles, not yet eating solid foods. "But she relates to us, she knows us now…isn't that what counts?" Sarah asked at the next session. It was to be a question she asked many a time. "When do we start therapy?" We planned the next steps, finding an occupational and speech therapist as well as calling early intervention. Sarah and Jeff knew Julie so well now, they worked with the therapists and made clear they knew what to do between sessions. When the evaluations came back they could hardly believe they were talking about their Julie with a list of delays and deficits too long to remember. Sarah reported, "Oh, she's dyspraxic, she has oral-motor difficulties, she's retaining all her reflexes, she's only babbling….it's global developmental delay right, not pervasive developmental delay. At least she did not have gastrointestinal problems, seizures, or sleep disturbance."

Though overwhelmed once more they held onto their feeling about Julie, watching her smile, reach and roll, almost crawling toward them, even protesting when they left her. Their journey continued. Julie worked very hard with at least one of her parents by her side during the various therapies and faithful follow up at home. I watched Julie develop more continuous interactions and referencing as parents followed her interests, challenged her, and facilitated comprehension. By 20 months old Julie was up on her feet, her joy at walking, though shaky, palpable. By 2 years she was pointing and following someone else who was pointing too. She picked up some toys, especially the phone or bottle to feed the doll, but could not imitate actions or finger plays. She kept vocalizing and finally whispered "hi" when waving but few other words. But she loved books and let her parents know which she wanted, protesting if they challenged her and read another book. I asked them to read simple story books that had a beginning, middle, and end so she could learn to understand ideas, more than just words. She especially loved the personal photo books Sarah made about visiting grandma, a trip to the zoo, or visiting the park and brought these over again and again. It soon became evident that photos and drawings could become a communication tool for her. "Will she ever talk?" Sarah asked again and again. "Why can't she sequence? Why can't she imitate? Will she be like other children?" Fair questions for sure. Sarah and Jeff only wanted what every parent wants.

## Our Journey Continued

Our journey continued and most of the time Sarah and Jeff contained worries about the "A" word (autism) and focused on Julie's functioning as she climbed the developmental ladder. We returned to the DIR framework often and they could see how much more intentional and reciprocal she was, seeking them and persisting until they figured out what she wanted. They enjoyed her discovery as she improvised to get what she wanted. She grabbed the toy baby bottle when she wanted some water but could not find her water bottle. She could not tell them how she felt but sometimes was found looking at a picture of a crying baby to show she was sad. Much of the time she seemed lost in space, relying on memory and sameness. But it also became apparent she could solve problems when her parents challenged her routine expectations and moved her chair against the wall so she would have to look for it when they called her to dinner. Similarly, they put only 2 inches of water into the tub she loved to be full, guaranteeing negotiations about how deep the water should be but only giving her cupfuls from the sink. Or, they sent her as a messenger to search for Daddy as he called her from different rooms to give him a tool.

## Development Has to Develop

Julie could not yet arrange the toys in the doctor's kit to tell a story, but used every instrument on her mama and laughed when Mama yelled "ouch." Plastic food all over the floor during tea parties tripped everyone, but Julie happily poured tea for everyone again and again. Ideas were evident but elaboration was difficult, requiring sequencing and spatial awareness. "But when will she play with other children?" Julie had become anxious and avoidant around them, even foregoing the gestures and few signs she knew. Sarah wondered if Julie was more aware of her differences. Was she regressing or freezing as expectations kept rising and she could not express her thoughts or sequence the actions? Only her parents knew she could be sneaky and funny and curious. How come these weren't on the checklists?

This journey would go on for some time. Her parents and I no longer talked in Julie's presence but met regularly to talk and to play with Julie, opening doors to each level. Julie related and communicated through gestures and by 4 years old she was seizing her visual boards to share more thoughts and feelings. Her comprehensive intervention program continued with the able advocacy of her parents. We met a little less frequently as Julie's schedule was so full and her parents so capable of understanding and prioritizing. But their daily floor time and talk time continued without fail, even after Julie's sister was born. We meet a little more often again as development moves forward and Sarah wants to be sure the baby is okay and she was keeping up with Julie. Her question now, "She's saying more, what do we do next?" We all smile remembering.

Development is a moving target with various pathways and we tap into the strengths as we shore up the weakness hoping for progress. It may or may do so partially, but with a foundation of reciprocal interactions, a continuous flow, and relationships that can tolerate and support a range of emotions and challenges, development will move forward. As I look back, I reflect on wondering if Sarah and Jeff would keep coming when I could not tell them there was nothing wrong or assure them of Julie's outcome. But as all the relationships grew I could serve as their anchor and beacon as we traversed this journey. It isn't over, but the pathways are apparent as development is on her side. Sarah and Jeff believe in Julie and so do I.

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# “Potential Space” in Therapy

## *Helping a Toddler Come to Terms With Her Mother’s Death*

**TERESA OSTLER**
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Stewart and Virginia came to the clinic in late February. Snow still lay on the grounds outside of the clinic. Exhausted and cold, Stewart hung up his winter jacket before sinking into a chair in the therapy room. I knew something from the intake notes about why Stewart had come. The notes mentioned that Stewart was anxious. He was seeing a therapist to help him, but needed help with Virginia, his 2½-year-old daughter. The intake worker wrote down the following words to describe the problems: temper tantrums, screaming fits, and fears of separation. Virginia also stared into space. She often did not want to hear what was being said.

Stewart, 30 years old, told me that he knew anxiety all too well. It paralyzed him. He felt it when he woke up, when he left for his part-time job, when he dropped Virginia off at preschool, when he tried to fall asleep at night. It rarely left, dwelling in his stomach, his bones, his very movements. Stewart revealed that he experienced his first symptoms of anxiety when he was a teenager, right after his father passed away. At that time, his symptoms were so severe that he developed panic attacks, attacks during which he felt he couldn’t breathe or move. At that time, his anxiety was paralyzing, so paralyzing that he struggled to finish high school. Stewart was helped by a psychiatrist, but continued to have anxiety in the ensuing years. Stewart also talked about his wife, Anna. He had met her 4 years prior in the library. They dated and married about a year later.

### Parental Mental Illness

“Anna had bipolar mood disorder,” Stewart noted a bit later. This is a mental illness characterized by bouts of depression and mania. When she was depressed, Anna was despondent, indecisive, and slept for long periods of time. When manic, she talked incessantly, her thoughts raced and she became grandiose. At times she showed rapid cycling, going from depression to mania in short periods of time. The mood swings worsened after Virginia was born.

The story continued in starts and stops. Stewart didn’t understand why Anna refused to hold Virginia after they returned home from the hospital. One day she said she “couldn’t stand all the fussing” but on other days Anna didn’t hear Virginia’s cries. Stewart became alarmed and contacted mental health professionals when Anna typed strange notes on the computer talking about how her baby was gone. Anna refused medication, he said, claiming that it was poison. Remembering those days, Stewart also recalled that he couldn’t reach Anna. Nothing was right.

Stewart took Anna to an inpatient psychiatric unit where she stayed for 2 weeks. There he learned that she had postpartum psychosis, a condition that begins abruptly, usually 3 to 14 days after giving birth (Attia, Downey,

**Abstract**
**To fully grieve a parent’s death, a young child needs to come to terms internally with the loss. The author describes this process in a toddler whose mother committed suicide. In therapy, the child formed a relationship with a stone statue and communicated her need to be found and protected. Drawing on the notion of *potential space*, an intermediate area of experiencing between reality and fantasy, the article underscores how creating potential space in therapy can help a young child tap into a wellspring of imagination and subjectivity where personal meanings about loss can be explored in ways that are uniquely helpful to the child.**

**Each week in therapy, Virginia asked to see the statue in the courtyard, which became a safe and protecting "mother" in her mind.**

Photographer: Muriel Scheinman, Courtesy of the University of Illinois Archives, Muriel Scheinman Papers, 1874-2002, Box 6, 26/20/131

Name of Photo: Spirit of Medicine Warding off Disease, cast stone sculpture, c. 1935, Edouard and Olga Chaissing, artists

& Oberman, 1999). Women with postpartum psychosis evidence severe and often dramatic symptoms, including insomnia, hallucinations, delirium, and confusion (Attia et al.). Postpartum psychosis is a rare condition that affects 0.1 to 0.2% of all women experiencing childbirth, and women with bipolar disorder are at higher risk than women without a psychiatric disorder for developing it (Altshuler & Kiriakos, 2006).

On the unit, Anna was treated with antipsychotic medication. In the meantime, Stewart became Virginia's caretaker. He learned how to prepare bottles and to change Virginia's diaper. He began to swaddle and rock Virginia when she cried. He cared for Anna too when she returned home from the hospital. Over time, and with antipsychotic medication, Anna seemed to improve, but Stewart remained anxious. "I took care of Virginia as much as I could," he told me. "But I was working too so I couldn't always be there." One day Stewart found that Anna had tossed her medication away. In the next weeks, Stewart noted that often Virginia was hungry or her diapers had not been changed when he came home.

Stewart's voice grew strained as he told me about a painful memory. One day, shortly after Virginia's first birthday, he trusted Anna to take Virginia for a walk. Later that day, the police came to the house. He learned that Anna was holding Virginia in her arms as she tried to run in front of a passing car. A man grabbed Anna, holding her and the child and saving both. I asked Stewart where Anna was now. Stewart paused for awhile. He then said she was gone. I asked if he could tell me more. "Soon after," Stewart said, "Anna committed suicide."

## Coping With Loss

Stewart told me that he had been seeing a therapist to better cope with both his loss and his own anxiety. I learned too that Virginia knew very little about her mother's death. Stewart didn't think she could handle or even understand what had happened. "She's too little, too fragile," he insisted. Stewart shared other worries: he had met someone new. He wanted to start a new relationship with Janet. "I don't think Virginia wants me to see her," he added, "she says she has her own mom, even though I never talk about her." Stewart did want help with Virginia and, for this reason, he had sought me out.

When I observed Stewart and Virginia together, strengths were also evident: Stewart had cared for Virginia since birth and the two could show genuine pleasure when they played with each other. Virginia herself was curious and articulate. A bundle of contradictions, she was also petulant, fragile, easily frustrated, and had a strong need to control. If Stewart didn't go along with her wishes, Virginia would tell him to "go away."

As I showed Stewart and Virginia the way to the bus stop, we walked through an inner courtyard in the back of the clinic, passing by a stone statue of a woman that stood half hidden by a copse of trees. With one arm, the woman fought off a dragon; in her other arm she held her baby up high to protect it from harm. Virginia stopped as we passed. I can still see her now—a dark-headed child looking with intent interest at the statue. It was only after Stewart called her name that Virginia came out of her daze.

## Where to Begin?

As I jotted down notes from my initial assessment, I began to synthesize in my mind what I knew about the family. This helped me to formulate steps that could be taken in therapy to promote healing. Throughout my account, I have modified details to protect confidentiality.

Two themes stood out in my notes: mental illness and suicide. Neither had been talked about or shared. Stewart and Anna both had a mental illness. Stewart was in treatment and therapy. Anna had received treatment, but had stopped. Her illness was also chronic and severe. These illnesses affected both Stewart and Virginia and their relationship. Stewart worried constantly that Virginia would develop bipolar disorder like her mother. His concerns about this made it hard for him to set healthy boundaries that might make Virginia feel safe. He caved in easily to her outbursts and let her make many decisions on her own. Anna's mental illness had also greatly affected how Virginia was cared for in her first year of life. Anna's illness had made it hard for her to recognize and meet Virginia's needs. On many occasions she had not responded to Virginia's cries. Virginia had likely experienced many lapses in caregiving. At one point, Anna had tried to kill both herself and Virginia.

Loss was another prominent theme. Anna was gone. She had taken her own life when she was severely depressed. Although Virginia was young when her mother died, Anna was still immensely important to her. For instance, when Stewart mentioned Anna's name, Virginia became all eyes and ears, clinging to any words that her father might mention. Virginia was also terrified of separations, something that was likely linked to her mother's death. Stewart too had been devastated by Anna's suicide.

## Approach to Therapy

How did I approach therapy? I started by laying the foundations for a relationship of trust to develop: I listened, supported, and tried to give Stewart

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**Bolstering security comes about through a parent's reassurances that the child is loved.**

and Virginia the safety to marshal their energies to articulate, express, and actively make sense of what happened. The format was flexible. Stewart and Virginia saw me separately, but we also had joint sessions (Lieberman, Compton, Van Horn, & Ghosh Ippen, 2003). When the two were together, I helped to bolster their own relationship and to further a sense of security in each other's presence. A secure attachment relationship to a parent is a powerful and positive force in a child's development (Bowlby, 1988). In a secure relationship, a parent helps a child to tolerate and make sense of painful situations and to feel confident and safe in exploring the world. I reasoned that furthering a sense of security in the relationship between the two was Virginia's best hope for long-term mental health.

Bolstering security comes about in many ways: through reassurances to a parent that they can give a child the love and support they need, through a parent's reassurances to a child that the child is loved, by a parent providing open, honest communication about experiences, including death. I reasoned that Stewart was the person best able to reassure Virginia that he was there. He was also the person best able to help Virginia understand what had happened. He needed to tell her more about her mother and why she had left. He needed to tell her about her mother's mental illness. Virginia also needed the space and freedom to ask her own questions, and she needed time to take in information in. Virginia was a toddler, however. How much could she understand loss or mental illness? How much did she even remember her mother?

To talk with Virginia about her mother, I reasoned that Stewart needed to feel comfortable himself about what he was going to tell Virginia. He also needed to tailor what he said so that she could understand. Stewart also needed help in how he told Virginia about Anna. Children listen both to the content of a message and to its emotional tone, or how it is said. Stewart needed to talk with Virginia in a way that led to understanding, not to more anxiety, avoidance, or fear.

We talked about mental illness and parenting. In this context, Stewart shared his fear that Virginia would develop bipolar mood disorder. Parenting is an important life role, including for individuals with mental illness (Apfel & Handel, 1993). Stewart came to learn that when mental illness is treated and monitored, it does not necessarily need to eclipse good enough parenting (Goepfert, Webster, & Seeman, 2004). We also talked about how parenting can be supported for an individual with mental illness who is struggling to raise young children (Henry & Nicholson, 2005). These discussions alleviated some of Stewart's worries.

There are many barometers of progress in therapy. Some indicators are unexpected and surprising as it was with Virginia. Her behavior with the statue, as described in the next section, became my barometer for change.

## What Was Therapy Like?

Whether Stewart and Virginia invested trust in me would depend on them, I knew, but also on me: whether I could be perceived as available and responsive, whether they felt that they could share with me through words or play what they were feeling inside, whether they felt that I could tolerate and understand what they shared.

### *Relief That the Truth Could Be Spoken*

A first priority was to understand more about Anna, Virginia's mother. I knew little about why Stewart kept information about Anna and her abandonment from Virginia. In the next sessions I therefore worked alone with Stewart. Together, we explored how Stewart met Anna, what he had felt about her, their decision to have Virginia, the times she was hospitalized, and when she left.

It soon became clear that Stewart had done much grieving work already in individual therapy. But he had never talked with Virginia about the loss, so I asked him why. Stewart said he felt he should have kept Virginia safe. He also worried about how Virginia would take the information: what she didn't know wouldn't hurt her.

Talking with Stewart directly about Anna's death helped built trust. He felt relieved that the truth could be spoken and shared. I understood too why Stewart had not told Virginia about Anna: He wanted to protect her from devastating information. But in so doing he had also cut off the possibility for Virginia to heal.

I had a dual message in mind when I spoke. I conveyed genuine understanding for his decision to remain silent. However, I also considered the potential damage that the silence was inflicting on her and on their relationship. She trusted him. She believed in what he told her. What if she heard from someone else?

"Can she remember?" was an early query of Stewart's. "Can she understand death, let alone suicide?" What he said was true. Virginia was very young when Anna died. She was still very young. Yet, Anna was Virginia's mother, and even very young children can remember experiences long before they learn to speak (Lieberman et al., 2003). I spoke about the intense interest that Virginia had shown when Stewart mentioned Anna's name. I explained that if children are not given the facts about death, they may persist in believing that the parent will return. The best reason I understood for sharing had to do with trust. If their relationship was to be viable, it had to be built on being accountable. Virginia had to know that Stewart would tell her what happened. She needed to experience that he could tolerate the pain of loss and help Virginia tolerate it too.

Over time, Stewart came to see that talking made sense. We agreed that it was best to give Virginia a simple explanation of what had happened: He would say to Virginia that he had something to tell her that was sad. She had a mother. Her name was Anna. She wasn't with them any more. She had died. She died because she had an illness of the mind. He wanted Virginia to know that Anna had loved Virginia. Stewart also wanted to reassure Virginia that he loved her and was there for her. He did not go into the exact details of Anna's suicide or her attempt to kill them both. With time, he would fill in these gaps too.

The larger message was conveyed over many sessions, often in small bits and parts, allowing Virginia space to absorb what he said. When Stewart first broke the ice, the emotions in the room were intense. "Do you remember your mother, Virginia? You had a mommy once. Her name was Anna."

Virginia stared at Stewart with seriousness and intent beyond her age. "Anna's my Mommy," she said. Stewart told her more. He told her that Anna was gone and would never come back. She had died. Virginia looked at Stewart for a long time before saying "I know." He told her that he wanted to tell her other things too. Some of the things he wanted to say were sad. Virginia said "OK," but then abruptly turned to play.

In other sessions, Stewart shared more about Anna. He brought in photos of Anna and showed them to Virginia. He told Virginia that Anna was sick in her mind and that she had hurt herself. He told Virginia that she had not made her mother go. Later, he told Virginia that her mother was buried and that she would never return. In the sessions, Stewart gave Virginia space to process what he had said. He answered her questions and listened, giving Virginia time to take in what he said in her own way. He also assured her that he was there for her. He was her parent. He loved her, was accountable, and would stay with her. He would be available to answer questions that she might ask.

### *Close Your Eyes and Count to 10*

The stone statue stood in the clinic courtyard, half-hidden in the shadow of the clinic and surrounding trees. Sculpted in the 1930s by Edouard and Olga Chassaing, the statue was created to symbolize "the powerful figure of Medicine clutching the infant Humanity high on her right shoulder while calmly but strenuously warding of the Dragon of Disease with her taut left arm" (Scheinman, 1995, p. 155). Each week, Virginia asked to see the life-sized statue of the woman safely holding her baby to keep it from the dragon. We went outside and she stood there, lost in thought, mesmerized for a short period of time. Then she ran off and hid. I was the finder, but also the one left behind, the abandoned one.

This is what a typical session was like: Virginia asks me to stay near a bench and "not" to watch. She runs. I count to 10. I search for her near bushes, behind the statue, calling her name. She is delighted. She grows flustered and angry if I don't find her soon enough. She perceives my difficulties in finding her as painful misattunements. In describing the urgency of Virginia's hide-and-seek games, words from Tom Waits song, *Georgia Lee*, come to mind:

> *Close your eyes and count to 10, I will go*
> *and hide but then*
> *Be sure to find me, I want you to find me*
> *And we'll play all over, we'll play all over,*
> *we'll play all over again.*

What Virginia might have been communicating dawned on me first slowly, then more forcibly: Would she be protected? Did someone care enough to find her? Was her mother gone? Could she be found?

With time, Virginia's hide-and-seek game included the statue. She hid near the statue, as if seeking safety in its shadow. Sometimes the game of hide-and-seek stopped as she stood to look at the statue or to touch the woman's hand. At times she placed small piles of stones, acorns, or leaves near the statue, often humming as she did. Sometimes she ran up and touched the dragon's face. In her games, Virginia expressed longings for her mother. In her mind, the statue who was not her mother became her mother, a safe and protecting mother.

Later on, she began to share fragmented pieces of herself through questions that were laden with meaning. She asked questions about the woman, the child, the dragon. She asked whether mothers love children and why they go away. She also asked about graves. Fathers, at first almost absent in her stories, became more prominent in her storytelling.

One day Virginia found a purple coneflower. She plucked it and asked me to wait. I saw her slight figure running to the statue. She placed the flower at the woman's feet. She looked at the woman for a long time before skipping back to me.

Virginia and Stewart came to therapy for 9 months. We finished in November, when leaves were still changing colors. There were strong indications that both were moving on. Stewart was dating Janet. Virginia too was changing in subtle, but significant ways. She was less clingy, more able to laugh, less prone to go into dazes, more herself.

## Lessons Learned

A PARENT PROTECTS a child in many ways, by words, by holding the child, by thinking of the child, and by being


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**Children listen both to the content of a message and to its emotional tone, or how it is said.**

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*A. F. Lieberman, N. C. Compton, P. Van Horn, & C. Gosh Ippen. (Eds.) (2003 ) Washington, DC: ZERO TO THREE.*

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*A. F. Lieberman (2008). New York: Guilford Press.*

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attuned to a child's feeling states (Bowlby, 1988). I tried to hold Virginia in mind when we told stories about the statue. I held her hand too when we returned to the clinic. Stewart held her in his arms during some sessions and he learned to hold her with words. He told her the truth about her mother. He told her that Anna had loved her. He told her that Anna had a mental illness. He told her that Anna was now dead. He told her Anna would never return. He also told Virginia that he loved her and was there for her. The words became a powerful bond. They helped Virginia to grasp and tolerate what had happened with Anna. They helped her to trust that she could believe in what her father said, that he could tolerate pain and help her to tolerate it too. The words calmed her in ways that were at times almost imperceptible.

Young children think concretely. They take explanations literally. But they are also learning symbols, words, or thoughts that stand for things (Piaget, 1951). Toddlers also develop play and an imagination—sticks become horses, statues become mothers. With symbols, children move from acting on to contemplating. With symbols toddlers begin to create and make internal sense of their own feelings and experiences. Words are shared symbols. Through words, children can remember and can talk about people that are gone, things that are past, experiences that are too painful to understand without help.

Death is one of the most painful experiences we know. It is painful to grasp, painful to talk about, painful to come to terms with. Mental illness too is hard to grasp in its entirety. Facilitating open communication between Stewart and Virginia about Anna's death and mental illness was a first critical step in promoting healing. Virginia took in what Stewart told her, but she also needed to make internal sense of what this meant to her. She came to terms with the death in a transitional space where she played hide-and-seek and created a relationship with a statue.

Hide-and-seek, the perpetual game played by young children, helped repair Virginia's fears of being lost, fears that had been fueled by the suicide and by early and painful gaps in mothering. In our games, Virginia enacted her fears of abandonment in play. I called Virginia's name and found her. In the space of the hidden courtyard, I let her know, again and again, that she could be found.

## Potential Space

*Potential space* (Ogden, 1990; Winnicott, 1971) is an intermediate and protective area of experiencing, an experiencing that lies somewhere between outside and inside, between fantasy and reality. In potential space, a toddler develops the capacity for symbols and selfhood through a dialectical process of oneness and of separateness. In this space, a subjective internal world emerges as the toddler comes to distinguish between what is "me" and what is "not me" and between symbol and symbolized.

The hidden courtyard where our therapy sessions took place likely helped to spark Virginia's entry into potential space. In this transitional space, she could begin to make sense of fragmented, frightening, and painful events that she had experienced but had not understood. The concrete nature of the statue and its likeness to a mother, especially a mother who was struggling to protect, may have also facilitated Virginia's entry into potential space in our sessions. In a safe place in the courtyard and in her mind, Virginia established a dialectical relationship with this stone mother who at the same time "was" and "was not" her mother. This dialectic afforded some safety for Virginia to explore and share feelings about a mother who had, at times, been dangerous. It also helped her to better grasp in mind what she had experienced.

Potential space can also be created in therapy, especially if meanings are played with, considered, shared, and understood (Ogden, 1990), but it is not inevitable. If a therapist intrudes "too much" on the child's imaginative play, potential space will not emerge. Similarly, steering away from imaginative play will reduce the likelihood of its emergence. The security of the relationship that Virginia established with me likely helped her to explore in her mind and to enter into her own potential space, a space she also shared with me. She trusted that she could play, imagine, and dream without getting lost. She could also ask me questions and share her meaning-making with me.

Coming to terms with loss is both arduous and painful. Being told promptly about what happened (Bowlby, 1980) and being able to share in the family grieving process and to ask questions in the aftermath are central to healthy grieving (Lieberman et al., 2003; Ostler, 2010). Facilitating a young child's ability to enter into potential space in therapy sessions can help further the grieving process even more, as it allows a child to tap into a wellspring of imagination and subjectivity as the child makes internal sense of the loss. Entering into potential space appeared to facilitate a child's ability to "work through" the meaning of a parent's death in a way that was uniquely helpful to the child.

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# Selective Mutism

## *Treating the Silent Child*

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A wide-eyed and adorable child shied away as the Infant Clinic team greeted her in the clinic lobby. Keylah, 31 months old, was accompanied by her mother, Victoria, to the diagnostic evaluation. She had been referred by her early interventionist for evaluation of limited vocalizations and feeding difficulties. Keylah gave no verbal greeting to the interviewers and walked closely beside her mother to the evaluation room. She glanced at the assortment of toys nearby and then to the team member designated to begin the play-based observation. The toys certainly looked inviting, but Keylah stood frozen in time and space. A look of panic washed over Keylah as the interviewer spoke and invited her to play with a string of beads. Keylah's mother encouraged her to play. Keylah retreated to her mother's lap for comfort and whispered that she had to use the potty. After returning from a short break, Keylah watched in silence as the interviewer blew bubbles. Keylah slowly inched forward to take a closer look at the toys.

As the Infant Clinic team observed the parent–child interaction from behind a one-way mirror, they noted Keylah's lack of speech. It was interesting that, when the interviewers left the room, Keylah's affect brightened. She spontaneously began speaking, engaged her mother in imaginative play, and even laughed with enjoyment. Keylah flipped through the pages of a storybook and retold the story to her mother. Keylah was articulate and spoke in full sentences. Amazed at the differences in Keylah's affect, the team sent one of the interviewers back into the room to observe the reaction. The difference was as vivid as if someone was turning off a light switch. Keylah immediately averted her eyes, stiffened her posture, and discontinued speaking. Once again, when the interviewer left the room, Keylah's affect brightened. She resumed playing with the toys and actively engaging her mother in creative play.

## Background Information

Keylah lived with her parents and extended family members. Keylah's father frequently traveled for work and was gone 2 to 3 days per week. As a newborn infant, Keylah experienced feeding difficulties. She had difficulty with latching on during

**Abstract**
**Infant mental health specialists are increasingly expected to treat complex mental health disorders in very young children. Selective mutism is an anxiety disorder which can lead to functional impairment across home, preschool, and community settings. The authors share their experiences with Keylah, a preschooler with significant social anxiety leading to selective mutism in social settings. The intervention included assessment, play therapy, systematic exposure, relaxation training, and interdisciplinary collaboration with community providers.**


Photo: ©iStockphoto.com/onebluelight

**Brief, planned separations between mother and child during visits to the clinic help build coping skills for real-life separations.**

breastfeeding. Attempts at bottle-feeding were complicated by sensitivities to milk-based and soy-based formulas. The next 4 to 6 weeks brought gastrointestinal distress including vomiting and stomach pain. By the time she was 6 months old, Keylah ate Stage I solid baby food but refused Stage II and Stage III solids with the exception of fruits. At 12 months old, Keylah was eating some table foods.

As a toddler, Keylah began to try some new foods, but generally spit them out without swallowing. Keylah showed a distinct preference for a few foods. Her diet consisted of french fries, baked beans, hot dogs, spaghetti, Stage II fruit, and infant formula. Although Keylah primarily ate foods in small amounts, she had recently begun to vocalize that she was "hungry" and ask for larger amounts of preferred foods. Victoria described Keylah as readily eating her preferred solid foods. However, any change in Keylah's routine triggered her to stop eating solids and revert to a diet of infant formula until she adjusted to the new routine.

Victoria reported that since infancy Keylah had other aversions to having nonfood items (e.g., teething rings, toys) in her mouth or near her face, with the exception of a pacifier. Keylah used a pacifier from birth until 18 months and Victoria worried that Keylah's use of a pacifier to self-soothe had contributed to her limited spontaneous speech.

To address Keylah's delayed oral–motor development and feeding difficulties, she started speech and occupational therapies at 12 months old. Victoria discontinued services after 6 to 8 months because of the lack of progress. However, Victoria reported that in the last few months Keylah displayed reduced oral sensitivity. Keylah had begun putting nonedible objects into her mouth (e.g., crayons, pencils) and would attempt to swallow them. The Infant Clinic team wondered whether this change was indicative of Keylah progressing through the stages of oral–motor development or another area of concern to be addressed through speech and occupational therapies.

Keylah attended child care beginning shortly after birth. From 6 to 9 months old, her father cared for her at home while he sought employment. Keylah's return to the same child care program was stressful. She cried and demonstrated little interest in the other children. Although she has transitioned to a new classroom and teacher each year along with many of the same children, she generally plays alone. Keylah doesn't have one particular friend but will periodically interact with playmates and may say a few words to another child if she believes that an adult is not nearby. She rarely speaks to teachers and tells her mother that she dislikes the current caregiver in her classroom.

At home, Keylah speaks readily to her family members but won't talk to extended family whom she sees on a regular basis. She plays silently beside her 6-year-old female cousin. At family gatherings, regardless of whether Keylah is in her home or a relative's home, she communicates by whisper to her immediate family when extended family are present. Keylah remains in close physical proximity to one of her parents or sisters when visiting relatives' homes. In community settings, Keylah either whispers or doesn't speak at all. She uses the toilet at home and child care but still has accidents. Therefore, she wears toddler training pants in public and at night. Keylah sleeps in her parents' bed as she is too fearful to sleep independently. She takes 2- to 3-hour naps at child care without reported difficulty; whereas on the weekends, Keylah resists separating for an afternoon nap and generally falls asleep on the family sofa for 1 to 2 hours. Keylah has some difficulty complying with directions. Victoria uses time-out and describes herself as the main disciplinarian.

There is a history of anxiety disorders in Keylah's immediate family. Victoria recalls her own history of panic attacks which resolved with ongoing use of medication. She describes herself as a "very shy" child who slept with her grandmother until she was 18 years old.

## What's in a Name?

The Infant Clinic team met to consider Keylah's diagnosis. Victoria's reports of Keylah's behavior at home were consistent with the Infant Clinic team's observations during the diagnostic evaluation. Keylah demonstrated severe social anxiety, limited vocalizations in social situations, and related difficulties with separations. Keylah used age-appropriate spontaneous speech when not in the presence of interviewers. Keylah demonstrated typical speech development in the home yet refused to speak in other settings, even in the presence of familiar relatives. Keylah's level of anxiety and lack of speech impaired her ability to attend child care. Keylah's food aversion limited her ability to try foods with different textures and led to difficult mealtimes in the home. The Infant Clinic team gave dual diagnoses of Selective Mutism and Feeding Disorder of Infancy or Early Childhood and recommended follow-up treatment through the Infant Clinic. Victoria identified Keylah's primary treatment goal as being able to attend a preschool program without fearful reactions.

## The Intervention

The treatment would begin with brief, planned separations between Keylah and her mother during visits to the clinic. In addition to exposing Keylah to short separations, play therapy would focus on confidence-building and promoting feelings of mastery. As Keylah's confidence level grew, the length of planned separations would increase by 15-minute increments until Keylah was able to separate without hesitation. There would be homework assignments of planned exposures to social situations. Keylah would earn rewards for positive participation and any approximation of "using her words" or "big girl voice" to speak in public. Her mother would avoid pressuring her to speak in public while praising all of Keylah's spontaneous efforts to speak outside the house.

Keylah's mother felt ambivalent about the planned separations. She wondered, What kind of mother intentionally exposes her child to frightening situations? Keylah was obviously distraught and needed constant reassurance in new situations. After all, isn't it counterintuitive for a parent to intentionally frustrate her child? Victoria was acting on a strong maternal instinct to protect and care for her child. Ms. Shott explored those feelings and supported Victoria. She was a good mother; however, her intuition to protect her daughter was "accidently reinforcing" Keylah's fears. Keylah was fearful in benign, safe situations. Keylah was unable to separate for child care. Victoria had planned for Keylah to attend public school. Would Keylah be able to speak to her teachers to communicate her needs?

As infant mental health specialists, the Infant Clinic team wondered how the intervention would impact the positive parent–child attachment. Victoria accurately read and responded to her child's cues. Was the intervention causing unnecessary emotional distress? Was there a less distressing way to target Keylah's symptoms? The Infant Clinic team reconciled to the fact that graduated exposure to anxiety-producing situations is a recognized and effective treatment for anxiety disorders. Ms. Shott reflected and empathized with Victoria's hesitancy and explained the behavioral theory behind the intervention. The Infant Clinic team made a plan to reevaluate along the way to ensure that the intervention was leading to positive change.

### *Play Is Hard Work*

At first, Keylah's mother accompanied her into the play therapy room with Ms. Shott, the therapist. Ms. Shott offered Victoria supportive suggestions on completing the exposure exercises in community settings while Keylah listened and played contently. Ms. Shott discussed the exposure exercises in Keylah's presence as part of the graduated exposure to social situations. Introducing the exercises in the clinic setting allowed Keylah's initial reactions to be monitored and explored in the security of her mother's presence. Victoria was encouraged to contact Ms. Shott by phone to process any of her own concerns or to problem-solve around Keylah's reactions to the exposure exercises. Ms. Shott reassured Victoria that phone calls were a welcome part of treatment.

Although no demands were placed on Keylah to speak, the play therapy sessions with the planned separations were particularly difficult. Victoria struggled with Keylah's high level of distress and her own anxious feelings that the sessions provoked. Keylah could initially tolerate only 15-minute separations before announcing, "I have to potty." Although praised for "using her words" when she was able to express her needs, Keylah still struggled to speak to the therapist to ask to use the bathroom and, as a result, had frequent toileting accidents. To avoid further accidents, Keylah was encouraged to "potty" upon arrival to the clinic. Ms. Shott arranged for Victoria to wait 15 minutes before briefly rejoining the session to handle any subsequent toileting needs. Victoria brought an extra set of clothes for use when Keylah had toileting accidents. Victoria patiently assisted Keylah in changing her clothing before returning her daughter to the play therapy sessions while Keylah was praised for any approximation of vocalizing her needs.

As therapy continued, Victoria eventually shared that the prior child care teacher had harshly reprimanded Keylah for toileting accidents. Ms. Shott reflected on how "scary" that must have been for Keylah. The impact was palpable. It appeared that a large weight lifted off her shoulders, and a turning point was reached. The toileting accidents stopped, and Keylah was gradually able to separate for 30-minute sessions. At home, Keylah was now chattering excitedly about "special play" and requesting to visit the playroom. During play therapy sessions, Keylah was showing less fear and speaking in a whisper.

The family therapy sessions continued, and Victoria explored how to apply the same behavioral strategies of graduated exposure and use of rewards to other areas of concern, such as sleeping independently. Keylah had difficulty separating from her mother at bedtime which frequently led to protests and nightly temper tantrums. Victoria quickly became a behavioral expert. Keylah was not pleased that Victoria was no longer accommodating her anxiety by altering age-appropriate expectations. During therapy sessions, Keylah would intrude by speaking so loudly that Victoria would struggle to be heard. The anxiety of speaking in our presence had become less intimidating than the new behavioral expectations. We were thrilled. Keylah had found her voice!

### *Community-Based Exposures*

Victoria identified several settings for Keylah to practice social interaction with same-age peers. Victoria discovered the public library offered a weekly story time. The library was an ideal, quiet location which allowed Keylah to interact without the expectation to speak. Keylah and Victoria started visiting the library and the park playground on a weekly basis. Ms. Shott encouraged Victoria to appear confident and relaxed during the community outings to avoid reinforcing Keylah's social anxiety.


Photo: ©iStockphoto.com/Kali Nine LLC

**The public library was an ideal, quiet location which allowed for interaction without the expectation to speak.**

Victoria agreed to remain a minimum of 15 to 30 minutes in each social situation regardless of Keylah's reactions. Victoria was coached on the use of relaxation strategies and was encouraged to develop a mantra to repeat silently to herself when Keylah's protests escalated. Victoria was to calmly reflect Keylah's feelings, redirect any behavioral outbursts, and remain in each of the settings until the panic subsided. Ms. Shott recommended that Victoria conduct the community outings once or twice a week as the family schedule allowed.

## Interdisciplinary Collaboration

The Infant Clinic team decided that if Keylah were to be successful, we needed to collaborate with early childhood educators and the other medical professionals involved in Keylah's care. Keylah had been prematurely discharged from speech and occupational therapies when her heightened anxiety interfered with treatment progress. Keylah would tantrum and refuse to participate in sessions. Her mother discontinued services because of Keylah's strong protests and extreme reactions to the therapeutic activities.

Victoria and the Infant Clinic team jointly decided to refer Keylah back to speech and occupational therapy services. Collaboration

To prepare for the transition to school, play therapy included playing out themes of separation using school buses and family figures.

Photo: ©iStockphoto.com/Stacey Newman

began immediately. Ms. Shott provided documentation on Keylah's psychiatric diagnoses and suggested behavioral strategies to reduce her fearful reactions. Speech and occupational therapists reevaluated her feeding difficulties and provided ongoing guidance on ways to support progress in the home setting.

Keylah needed a child care environment in which the early childhood educators possessed expertise in dealing with strong behavioral reactions. Keylah had endured well-meaning child care teachers pressuring her to speak and insisting that she eat the full contents of her plate at mealtimes. These strategies left Keylah frightened to return to the center she had attended. She panicked and cried incessantly whenever the family drove near the center. Victoria felt sending Keylah back to the same environment would achieve the same results. The Infant Clinic team agreed.

### *Learn More*

**Diagnosis and Treatment of Feeding Disorders in Infants, Toddlers, and Young Children**
*I. Chatoor (2010) Washington, DC: ZERO TO THREE*

**Helping Your Child Overcome Selective Mutism or a Fear of Speaking: A Parent's Guide**
*A. E. McHolm, C. E. Cunningham, & M. K. Vanier (2005) Oakland, CA: New Harbinger Publications*

**Cat's Got Your Tongue? A Story for Children Afraid to Speak**
*C. E. Schaefer (1992) Washington, DC: Magination Press*

Keylah was referred to the preschool special needs program in her local school district. Ms. Shott advocated that Keylah would qualify for services on the basis of her emotional issues, feeding difficulties, and lack of speech. Keylah was accepted to the program. Keylah was assigned to an experienced, caring teacher who recognized Keylah's emotional needs and was willing to gradually transition her to the program. The transition would occur in a stepwise fashion with Keylah's attendance increasing over small increments of time. An interdisciplinary team including school district personnel (e.g., teacher, speech therapist, occupational therapist, school psychologist) and the Infant Clinic team formed and put Keylah's needs central to treatment planning. The team began efforts to prepare her for preschool attendance.

As Keylah's first day of preschool approached, Victoria scheduled a visit to the preschool. Keylah met her teacher and spent some time in the classroom. In play therapy, Keylah began playing out themes of separation using school buses and family figures. She was expressing her distress about attending school. Victoria used the public library trips to obtain books about children going to school. We recommended the children's book, *The Kissing Hand* (Penn, 1993), which describes a young raccoon separating from his mother to attend school. Keylah identified with the little raccoon's fears about going to school and enjoyed having her mother read the book regularly.

Victoria attended Keylah's class for the first week then began the separations in a stepwise fashion. Over the next few weeks, Keylah gradually increased her independent time in the classroom. Ms. Shott encouraged Victoria to develop transition routines to create predictability in the school day. Soon, Keylah was transitioning without protest and looking forward to each new school day.

## Ongoing Progress

Keylah, now 45 months old, has made good treatment progress. She visits the home of familiar relatives without fearful protests. Difficulties with nighttime separations have resolved. Keylah sleeps independently in her "big girl bed" without disruptive or tantrum behaviors. She is making strides toward her speech and occupational therapy goals. She tries new foods with less resistance, and minimal regression in feeding progress has occurred. In play therapy, Keylah uses a mixture of gestures and vocalizations to communicate. Her affect is brighter, play is more spontaneous and imaginative, and she appears more confident with separations. Keylah is learning to recognize her own emotions and, with coaching, uses relaxation breathing to calm herself.

Victoria is pleased with Keylah's positive adjustment to a preschool special needs program (5 days a week) through the local school district. She separates without fearfulness and enjoys attending school. Although Keylah prefers not to speak regularly in public, she participates in classroom activities and plays alongside her peers during unstructured times. Keylah continues to gain academic skills.

## Lessons Learned

The team supporting Keylah, including her mother and the Infant Clinic staff members, are fully aware of the challenges that lie ahead. Keylah continues to demonstrate clinically significant levels of anxiety. Recent parent ratings on the *Child Behavioral Checklist for Ages 1.5-5* (Achenbach & Rescorla, 2000a, 2000b) revealed that she experiences difficulties in the areas of withdrawal, emotional reactivity, and problems suggestive of anxiety or depression.

Despite tremendous progress in the preschool setting, Keylah has difficulty making her teachers aware of her needs and often struggles to socially engage with her classmates. Next year, Keylah will transition to a full-day, four-year-old preschool program. More interdisciplinary collaboration is necessary to ensure a positive transition. As the academic demands increase, so will the expectation for Keylah to speak, necessitating additional educational accommodations for success in the school setting.

In the coming months, play therapy sessions will take a more directive approach. Ms. Shott will assist Keylah in building her confidence through social skills training. As Keylah matures and her self-awareness increases, cognitive–behavioral strategies will be incorporated into treatment. Keylah will learn to identify "worry" thoughts and use calming strategies to decrease her heightened, anxious states.

The issue of psychopharmacological intervention will likely be revisited as Keylah matures. Keylah's age at the onset of symptoms warranted the use of behavioral intervention prior to the consideration of psychiatric medications. Victoria indicated a clear preference for behavioral therapy because of her daughter's young age, however, the use of medications, in addition to cognitive–behavioral intervention, may be considered in the future.

As infant mental health specialists, we used reflective listening to create an atmosphere of mutual respect in which interventions were developed across caregivers and professionals. Victoria instinctively knew Keylah's needs yet was uncertain of how to react during her fearful protests. Through the process of reflective listening, the Infant Clinic team gathered valuable observations that guided and informed behavioral interventions. Victoria, as the "expert" on her child, gained confidence and the support she needed to implement behavioral strategies which initially appeared counterintuitive to her positive parenting. Our Infant Clinic team gained greater insight into the complex challenges faced by parents of children living with emotional or behavioral disorders. We are honored that Victoria permitted us to share in the difficult journey of treating the rare preschooler with a selective mutism diagnosis.

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Penn, A. (1993). *The kissing hand*. Washington, DC: Child Welfare League of America.

## Errata

The credit for the photo on page 53 of the May 2011 issue should have read Photo: © iStockphoto.com/ Paul Vasarhelyi and Carole Yelle

# Opening Doors for Marina and Carina

MARGARET RITCHEY

*Children's Hospital Oakland, California*

I recently discovered a faded picture. It reveals a jubilant cap-and-gowned graduate waving a newly conferred master's degree in physical therapy. This 1979 photograph of me exuded naïve eagerness to begin my new job at Children's Hospital Oakland. In the following decade, while I concentrated on my craft in pediatric physical therapy, there was a concurrent explosion of research, paradigms, policies, and programs focused on the importance of social and emotional development and the impact of relationships, especially on the development of young children. My graduate physical therapy curriculum was strong on anatomy, kinesiology, neurology, and motor development, but deficient in this emerging critical aspect of child development. This deficit in the formal education of allied health professions that staffed the expansion in early intervention programs continued in the 1980s and 1990s. This disparity persisted into the new millennium as acknowledgement of "the interrelatedness of developmental systems… (remained)… in sharp contrast to the systems demarcated and function-specific nature and service delivery in the scope and boundaries of traditional specialties" (Foley & Hochman, 2006, p. 24). Today, silos of expertise still interrupt the delivery of integrated services to children with identified developmental struggles.

## Challenges to Effective Intervention

The process of becoming a more reflective practitioner in the delivery of pediatric physical therapy revealed three important challenges: (a) my resistance to addressing infant–parent mental health issues; (b) working effectively with the parents' resistance to acknowledging their infants' delays or disabilities, and (c) the ability to establish a therapeutic alliance with the parent in order to see the baby they see in order to help the parents hear my interpretation of the baby's body language.

### *Whose Responsibility Is It?*

The lack of training in principles of infant–parent mental health fueled the first challenge : My resistance to assuming responsibility for paying attention to socioemotional development. Attending to infant and parent mental health was not part of my discipline—I had no training in psychology or counseling. It wasn't part of my practice act—legal consequences existed for working outside one's scope of practice. It wasn't my chosen profession—I chose physical therapy specifically for its "to do" nature where one could see it, touch it, move it. Infant–parent mental health wasn't part of my job description—it was someone else's responsibility and would constitute duplication of services rendering it non-reimbursable. It was not my comfort zone—I was not fluent in a language to make mental health inquiries, which felt intrusive, even voyeuristic, and not relevant to my targeted client, the baby. When I engaged in reflective practices later in my career, I was aware of another source of resistance—fear that I couldn't handle what those kinds of questions might unveil; they might open a Pandora's box that I couldn't contain.

Working with the home visiting Neonatal Follow-up Program at Children's Hospital

**Abstract**

**This article describes the process of becoming a more reflective practitioner in the delivery of pediatric physical therapy through attention to 3 challenges: the therapist's resistance to addressing infant–parent mental health issues, the parents' resistance to acknowledging their infants' delays or disabilities, and the therapist's realization that establishing a therapeutic alliance with the parent in order to see the baby they see was essential before the parents could hear the physical therapist's interpretation of the baby's body language.**

Oakland, my caseload of intensive care nursery (ICN) graduates are at highest risk for neurodevelopmental morbidity because of their medical histories. The infants in the ICN have problems such as extreme prematurity, breathing and feeding difficulties, brain injuries affecting sensorimotor and regulatory functions, and musculoskeletal anomalies—all impacting their developmental trajectories. Close monitoring of their development, especially the evolving motor control, is my priority to ensure early prevention of and intervention for potential consequences of their medical condition. When a parent is not ready to acknowledge her infant's physical delay or disability, you can imagine my frustration.

### *Why Don't They See the Baby I See?*

This family resistance created the second challenge: "Why don't they see the baby I see?" At times, a parent's denial is expressed through their confident reports of a baby's skills, despite the fact that those skills are not observed by others. Other times, the resistance is expressed in more passive ways, for example, by failing to make the baby available for our visits or not complying with my recommendations.

The baby is utterly dependent on the parent, as is my access to and impact on the baby. This physical control the parent wields, whether she arranges for the baby to be present in the room or not, speaks volumes. The parent's physical control also reflects their psychological control. A parent perceives her child through the well-worn but tremendously telescopic ghosts in the nursery (Fraiberg, Adelson, & Shapiro, 1975). These ghosts, or childhood experiences and memories that have an impact on parenting, "cloud the mother's perception of and ability to respond to her infant… these selfsame obstacles are the chief impediment to the mother's accepting any help we have to offer" (Birch, 2008, p. 15). If a mother holds a distorted picture of her child, then to acquiesce to a physical therapist's presence or to follow a home program might conflict with her own reality. Before these ghosts that obstruct the delivery of services to that infant can be banished, the parent's reality (Kalmanson & Seligman 2006) or meaning making (Tronick, 2007) needs to be explored.

Child development professionals tend to focus on child development but are often oblivious to the challenges of parenthood development (Costa, 2006; Foley & Hochman, 2006; Shahmoon-Shanok, 2006). Most new mothers question whether they can adequately provide for their newborn and whether they can successfully feed their baby, relate to their baby, provide a safe and secure environment, and reorganize their own identity to embrace motherhood (Costa, 2006; Stern, 1995). A mother's development as a parent will be influenced by the available support from her present circumstances and by how she manages the ghosts from her own childhood.

Photo: Marilyn Nolt

**My graduate physical therapy curriculum was strong on anatomy, kinesiology, and neurology, but deficient in teaching the importance of social and emotional development.**

In the meantime, an infant's developmental challenges will be silently but powerfully impacting not only the infant's physical control over his developing body and his access to and experience of the world around him, but also the way his parent holds (both physically and emotionally) and interacts with him. A domino effect transpires as the "infant's motor difficulties become a part of the cumulative cycle of adversity that spawns a parent-infant relationship problem…an infant mental health problem" (Foley & Hochman, 2006, p.4).

### *How Do I See the Baby They See?*

The third challenge in becoming a more reflective practitioner arose as mounting dissatisfaction with ineffective attempts at "How do I get the parent to see the baby I see?" coincided with increasing reflective practice and the ultimate question emerged "How do I see the baby they see?" or as Seligman asks "How do we 'see the same baby'?" (Kalmanson & Seligman, 2006, p. 249). How do I shift from "doing to" to literally sitting on my hands and "being with" to gather insights from the parent to access the developing baby?

The realization that the parent–child dyad co-creates its relationship from the initial interaction, as the parent and the child are influencing each other and the direction their relationship is growing (Tronick, 2007) was a significant step in recognizing that the physical therapy intervention could be initiated with the reluctant parent through a therapeutic alliance. Any movement or shift in the mother's perception of her baby would impact the baby—not necessarily initially directly on the motor system, but through the potentially changing parental perceptions of her role and the baby's contributions to the ongoing relationship.

## Creating a Therapeutic Alliance

I have long viewed myself as an interpreter of baby body language. One must have a language, descriptive words, to represent heretofore inaccessible or poorly recognized feelings or behaviors. As with any language, one must be familiar with the idioms and the slang specific to that culture or family. One needs to continually remember that language is bidirectional. To be fluent in a particular baby's body language, I must be attuned to the expressive and receptive nature of the dyadic relationship. I need to understand the meanings a parent assigns to her baby's motor behaviors before jumping immediately to the behavior itself to, in my role as the supposed expert, describe the source of the inefficient biomechanics, regulatory challenge, or noncontingent dialogue. This is where I have come to realize I need to first see the baby the parent sees, which is a composite of the parent's dreamed-about unborn baby, the fragile dreams for the baby's future, and the babe-in-arms (Pawl & Milburn, 2008) I need to meet the parent where she is about the baby she sees. I am present in an implicit therapeutic capacity for the mother, to hear her story to establish the

Photo: ©iStockphoto.com/Alison Conklin

**Intensive care nursery graduates are at highest risk for neurodevelopmental problems because of their medical histories.**

alliance. From this alliance, I can eventually interpret other plausible reasons for the identified physical behavior or perceived emotion, thereby giving voice to the baby and maximizing the opportunity for a contingent response in the moments of meeting (Birch, 2008; Tronick, 2007), gradually, opening doors wider for the dyad.

While I expect to explore the parent's meaning making and provide alternate interpretations of the baby's expressive and motor behaviors, I am also focused on expansion of the parent's consideration of the meaning her actions and emotions have for the infant. This parallel process, promoted by Pawl, of doing unto the mother what I hope the mother will do for the baby (Birch, 2008) is the foundation of this therapeutic alliance.

## Marina and Carina

What follows is one of the first families I encountered as a new framework of understanding was coalescing with my traditional physical therapy approach.

### *Background Information*

Baby Carina was born 3 months early weighing less than 3 pounds. She was transferred to Children's Hospital Oakland's ICN. Her mother, Marina, was actively using alcohol, marijuana, cocaine, and heroin while intermittently living in the streets with Carina's father during her pregnancy. At other times, she lived with members of her extended family. Marina suffered from diabetes and asthma. She was in a drug treatment program for her illicit substance use during Carina's 9-week hospitalization in the ICN. Carina had significant lung disease requiring 1 month of assisted ventilation with oxygen. She was tube fed for 5 weeks but continued to have problems with subsequent oral feeds. This was thought to be due to poor suck-swallow coordination. There were no neurological insults documented, and she passed both her audiological and vision exams prior to discharge.

### *Referral Concerns*

Following discharge from the hospital, Carina was assigned to a Neonatal Follow-up Program social worker who visited weekly. The social worker's initial concerns during the first month of visits were that Carina kept her head turned to one side, she was arching in all positions, and she was tremulous both when being moved and in her own spontaneous movements. The social worker requested a physical therapy consultation.

### *Assessment Concerns*

I scheduled a joint visit with the social worker. Although Carina was difficult to assess, being alternately fussy, fed, or drowsy for much of the visit, I determined that she had torticollis, an asymmetry in neck movement, often with associated muscle tightness, making it difficult to turn her head out of preferred position, and this was contributing to plagiocephaly, an asymmetric flattening of her head. She had regulatory issues and was overwhelmed by her internal and external sensory experiences which adversely impacted her autonomic system, state control, and motor system. It was not surprising that her feeding problems, identified in the ICN, persisted. Marina's concerns came across as complaints, and revealed that she was struggling with her new role as a mother, was not aware of how much her infant was struggling, and did not realize the role of their mutual dysregulation, or how their individual struggles negatively impacted each other and their developing relationship.

During a subsequent solo encounter, I practiced integration of my role as a physical therapist for this developmentally high-risk infant with my role as a mental health practitioner for this dyad. The accumulated risks were many: baby's medical history, current status with neurological immaturity, regulatory challenges, feeding concerns and emerging motor problems, and the mother's history of risk-taking behaviors, ongoing health problems, volatile family dynamics, and difficult adjustment as mother of this particular baby.

### *Snapshot of a Home Visit*

Lively mariachi music pulsated from the house as I parked across the street. Even louder voices punctured the air as I climbed the stairs. I peeked in the open doorway and heard, then saw Grandpa's enthusiastic gootchy-gooing of Carina in the adjoining living room. I couldn't tell whether her response was quiet enjoyment or total shut down. Regardless, I would discover, he could no more contain his exuberance than she could tolerate it. This would become a recurrent theme for this baby in this family.

Simultaneously, I became aware that Marina was inside the house arguing with a family member. As we greeted each other, I noted that she was grimacing and still agitated over the unfinished argument. I asked "How has it been being Carina's mom this week?" Marina shook her head as she led me to the living room and replied "Rough, really rough. She won't stop crying…and I've tried everything—change her diaper, put her down, pick her up, feed her. And you know they said I had to be sure she got enough of that special formula to grow—well, I have to fight with her to get her to take the whole bottle, and then she throws it up all over me!" She said this with a sigh of exasperation and in one quick swoop, plucked Carina off her grandfather's lap and chastised him for tickling her too vigorously. "You're going to make her throw up!" She was unaware of how brusquely she grabbed her baby. Carina's extremities responded with faint tremulousness to the coarse handling and the sudden sharp voice.

I was conscious of my rising anxiety with the noise level and being witness to this baby's experience. I was also aware of a parallel process with the family's ongoing experiences of loud altercations and possible anxiety about my witnessing them. I attended to my own frazzled regulation by relaxing my shoulders down and taking measured breaths. I hoped my calm façade communicated an invitation to Marina to defuse her agitation.

I acknowledged how challenging it must be to do all the right things and still feel unsuccessful. I probed deeper about the feedings, and Marina insisted that Carina vomited because she was a bad "burpee," but also revealed that she was giving Carina 6 ounces of high-calorie formula in response to Carina's "screaming every 2 hours day and night." At 1 month corrected age, I expected Carina to want to eat small amounts frequently. But at this reported rate, 72 ounces was an inappropriate 24-hour volume as 1 month olds generally consumed 16-26 ounces, 1.5 to 4 ounces at a time, in a full day/night cycle.

Again, I needed to monitor my own reaction to avoid conveying alarm or judgement in order to continue exploration of Marina's story and not preach about intake volumes, which would only alienate Marina and sabotage her already conflicted image of being a good mother in providing for her baby. Instead, I inquired about pacing, and Marina described that Carina gulped down the formula and cried when she came off the nipple, so Marina waited until the end of the feeding before burping. I wondered with Marina if the gulping might mean something else, possibly Carina's difficulty with the suck-swallow-breathe timing. I explored Marina's plaintive comment that she had "to fight to get her to take the whole bottle." This netted the discoveries that there were actually a lot of interruptions related to the gulping behavior and that Carina's arching contributed to coming off the nipple. Marina felt she had to chase her with the bottle because these interruptions were met with Carina's crying, which Marina interpreted as meaning that Carina wanted more, NOW! I empathized "I can see how hard you are working." One could see how hard Marina was trying to respond to her reality.

Marina's descriptions of Carina's arching begged attention. With a life-sized doll, I mirrored Marina's holding Carina at the moment, not only the aloof yet tense way Marina held her baby, but also Carina's posture with her head turned to one side and her neck hyperextended. I asked Marina to swallow with her own head turned to one side and hyperextended to mimic how this might feel (both physically and emotionally) to Carina. I followed this with instructions to swallow with head in a neutral position. I adjusted the doll's head in my arms, rather than jumping in to correct Marina's and Carina's postures. When Marina agreed the hyperextended position was more difficult, a door opened to suggest both an alternate explanation for Carina's behavior and alternate ways of holding Carina so she didn't struggle right from the start of a feeding, which had always ramped up the anxiety for both of them. I offered to videotape a feeding in the near future so that we could watch it together objectively, reducing the urgency and tension in the moment of a feeding.

I had yet to watch Carina feed but this visit helped me formulate a number of hypotheses. I shared that I wondered if the arching was part of her extensor motor pattern due to her premature birth, if reflux contributed to the arching and was a source of the vomiting, or if recognition of her chronologic age guided the amount Marina offered and led to overfeeding and vomiting.

I wanted Marina to feel what Carina might be feeling, to practice reflective parenting. I asked Marina if she remembered a time when she experienced heartburn or was too full. I reassured her that Carina was getting ample formula, despite the vomiting, by showing her a growth chart adjusted for prematurity which demonstrated that Carina's weight gain was on target, even generous. Addressing Marina's primary concern about her baby's vomiting gave her control over the direction of the visit and encouraged our therapeutic alliance. Ultimately, successfully addressing Marina's concern would impact Carina's experience of her body and the relationship growing between this dyad.

Later in the visit, in this boisterous, contentious household with music blaring and tempers flaring, Marina mockingly accused that Carina "needs anger management." This was a blatant projection given the intermittent heated exchanges between Marina and other family members. Marina's accusations escalated "I don't think she likes me. She gets mad at me all the time, pushes me away, shakes her fists at me. When I talk to her, she won't even look at me—she turns her head and looks away. Or if she does look at me, it's this evil look [Marina imitated a sideways glance with furrowed brow] or she's just wild-eyed like she's crazy." Marina's numerous projections confirmed the urgency of an intervention. Marina's fragile sense of competence as a new mom was threatened and the baby's regulatory system screamed "HELP!" The derailment of this preciously young relationship was already occurring with far more ruptures than repairs (Tronick, 2007) in their daily caregiving interactions. I slowly inhaled and recognized that any change would have to be brokered through the dyadic relationship with attention to Marina first.

I wondered with Marina how she imagined a baby might learn to be "mad." Marina responded that Carina got mad at her because she didn't feed her quick enough or didn't change her diaper the minute it was dirty...but she was doing the best she could, and besides she had other things to do and wasn't able to drop everything every time Carina cried. I asked how it felt when Marina perceived Carina as "mad" at her. Her pitch dropped a notch and she teared up. "It feels bad, I'm doing everything I can to take good care of her, and it seems it's not enough—but it's hard and I get tired."


Photo: Kiwi Street Studios

**Attending to infant and parent mental health was not part of the discipline of physical therapy.**

I validated Marina's feelings by replying "It does feel bad to think you're not appreciated and all that you're doing is not enough. What if I told you there are some physiologic reasons for Carina's behavior and rather than being angry with you as you imagine, she's asking the most important person in her world—you—for help. Can I show you something?"

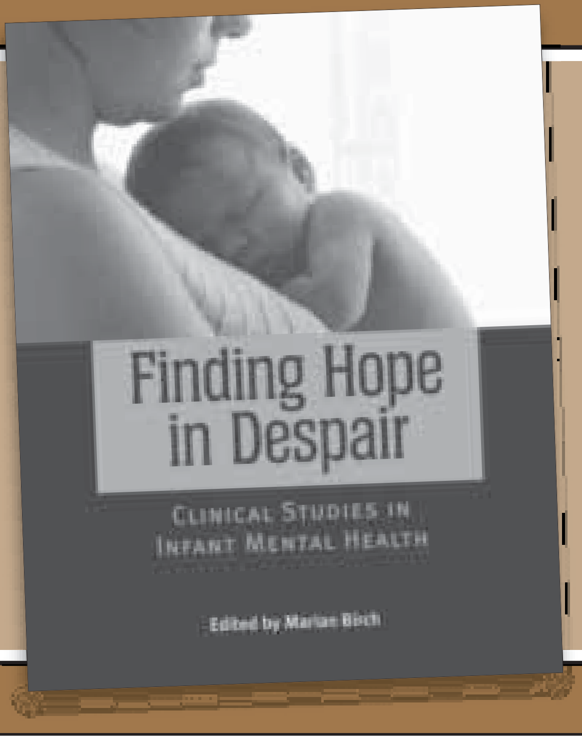
I asked to hold Carina and modeled interruption of her arching and preferential head position by placing one hand at the base of her skull to introduce posterior neck elongation (to relax and lengthen the muscles at the back of her neck) and support midline orientation (a forward-facing position), and placed my other hand over Carina's hands which I gathered on her chest to provide reassuring containment and gentle pressure to interrupt her tendency to arch. With minimal animation, I slowly stuck my tongue out. Carina watched with hesitant attention and made a slight adjustment with her own tongue between her lips, made more possible because I helped her gain better control of the neck muscles that stabilized her tongue. I commented that this showed us that even very young babies can imitate us. This was how they learned things, like facial expressions and feelings that accompanied them, from the important people around them. I returned Carina to Marina's lap and suggested she try this game. I emphasized my hand placements to interrupt arching, maintain midline orientation, and contain arm tremulousness to afford Carina a sense of postural security to free up her attention for her mother's face and voice.

Marina and I talked about the pressures she felt in her life which distracted and drained her. Building on our recent discovery that Carina could begin to learn the calm, troubled, or frantic communication Marina's expressions carried, I suggested Carina might be sensing and experiencing Marina's own frustrations and anxieties. Then I helped Marina think about her baby's own preoccupations and the possibility that she was overwhelmed with all the activity that swirled around her—sights, sounds, internal and external sensations, movement—things we adults might take for granted or they might irritate us too, recalling the reflux-heartburn analogy.

I continued along this path and returned to the "looking away" that Marina interpreted as Carina's being mad at her, not liking her. I asked Marina what she did when she couldn't handle "one more thing." Marina chuckled "Check out." I likened the demands Marina experienced as similar to the exposure to so many new things every day in Carina's young life. Carina was so preoccupied with listening, looking, and feeling that something as natural as eye-to-eye contact was what tipped her scale and she would check out. She couldn't run to her room and shut the door nor could she run back to the streets, which were Marina's primary ways of checking out. Carina's limited means of checking out included gaze aversion or turning her eyes away, effectively "shutting the door" to further interaction, and her protective "salute" arm postures that Marina interpreted as "pushing her away." I did a salute posture, not unlike a traffic cop stopping on-rushing cars, and explained that premature infants like Carina actually use this body language to tell us to "STOP! I'm overwhelmed, I need a break, or help calming down."

Marina brought up the "crazy look and the fist shaking like she wants to hit me." Marina held Carina loosely in one arm and as her voice amped up and she shook her free fist to demonstrate her point, Carina, as if on cue, became tremulous with wide open eyes. I reassured Marina these too were ways Carina told us she was overwhelmed, that her immature nervous system was maxed out and needed a break or different support to regroup. I asked Marina to do an experiment the next time these behaviors felt hurtful… take 10 slow breaths and reconsider what Carina might be trying to say. This rhythmic regulation and nonverbal conversation was an opportunity for the two-way communication that might just be the right contingent response to Carina's gaze aversion or tremulousness. They would provide Marina with a chance to note whether there was any change in Carina's behavior or availability, and I hoped she would realize her baby was not mad at her, didn't want to hit her, and wasn't crazy.

Marina heard the washer buzzer and announced she had to put the baby clothes in the dryer because Carina had puked on everything. She plopped Carina down on the floor beside me. I rolled her over onto her tummy. Carina wailed immediately. I stabilized her bottom down to interrupt her impersonation of a seesaw. When Marina reappeared, I noticed the deflated expression just before she said "See, she won't let me get anything done. She expects to be held or fed all the time." Simultaneously, noting that Carina was on her tummy, Marina stated emphatically "and she hates being on her tummy." I credited Marina with being so observant of her baby's preferences. I suggested that her arching might make tummy time unpleasant and availed myself of another opportunity to help Marina experience Carina's motor and emotional world. I asked Marina to consider Carina's effort to lift her head, to mimic the arched trunk and seesaw dynamics by imagining herself lying on her stomach with her legs elevated and then trying to lift her head. Marina instantly realized this put pressure on Carina's chest and compromised her breathing with a feeling of restriction familiar to Marina because of her own chronic asthma.



Because tummy time was important for development, I demonstrated ways it could be modified to stabilize Carina's hips down, shifting weight off her chest and toward her pelvis.

## Outcomes and Impact

In the 1-hour visit described above, I addressed the authentic physical therapy concerns about the baby's self-regulation, feeding issues, arching, and productive tummy time. I made an effort to see the baby Marina saw. I validated Marina's reality without further threatening her fragile view of self and ability to meet the demands of motherhood. I confronted Marina's negative projections in her meaning-making of Carina's behavior by interpreting her baby's body language. I offered a window into her baby's reality through some verbal, kinesthetic, and emotional language to plant the seed for reflective parenting. I did not deal directly with the most prominent physical therapy concerns of torticollis, plagiocephaly, and emerging asymmetries in this visit except to demonstrate a midline hold for quiet face-to-face social interaction. I did lay the foundation for an alliance with Marina that demonstrated these visits were about helping both her and Carina. I heard her and focused on her concerns, keeping the door open for future visits that might be tolerant of more traditional physical therapy focused on the baby.

Prior to learning about the importance of early social and emotional development and the importance of relationships for healthy development, I would have conducted a hands-on assessment of the torticollis and left written instructions for how to intervene with the emerging plagiocephaly, motor asymmetry, and arching during routine caregiving. Without exploring Marina's projections and meaning-making, the derailment would have continued to poison their interactions. I would have instructed Marina about limits of formula intake and usurped one of her primal roles—that of knowing how to feed her baby, thereby destabilizing Marina's feelings of efficacy and competence.

I left this home visit appreciating that Marina had revealed to herself the capacity to be reflective, and I was relieved that I had not cast the image of "therapist as expert" and yet had been therapeutically effective for this dyad's socioemotional and physical development…keeping the door open.

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*__Margaret Ritchey__, MA, RPT, received a master's degree in physical therapy from Stanford University in 1979. She is in her 32nd year of working at Children's Hospital Oakland, Oakland, California, currently as a case manager and the physical therapy consultant with the Neonatal Follow-Up home visiting program, a position she has held for 29 of those years. There have been two career-changing experiences over the past 30 years. The first was being trained by Heideliese Als in her Assessment of Premature Infant Behaviors while working in Children's Hospital's ICN in the 1980s. The second was the growing awareness of the importance of the emotional life of a child developed through the parent–infant relationship. This seed was planted during the persistent mentorship of Dr. Mary Claire Heffron in the 1990s and was nurtured through participation with two separate cohorts of fellows in the University of Massachusetts Boston sponsored Infant Parent Mental Health Post Graduate Certificate Program in Napa under the leadership of Drs. Ed Tronick and Kristie Brandt in the past 3 years. These experiences have had a profound influence on the way she serves her infant patients and their families.*

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# Learning the Dance of Connection

## *Helping a Foster Mother and a Child With Fetal Alcohol Spectrum Disorder*

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The arrival of a new child into a family's life may offer various opportunities for change as well as challenges. Adopting parents, similar to biological parents, await the arrival of the newcomer into their lives with expectations, anticipations, and hopes. At times, the actual experiences include pain, disappointment, and other negative emotions that seriously impact the fragile relationships between the young child and the caregivers.

As a clinician, I am privileged to witness and share the experience of the relationships in families I serve. I strive to remain mindful of my boundaries, judgments, intentions and emotions, and my role and responsibilities in the therapeutic process by identifying the needs of each child and her caregivers, and providing support, tools, and resources when needed. In the following article, I share my experiences with a family that taught me the power of positive interactions, the healing power of timely repair, and mindfulness and compassion, which grew out of a deep understanding of the developmental challenges of a young child with complex special needs.

## Background Information

Lana was born full term with the presence of alcohol in her system. In addition, the hospital's medical team who evaluated Lana at the time of her birth thought that she had suffered a stroke at the time of delivery; she seemed paralyzed in her left side. There was no clear evidence of genetic anomalies. Her mother had denied the pregnancy until the 8th month and had used alcohol throughout her pregnancy and at the time of delivery. Following childbirth, her mother had returned back to the streets, her whereabouts unknown, and there was no mention of a known father. After birth Lana spent more than 1 month in the hospital before being discharged to a foster family.

Glenda, Lana's foster mother, was considering adopting her. However, her immediate and extended family members were initially against the adoption because of the complexity of the challenges and concerns Lana presented. At 14 months old, Lana was brought to the attention of the Los Angeles County Children's Court (LAC-CC) for the refill of her medication. (All medications for children in foster care within Los Angeles County are supposed to be approved by the residing judges in the Children's Courts, in consultation with a mental health team located in LAC-CC.) Lana was not receiving any intervention with the exception of psychotropic medication that had been prescribed by a child psychiatrist. LAC-CC team consulted with me as to whether or not to authorize psychotropic medication for Lana. I met Lana when the residing judge on her case referred her to a clinic where I could provide her neuropsychological evaluation and mental health treatment.

## Developmental Challenges and Needs

Lana had a clear physiological profile of a child with Fetal Alcohol Spectrum Disorder (FASD), but had neither been evaluated nor diagnosed. Her facial features and history, as well as a neurological

**Abstract**

**Prenatal exposure to alcohol results in complex problems for the developing child, some of which are long lasting, and may be irreversible. The earlier the intervention, the higher the probability of a positive outcome. In this article, the author illustrates the complex challenges stemming from Fetal Alcohol Spectrum Disorder (FASD) and how a multidisciplinary team of caregivers and professionals, using a treatment intervention model based on the Neurosequential Model of Therapeutics (NMT), made a significant difference in the quality of life for a child with FASD and her caregivers.**

Photo: ©iStockphoto.com/Mark Goddard

**The arrival of a new child into a family's life may offer various opportunities for change as well as challenges.**

evaluation, suggested FASD. Lana was able to walk, but with a limp. Her left eye was half-shut and her left arm was moving but with difficulty. In collaboration with her pediatrician, medical evaluations showed significant congenital neuro-physiological damage, problems with her digestive system, problems requiring prescribed eyeglasses (which she did not wear), inner-ear surgery, and heart surgery.

Lana had difficulty processing environmental cues, even the ones she received frequently from Glenda in the form of commands. She was not able to self-organize, and she became overloaded and overwhelmed rapidly by the sensory stimuli, thus over-reacting and presenting what seemed like symptoms of attention deficit/hyperactivity or autistic behavior. Lana was usually dressed beautifully, but was scratching herself constantly. As soon as she walked into the playroom, she took her shoes and socks off and cried out to her foster mother to take her dress off too. Glenda reported Lana did this wherever they went—wanting to take her clothes off, and scratching herself whenever she was dressed with a new outfit. Lana over-reacted to touch and sounds, and she did not like to be around too many people. She put her hands on her ears at any loud noise or sound. When she walked into the playroom for the first time, Lana ran around the room, checking out the toys by touching each and every one. She then went under a table and did not come out for about 15 minutes. When Glenda took her out of her hiding space, she closed her eyes and covered her face with her hands.

Lana was fussy during feeding and had had digestive problems since birth. Lana could not tolerate delays when hungry but at other times she played with her food and had to be force-fed. Her feeding challenges seemed to be somewhat related to the congenital digestive problems. She mouthed nonfood material and had to be watched constantly.

Lana fell down frequently and walked into things and over things without notice. She did not react to pain. When she fell down she did not cry, nor did she ask for help. Lana was restless, running around and banging at furniture, climbing furniture, and jumping up and down on her high chair. She seemed accident-prone and did not avoid risky or dangerous situations. She could not do simple motor tasks such as roll a ball or pull a ring.

Lana did not express her needs and wants verbally, and her caregivers did not understand her nonverbal cues. She did not speak a word when I met her but made indistinguishable sounds. Glenda expressed frustration about Lana's inability to respond to her verbal or nonverbal instructions and cues. Glenda reported that Lana would get upset easily and when upset, she would bang her head, scream, kick, or bite, and would not want to be held. She had difficulty calming down or soothing herself; would cry until she vomited or sometimes until she fell asleep.

Lana showed frustration when she could not do things for herself. For example, when in pain, hungry, wet or soiled, sleepy or in need of being held, when she wanted to take her shoes off, or find her spoon that she had dropped, she cried, banged her head, threw tantrums, kicked, and threw things around. One major challenge for Lana was to learn from her experiences, and to remember and generalize what was shown to her. Glenda also complained that Lana did not sleep at all. She was getting out of her bed and roaming around the house during the night, preventing her foster family from having their rest and sleep.

Lana would approach any stranger without fear and did not differentiate strangers from significant adults in her life. On the first visit, I was in the waiting room to greet them. When they arrived, I went toward her offering her my hand. She looked at me, took my hand and walked with me to the playroom without looking back at Glenda. During the first session, Lana played by herself with one toy, and repeated one movement (whirling) for a long time. Lana did not seek Glenda, and Glenda did not engage Lana. At one point, Glenda left the room and Lana did not react. She was indifferent to Glenda's return to the playroom after 10 minutes. During the first two sessions, Lana and Glenda did not play with each other, did not exchange toys, gestures, signals, or objects. The extent of Glenda's engagement with Lana was to call Lana to go to her.

## The Neurosequential Model of Therapeutics

THE INTERVENTIONS PROCESS began from the initial visit with Lana, Glenda, and her family members, and consisted of a comprehensive evaluation, including history taking, therapeutic observation, standardized screening and assessment, and videotaping Lana's interactions with Glenda and her family members. Intervention was based on the Neurosequential Model of Therapeutics (NMT; Perry, 2006) which includes using a Brain Map to show where and to what extent different parts and functions of the brain are developed, and how development can get stuck in these different areas. NMT is not an intervention model, but a way to understand how the child's ecological history (including genetic, epigenetic, and environmental factors) has impacted the young child's current functioning, in order to plan for the best suitable therapeutic procedure and process (Perry). The comprehensive assessment included measurements to assess Glenda's stress response level, and Lana's memory, sensory, cognitive, psychosocial, and regulatory systems' functioning level. These measures were administered at the initial assessment phase, annually, and at the discharge point. I was the single fixed point of responsibility, coordinating the family's access to the needed services in addition to providing mental health treatment for the child and her caregiving family. Treatment goals were updated semiannually.

Treatment was based on the underpinning belief in the importance of the child's early experiences (including epigenetic factors)

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**Infant massage was applied to facilitate positive, face-to-face relationship, to improve vital signs, and to reach the regulatory, sensory, and emotional brains simultaneously.**

and face-to-face relationships with the significant adults in her young life, individualized for Lana and her caregivers. Treatment included relationship-focused and strengths-based therapeutic intervention, and parent education and support. Some specific tools for reaching the treatment goals included Biofeedback, using simple games to assist with focus of attention, concentration, and delayed gratification. Also, infant massage was applied to facilitate positive, face-to-face relationship, to improve vital signs, and to reach the regulatory, sensory, and emotional brains simultaneously. Music played a significant role in treatment sessions as Lana began responding positively to some melodies, tunes, and rhythms. I also trained Glenda to use rhythmic, repetitive movements to soothe Lana when she was upset, instead of placing her on “time out,” leaving her alone to cry and bang her head, signaling abandonment and lack of empathy.

Creating an environment of safety is a priority when providing mental health services for families, particularly those with young children, and especially young children with complex special needs, such as Lana. A sense of safety includes the service provider’s predictability, consistency, patience, mindfulness, and compassion. It also includes the quality of the environment in which services are delivered: the lighting, colors, furniture, arts, plants, music, warmth and welcoming of the waiting room, and verbal and nonverbal communication of those first encounters with the family.

## The Dance of Connection

Following the clinical assessment, the residing judge decided to order against further psychotropic medications for Lana for the time being and placed her under the supervision of her pediatrician. With direct input and full engagement of Lana’s foster/adopting family, I put together an interdisciplinary team which included representatives from Los Angeles County Departments of Health, Children and Family Services (DCFS); Children’s Courts Mental Health Team; Children’s Court Appointed Attorney for Lana; Court Appointed Special Advocate (CASA); Regional Center agent; occupational therapist; physical therapist; speech pathologist; and Lana’s pediatrician. As other members of the team joined in and we were able to receive more support for Lana, it became very difficult for Glenda to make all the rounds about town every day, from one appointment to another. Although we met twice a week at the beginning, I gradually limited my face-to-face sessions to once a week, and I visited them at home. Glenda was able to call me wherever and whenever for whatever reason she felt she needed to contact me.

Lana’s over-reactivity to various sensory stimuli continued beyond her second birthday, but in lower frequency and intensity. With support, Glenda and her family members became more skilled in helping Lana to eat well and eat regularly. Although there were setbacks, Glenda remained committed to Lana’s healing process. She was able to read Lana’s cues better so she could prevent meltdowns before they occurred. And when they did, Glenda remained calm and helped Lana to do the same. She used soothing techniques she had learned, and they worked. However, Lana’s sleep–awake cycle remained disorganized and at times problematic until Glenda became able to spend more time with Lana, following a certain sleep ritual to help Lana to increase from sleeping in short napping cycles to sleeping 4 hours straight every night without any medication. Reportedly, Lana became able to take naps while she was driven in the car.

Lana showed increasing interest in sharing her experiences with Glenda and other adults in various settings and situations. Gradually, Lana began to seek Glenda to show her small discoveries and began sharing toys and objects with her during play. Lana no longer wished to remain behind when Glenda left the room. She began to hold her hand and walk with her, at times looking up toward her face, pointing at children, animals, and flowers she saw in her path. She learned to seek help, initiate interactions, and respond to others attentively.

Her positive response to music increased further. After 2 months of treatment, each time she walked into the playroom, she went straight toward the stereo and pointed to it, making a distinguishable demanding sound, moving her body, gesturing dancing. She began to distinguish between music CDs I played for her. When she did not like the music, she stayed still, folding her arms on her chest. When she liked it, she began dancing. Glenda enjoyed this very much and began holding her hands, dancing together. This relational, literal and symbolic dancing of the dyad appeared to me as a significant point in their relationship. Glenda spoke to her, lead her, and at times let her lead their swirling and turning around movements, which directed Lana’s energy, brought visible joy to her face, as she gestured and pointed more, and babbled in a various range of sounds. One day she walked in with a music recording, which she wanted to play on the CD player. She had made Glenda understand that she wanted to bring it to play at her session that day. As soon as the sound of the music was heard, she approached me, reached for my hand, and began moving her body. I interpreted this as her invitation to dance with her. She began to laugh with joy as we held hands dancing together while music was going, and Glenda clapping with tears of joy coming down her face.

By the time she was 18 months old, Lana was able to sign over ten different signs in American Sign Language correctly and showed clear improvement of receptive language over her expressive one. Lana had also learned a few words, one of which was “ouch” that she used when she sensed an object of her discomfort. One day, as they walked in to the playroom, she looked at my hand that was wrapped because of an injury I had experienced a few days before. She came toward me, pulled my arm, took hold of my hand wrapping, trying to take it off, repeating, “ouch, ouch.” I took the wrapping off my hand, and she took it from me and threw it in the trash can. I interpreted this interaction as meaningful, as I sensed empathy and concern from her toward me, and a significant developmental milestone. In my judgment, Lana’s success for communicating her feelings and sensory input in an organized manner, in such a short intervention time, was due to her caregiving family’s commitment in helping her to grow once they learned and understood her developmental dilemma, benefiting from the ongoing support and collaboration of the professional team members.

Lana and her caregivers were taught to practice together a simple meditation technique symbolized by sequencing breathing in, "smelling the flower," and breathing out, "blowing out the candle" with her eyes open or closed. Lana learned to seek her caregivers, especially Glenda, when she needed to self-regulate. Glenda communicated with Lana when she felt she needed to take a time-out before the stressor became overwhelming for her. She learned to sign stop, and closed her eyes, while standing next to Glenda, breathing out loudly enough for Glenda to understand her need to "meditate"; a time to calm down.

At her second birthday, with the medical specialists' support, occupational therapy, ongoing use of some massage movements and family's support, Lana's left eye was almost as open as her right eye, and she was able to walk with improved gait. Equally, her digestive system improved, which in turn helped her with her feeding habit. Her height grew but remained below the standard. Each time they visited the clinic, just before she walked out of the playroom, Lana stopped against the wall where I had set the height measurement, to check her height, smiling when she was told that she seemed taller, even by smallest measurement. By 3 years old, Lana's motor skills enabled her to throw and kick balls of different shapes and sizes, manipulate simple tools such as sucking on a straw; push a stroller toward the wall and turn around rather than banging it to the wall; walk around toys rather than over them; and reduce the frequency with which she fell down.

Shortly after she turned 3 years old, Lana's foster family moved across the country to be near their family members. She was discharged from all the services she was receiving in Los Angeles County. I made referrals for transfer of services to facilitate the family's transition and access to services available for them in their new home. A 1-year follow up was made through a written communication by Glenda, giving the good news that they have finally adopted Lana as their child, and describing increasing growth and improvement in her abilities to cope with changes and challenges as she faced them.

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**Families require commitment, patience, mindfulness, empathy and compassion, respect, and inclusion.**

## Keys to Success

Lana and her foster family, who ended up adopting her, allowed me to share 26 months of their lives with them. When I first met Glenda, and later the rest of Glenda's family, I learned that they were reluctant to participate in the therapeutic process with Lana but they had to, because it was court-ordered. However, when the intervention process was explained to them, and their major roles in the process were emphasized, their behavior and interactions positively shifted.

Education and training on human development and various brain functions became an ongoing part of the family sessions both at the clinic and during home visits. Glenda's paradigm shift took place early enough during the intervention process that the success was made easier. By learning about the developmental process of a human brain in general, and Lana's in particular, her caregivers learned to work through their own emotions, feelings, beliefs, and expectations.

In serving families with young children, collaboration and interdisciplinary teamwork is essential. At the same time, different professionals from various agencies with different plans and objectives overwhelmed this family. Prioritization and a gradual inclusion and expansion of the needed services might have been a more effective strategy to implement. There is a significant need for a central place for families to receive interdisciplinary services so the family does not have to travel to all directions on all hours of most-every day of the week to receive different services.

During this time period, I witnessed Lana's relationship with her foster family change from her indifference in their presence, to wanting to be with them, seeking their attention and approval, and running to hold and hug them. Glenda and her family also moved forward in their care for Lana by actually adopting her. I saw Glenda learning to mother Lana, as she began to re-mother herself. Holding my hand when she traveled back to her own childhood, recalling memories she said she had never known she had, filed somewhere in her brain. She cried, laughed, and processed a wide range of

### *Learn More*

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*www.hss.state,ak.us/fas/*

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**Washington State: Fetal Alcohol Spectrum Disorders**
*http://depts.washington.edu/fasdwa/index.htm*

emotions from anger to forgiveness, to compassion for herself and her family, including Lana. For me, professionally, this was another valuable experience to witness devastating impacts of prenatal exposure to alcohol, as well as the miracle of the brain's elasticity and its capacity to develop new pathways to learn and grow. I also observed this family travel from alienation to unity as a family; from anger, disappointment, regret, indecision, and doubt, to competency, empowerment, collaboration, empathy, compassion, and hope. I confess it was not always easy. One key to the success of this story was that no matter what happened, I did not give up on Glenda and her family going through the whirlwind of emotions and indecisions.

I also grew stronger and more skilled in using the NMT as a scientific base to set up the intervention plan for Lana and her family, taking the responsibility of teaching the adults in Lana's foster/adoptive family as well as other professionals involved with them about the devastating impacts of FASD on Lana's organs, especially her brain, the power of a scientific approach, and working closely together every step of the way. I maintained my ongoing reflective supervision with my mentor regularly, no matter where he was traveling around the world, and no matter how financially expensive that became for me.

In their path from pain to healing, families require commitment, patience, mindfulness, empathy and compassion, respect, and inclusion. Behavioral and emotional problems due to FASD, and caregiving family's pains, cannot be resolved through some of the short-term treatment interventions. Challenges for families with infants and young children like Lana are complex and multidimensional, demanding effort and full collaboration of everyone involved. Clinicians must hold tight to the pillar of ethical and legal guidelines while moving beyond the desk to be available and accessible, shifting and expanding the clinician's role to act as a parent, a friend, a teacher, a secretary, an assistant, and always an advocate.

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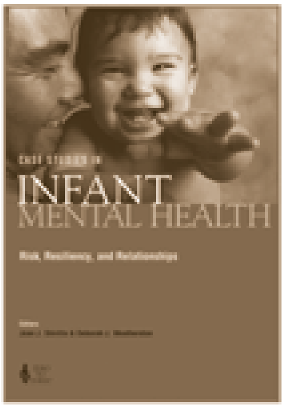

# Using a Team Approach to Meet Complex Family Needs

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Samantha was the result of an unplanned pregnancy to a very young couple, Eden and Gabriel. The couple had to face numerous struggles as their relationship was quite tumultuous. With the news of the impending pregnancy their relationship became increasingly hostile and violent. The couple lived in a trailer on the maternal grandfather's driveway and had very limited resources. As the delivery date approached and their quarrels worsened the space seemed smaller and smaller, and they found it more difficult to simply walk away from their arguments. The yelling arguments escalated to throwing objects at one another, and finally culminated one night in battery. The argument was violent and loud enough that the disturbed neighbors called the police who found Eden, who was 6 months pregnant at the time, on the ground attempting to cover her head and face as Gabriel beat her, deliberately avoiding blows to her unprotected abdomen.

Gabriel was immediately taken to jail. Due to the extensive bruising to Eden's face and concerns for the fetus, she was rushed to the hospital. She suffered a mild concussion, swollen and bruised face, as well as extensive bruising on her arms. Her abdomen was untouched. The results of the fetal ultrasound showed no harm to the developing fetus or placenta, or loss of amniotic fluid. Eden was encouraged to file charges immediately and to request for a restraining order barring Gabriel from returning home once he was released from jail. The hospital social work staff discussed with Eden the importance of her and the baby's safety, and ensured her that by filing the appropriate paperwork, her husband would be barred from communicating with her in any way, and would have to remain a certain distance from her at all times. Eden appeared to listen to the recommendations, and was found by nursing staff spending a lot of time looking at her bruised face in the mirror.

As the police and social work staff encouraged Eden to press charges and complete the requisite paperwork, she wondered how she could possibly handle the rest of the pregnancy by herself. She knew her family's involvement consisted of acquiring the trailer and allowing it to remain on the driveway, but they were quite clear they could not help her any more than they already had.

## Concerns During Pregnancy

Eden had always been ambivalent about the pregnancy. In fact, Gabriel had dissuaded her from aborting the fetus, convincing her that they were "ready" to have a child. Gabriel had been invested in this pregnancy, and was excited by the idea of becoming a father. During the quiet and happy moments, he sat calmly rubbing her belly, talking with her about the

**Abstract**

**Mental health clinicians who work with families with infants and toddlers often face complex challenges that require collaboration among many professionals and disciplines. A team approach to addressing infant mental health is critical to successful intervention. In the story that follows, a fractured family dealing with interpersonal violence and maternal mental illness seeks help to enhance the life of their developing child. The case reveals how the multiple providers worked together to move treatment forward, manage setbacks, and ultimately help a family overcome the barriers to treatment and provide for the well-being of their child.**

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**A team approach to addressing infant mental health is critical to successful intervention.**

plans he had for the child, including sporting events, camping, video games, all of the things he enjoyed. Eden listened intently to Gabriel's dreams, silently imagining them as fairy tales, where everyone lived happily ever after. As she listened she wondered how any of this could possibly come true as they were currently unemployed and living in a trailer on her father's driveway. Eden wondered how they could possibly afford any of those dreams. She had a difficult relationship with her in-laws as she knew they blamed her for their Gabriel's behaviors, and saw her as a corrupting influence in his life. Even though they had money and means, she refused to ask them for help. So she held her tongue, and quietly listened knowing his dreams would never happen, not in their world, not in their baby's world.

Secondary to her continued ambivalence about the pregnancy, Eden often missed prenatal visits, and would take the prenatal vitamins occasionally, when she remembered. She decreased her cigarette smoking from two packs a day to half a pack and occasionally a full pack, if she was particularly stressed. She did not read all of the materials given to her by the free clinic, as she believed they judged her for coming in with bruises on some visits, and one of the nurses had witnessed her smoking in the parking lot before another visit.

Eden finally decided she could not "go it alone" and refused to press charges or file any paperwork that would keep Gabriel incarcerated for any protracted length of time. She thought her generosity would be appreciated. She thought her boon, combined with the nights spent in jail, would suitably frighten Gabriel enough that, she reasoned, when released and returned home, his behavior would change. After returning home, Gabriel did express his gratitude and promised that he would mend his ways and would not hurt her anymore, "even if she pushed him." Life became routine and things were calmer as they approached their due date.

## The Baby Arrives

The delivery itself was uneventful. Samantha was the result of a normal, spontaneous vaginal delivery. They remained in the hospital slightly longer than usual, as the hospital staff was concerned with the degree of Gabriel's jubilation, which they found excessive. They were equally worried about Eden's apparent disinterest in the infant, as she refused to hold her and elected to not even attempt to breast feed. She did not show any interest in the care of her daughter and abdicated all duties involving the infant to the father who eagerly participated in any and all responsibilities. Nursing staff shared their concerns with the social work team which, after visiting the young family, also had grave concerns. The family was encouraged to use voluntary services from the Department of Children and Families. The family thanked the team for the information and declined services. After their extended hospital stay, the family was discharged, leaving behind deeply concerned providers. The information on voluntary services was found later discarded in the bathroom trash can.

Upon returning home, the family was woefully unprepared for the reality of caring for a newborn. Eden became increasingly depressed, and Gabriel's moods fluctuated from despair to elation. When Eden finally confronted him about substance use, he left the home and did not return.

Eden was left with a child whom she had never wanted and to whom she felt no attachment. Her mood worsened without Gabriel's presence, which had surprisingly stabilized her somewhat. As she grew more depleted each day, she finally called the people whom she never thought she would call for assistance, and took the baby to the paternal grandparents' house.

The paternal grandparents had been worried throughout the entirety of the ill-prepared couple's relationship. While Eden was correct in thinking they blamed her, they also realized their son had significant mental health issues which were never addressed and had led to his substance use and running away to cope. The grandparents worried the relationship and subsequent marriage would end poorly secondary to Gabriel's difficulties, and when they heard about the pregnancy their concern increased. Due to their differences with Eden, the grandparents felt they had been "cut out of their son's life."

## A Cry for Help

When Eden dropped the infant off at the grandparent's home and left her, they were initially overjoyed. This pattern continued, when Eden would call with little notice and leave Samantha for indeterminate periods of time from a few hours to days. The grandparents created a room for their granddaughter at their home, since some of her "visits" became extended stays. They bought her clothes, as hers reeked of smoke. And she suffered from multiple ear infections and runny noses. The grandparents were very concerned each time they saw Samantha as she was an extremely quiet baby and was very small. They tried to approach Eden cautiously, for they feared if they were seen being too aggressive she would stop bringing the baby over and they would lose all contact with their granddaughter. They treaded carefully; however, over the ensuing weeks and months, they could no longer keep silent, as the child appeared more atypical. At 11 months of age, she could not yet crawl and was missing other milestones. The grandparents became increasingly concerned with what they described as an odd expression on her face. They stated that she would sit quietly, with her eyes closed, making a sonorous sound. The grandparents alarm increased when Samantha would close her eyes and hum for hours, without pause unless deliberately interrupted.

The grandparents had successfully reared children of their own and were retired educators. They were familiar with the various aspects of normative child development and had never witnessed these types of behaviors. They thought that the constellation of symptoms meant Samantha was on the autism spectrum, and again attempted to gently engage with Eden, soon realizing that she appeared increasingly compromised as well. On one occasion, they thought that Eden's affect mirrored Samantha's in that she sat on the couch and stared blankly at them, without comment or expression as they outlined their concerns.


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**Was her experience with her mother so devoid of interaction that all she knew to do was sit, rock, and hum?**

The grandparents were initially heartened as she listened to their concerns and did not storm out as they had feared. They outlined their concerns, starting with the Samantha's motor development; her inability to crawl or sit up unassisted. They segued to concerns about the baby's apparent lack of interest in her surrounding environment, how she never appeared surprised or upset or joyful. They discussed how she never babbled happily like other babies, and, when she did vocalize, it was a low, monotone, sonorous sound. They mentioned that she never cried, not even when distressed, such that it was hard to know when she was hungry or wet or to read any of her cues.

They wondered with Eden how Samantha's needs could possibly be met by anyone. They confessed their worries for her as well, as she seemed more depressed since she and Gabriel had informally dissolved their relationship. They wondered with her about finding someone to talk to about her concerns, worries, and fears. As they talked, Eden sat and listened, and wondered. She wondered when they would finish as she was tired and wanted to go home and go to sleep. After the discussion was over, Eden left and did not return for weeks.

The grandparents became convinced that they had to formally intervene. They knew things were becoming worse, and Samantha could no longer wait. They called child protective services and told them the entire story as they had kept a record of the unexpected visits and the lengths of stay. They talked about the room they had created for the baby and discussed their multiple concerns. They confessed that they had not called before in the past, for fear that Eden would discover that they had called and would punish them by not allowing them to see the baby. Now, they were now more worried about Samantha than they were about Eden's potential upset. They outlined their concerns about their grandchild's physical, cognitive, social-behavioral, and emotional development. They shared their concerns over the frequency of her multiple illnesses. They stressed that they were not sure if Eden was taking the child to all of her pediatric visits.

The case was investigated and a file opened. Eden was given guidelines, which included taking Samantha to all scheduled pediatric visits, participating in all aspects of her care, and attending parenting and child development classes. She was also to participate in meetings with her social worker and the grandparents and any other team members deemed pertinent. Eden attempted to comply; however due to her depression, she began to miss appointments. The pediatric provider was highly concerned as the child was in the third percentile for height and weight, had no language, not even babbling, could not sit unassisted, and was not ready to crawl. She also exhibited the odd behaviors of humming uninterrupted with her eyes closed for long stretches of time. As it became apparent that Eden was unable to be successful with the clearly outlined expectations, Samantha was placed in the care and custody of her grandparents. Eden was allowed supervised visitation weekly, initially for 3 hours, and was strongly encouraged to seek out a mental health professional as there was ample evidence that she was suffering from a psychiatric illness.

## Intensive Early Intervention

After the now 14-month-old Samantha was placed in their care, the grandparents immediately accessed services, including an assessment from the birth-to-three early intervention team. After a thorough evaluation, the toddler was diagnosed with global developmental delays and qualified for intensive early intervention services, including speech/language and occupational therapy. The grandparents enrolled Samantha in a day care setting, as they were concerned about her lack of socialization, and thought she needed to spend time with typically developing peers in a play-based setting.

The grandparents contacted the pediatrician regarding child nutrition, and she was placed on a high caloric diet in an attempt to increase her weight. She was also placed on an aggressive regimen of antibiotics to tackle the pervasive ear infections, and there was plan to have her hearing tested when the infections finally cleared and to consider placement of tubes in her ears. Even with aggressive implementation of all recommended services, Samantha's grandparents were still concerned regarding the humming/eyes closed behaviors, as that remained unchanged.

The grandparents identified that within 4 months of being placed in their home, Samantha went from not being able to sit unassisted to walking, albeit with an unsteady gait. The grandparents were concerned that language did not have the same amount of gains; however they were convinced this was secondary to the unrelenting ear infections. The grandparents believed an appropriate medication regimen, placement of tubes, lack of exposure to cigarette smoke, and weekly speech therapy would result in language gains.

In the ensuing months they became concerned that the humming behavior had not abated. If left unattended, Samantha would immediately close her eyes, rock, and hum. The grandparents began to fear that none of the therapies which she received addressed this particular domain of development, and they felt out of their depth. The grandparents confessed that although they knew the challenges when they agreed


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**The work became increasingly complicated as for every gain there appeared to be a setback.**

to become guardians, they had thought that once placed in a loving, nurturing, healthy environment and with implementation of services, Samantha would "come around quickly."

Samantha was brought in to the Early Childhood Clinic (ECC) by the paternal grandparents when she was 18 months old because of their concerns. The clinic took a thorough history from the grandparents and gathered all of the pertinent records from child's multiple providers including the medical records, the birth-to-three team's initial assessment, and current status reports. Samantha began attending weekly behavioral observation sessions, with a grandparent present, to attempt to address the social-emotional-behavioral concerns.

At the initial session, the toddler was greeted in the waiting room, where she appeared engrossed in a fish tank, tapping the window and following the fish with apparent interest, though with little affect and no vocalizations. Samantha was picked up and placed on the ground by her grandfather, as she had been standing on a couch to interact with the fish. She hesitantly walked back to the playroom, with an unsure and unsteady gait, her steps slow and measured, as she walked down the long corridor to a large mirrored playroom. Upon entering the room, she stood in the middle of the space, not exploring the room nor any of the toys which had been placed in the center of the room. Instead she stood, appearing frozen, without any affect to enlighten her observers if she were frightened, interested, or bored. Instead she stood still and unmoving. Only after being encouraged and helped to the floor by her grandparent was she finally able to sit.

As Samantha sat on the floor, she immediately closed her eyes, began to gently rock, and hum, just as described by her grandparents and the other providers that administered in-home services. Samantha sat, rocked, and hummed, until her face was gently touched and her name called, at which point she opened her eyes and looked around the room. She was handed a toy ring, which she immediately brought up to her face to explore, taste, and smell, before banging it on the floor, reaching for another ring in the container and banging it as well. As the child continued to bang the rings on the floor, a clinician made comments about the colors of the rings, the sounds she was making, and the shape and feel of the objects. Occasionally during the first session she appeared to be interested in her play partners and would look at them, however it was not until many weeks later that she would truly examine the play partners.

Samantha's behavior could have been deemed intrusive, as it consisted of standing very close, and she made tactile as well as visual examinations of hair, eyes, nose, teeth, mouth, clothes, earrings, and any other item that appeared of interest to her. Of note, as she performed her inspections she did not have any vocalizations but appeared to listen to and perhaps even search for the words spoken by others as she placed her fingers in the clinician's mouth attempting to open the organ, as if searching for the mechanism behind the elocution. Once her curiosity appeared to be satisfied, she would wander around the room, and sometimes go to the mirror and stand in front of it, much as she stood in front of the fish tank. She would bang on the mirror and at times appeared to look at the others in the room in the mirror.

The initial work consisted of allowing Samantha the freedom to explore the space and the contents of the room. Separation from her grandparents was not attempted due to her young age, even though she did attend a day care facility several times a week for socialization. According to her teachers, while she reportedly did not talk to the children, she appeared to enjoy them, and often smiled at their antics.

One peer interaction was witnessed in the clinic. As Samantha typically arrived to sessions early, she often had time to play in the waiting room. Occasionally other children were present, and on one such occasion there was a boy, younger than she but her size, who appeared quite intrigued with the "baby" as he called her. He followed her around talking to her, trying to engage her with language. Samantha appeared simultaneously intrigued and horrified by the little boy's persistence. Finally it was time to start the session and the little boy said "bye" and hugged her while Samantha stood frozen, closing her eyes, clenching her fists, and turning her face from the other child's touch and kisses. While Samantha appeared to both struggle and at times enjoy the interaction, her lack of language skills set her apart from her peers.

The work at the ECC continued for months, working with the grandparents and later including Eden, whose visitation had been modified to one 8-hour, unsupervised visit a week.

Samantha's reaction to her mother was quite interesting in that she began to slowly include her in play, taking objects over to her, at times in an apparent bid for assistance. Other times, Samantha took toys to her mother, and would sit in front of her as her mother examined the toy. Samantha would close her eyes, rock, and hum. Was a pattern emerging, did she exhibit these behaviors not just when introduced to a new place, situation, or person, but was her historical experience with her mother so devoid of interaction that, even with toys, all she knew to do was sit, rock, and hum? Eden, aware that she was being observed, would become somewhat frantic in her attempts to engage her daughter and, much like the little boy from the waiting room, would become increasingly intrusive, even slightly aggressive in encouraging Samantha to "play with Mommy." Samantha would appear repelled by her mother's actions, and would physically leave Eden and walk to her grandfather or to the clinician. This type of interaction was played out again and again, week after week, seemingly seeking her mother out for play and then rejecting Eden's attempts.

As treatment in the ECC continued, collaboration with in-home service providers, which consisted of occupational therapy and speech/language therapy, became necessary. The ECC clinician would communicate via email with the early interventionists regarding the weekly goals of the therapies. Through weekly emails, the providers were able to discuss different treatment options as well as share impressions and concerns regarding Samantha's progress. An attempt to help Eden understand her behaviors and her daughter's responses occurred across sessions at the ECC and during in-home services. Suggestions offered for positive interactions, however, resulted in Eden's appearing more defensive and more flippant in her responses. Eden began to suffer from various maladies which prevented her from being able to regularly attend sessions at the ECC, as well as in-home services. She stated that she feared she would infect the child, as Samantha experienced bronchiolitis and still suffered from numerous ear infections, even with the placement of tubes. Eden began to miss sessions and when she attended she appeared less engaged, often checking her cell phone or playing with the toys.

During one session, Samantha attempted to engage her mother, using a Mr. Potato Head arm as a brush to brush mother's hair, however, after initial participation the mother cried out in pain as the child pulled too hard. There was also continued tension between the family, with Eden appearing to resent the easy way in which Samantha interacted with the grandparents, particularly the grandmother, seeking them out for play and comfort, sitting on their laps easily. There appeared even more tension when Samantha interacted warmly with the ECC clinician, someone whom she only saw once a week.

The work became increasingly complicated as for every gain Samantha made there appeared to be a setback. She continued to have multiple ear infections, even after tube placement, which was linked to the fact that Eden smoked in her presence. Her speech was still delayed, though she was using sign language more frequently. She still was not using language to communicate her needs consistently, although her babbling increased significantly. After collaborating with the speech and language pathologist and devising a plan to work on a couple of words intensely for several weeks, across all settings, the child finally began to say and sign "more," linking the word with eye contact.

Working with the family was extremely complicated, as Eden continued her ambivalence in the sessions, at times attending dutifully and appearing interested in the various providers opinions, at other times appearing dismissive and uninterested. Eden also struggled with the interactions with her daughter, not appearing satisfied unless Samantha chose her over the grandparent or clinician, which she rarely did. On occasion when Samantha would spontaneously seek Eden's attention over that of the others in the room, she appeared to preen, and looked pointedly around the room.

## Lessons Learned

THE THERAPEUTIC METHOD included working together with the birth-to-three early intervention in-home service providers. The multiple disciplines involved in the case were able to collaborate via regular email communication and close coordination of services to assist the fractured family and the child. It was difficult at times to work with the different family members, each believing that they were the proper guardian. We continuously struggled with having the family ally, although uneasily, to move the treatment forward.

This case highlights that weekly work with families of young children and collaboration with various providers positively impacts child's treatment outcomes. The aspects of the different therapeutic treatments were shared, created, implemented, and modified through virtual discussions with the early interventionists providing in-home services. At the time of this writing, the child is 30 months old and is still attending weekly behavioral sessions with her grandparents and, at times, with her mother. She is still receiving birth-to-three early intervention services, though they are now clinic-based.

Samantha has begun to speak.

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# Using Evidence-Based Assessments to Evaluate Parent–Child Relationship Quality

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Child development professionals have a long history of viewing the attachment between infants and their primary caregivers as central to healthy growth and development. For children in foster care, the issue of attachment is complicated. When a child is removed from biological parents and placed into foster care, the law requires that "reasonable efforts" are made to reunite parents with their biological families (Adoption and Safe Families Act of 1997, Public Law 105-89). The law also calls for "concurrent planning" to limit the amount of time the child is in foster care before a permanent home is found. Concurrent planning means that child welfare workers must pursue the primary goal of family reunification while, at the same time, they are also developing an alternative permanency plan for the child.

In reality, there are many obstacles to facilitating strong relationships with biological parents when a child is living in a foster home, and it is a particularly difficult challenge for infants and toddlers because of their developmental skills and needs. However, the strength or quality of the child's attachment to his caregivers often comes into play when decisions must be made about placement and permanency planning.

A thorough assessment of child and family functioning is necessary to determine what is in the best interests of the child when it comes to decisions about placing a child in a permanent home. Evaluating the quality of the relationships between a child and her caregivers provides an opportunity for more informed decision-making, but is difficult to measure. This article describes the use of the Emotional Availability Scales (EA Scales; Biringen, 2008), a research-based, scientifically driven way of understanding the quality of communication and connection between a parent or caregiver and child, as an important tool for developmentally appropriate evaluation of parent–child attachment. In addition, the Adult Attachment Interview (George, Kaplan, & Main, 1985) was used as a way to understand a mother's internal world.

## Erin and Belinda

Sarah gave birth to twin girls, Erin and Belinda, and because trace amounts of crack cocaine were detected in the newborn babies at the time of delivery, the girls were removed right at birth and put into foster care. The biological parents were allowed supervised visits with the girls. The visitation supervisor found Sarah to be a loving and appropriate parent who was very involved in her children's lives, who tried very hard to meet their needs even though she worked at unskilled jobs and did not make a lot of money.

**Abstract**

**Evidence-based assessment tools provide a scientifically driven way of understanding the quality of communication and connection between a parent or caregiver and child. In this article, the authors describe how these tools can play an important role in the developmentally appropriate evaluation of parent–child attachment in the child welfare system. The authors describe a custody dispute between a biological mother and a foster family, and how information from these tools provided an unbiased way to understand the quality of the relationships between each child and caretaker to help make informed decisions on behalf of the children.**

The foster family included Emily and her husband, Don. Emily became the full-time, primary caregiver for Erin and Belinda following their discharge from the hospital. She and Don were interested in adopting the girls if their birth mother could not care for them. Both girls were relatively healthy and happy and flourished in their foster home. Erin had asthma, which was controlled with careful management. Emily and Don were financially well-off and able to amply provide for the needs of these twins, and their marriage was stable enough to manage the stresses of parenting twins. These girls did not show ongoing consequences from their exposure to drugs in utero. They were calm and well-regulated, and slept and ate well, right from birth.

Sarah's life was unstable for the first year and a half of the children's lives, and she did not spend much time with the girls. As the courts were moving to terminate her parental rights, she stabilized, was ready and able to focus on her children, and it was determined to be in the best interests of the children to pursue reunification. Thus, efforts to reunite her with Erin and Belinda (about 2 years old by this point) began in earnest. A plan was devised to provide increasing contact between her and Erin first (as she was the more medically vulnerable and coping with asthma), and those visits were closely scrutinized. Soon, the reunification visits with Belinda also resumed. The social services caseworker decided to hire an attachment expert to evaluate the relationship between Sarah and both girls to see if these were viable relationships and also to look more objectively at Sarah's parenting capacity.

Sarah was determined to regain custody of both girls. Simultaneous with Sarah's resolve was Emily's resolve—to keep her family together, with the twins very much a part of it. After all, she had parented them over the course of their first 2 years to become bright, lively, and healthy children, and they were obviously attached to their foster parents. Efforts to support reunification with Sarah included her participation in individual and group therapy; facilitating her ability to make life style changes; drug testing; supervised visitation; and parent coaching using an attachment-based model to strengthen her relationship with each of her daughters. The children were supported through play therapy with their foster mother, which also provided an opportunity for the play therapist to see how they were adjusting to their overnight visits with their biological mother.

The judge overseeing the case was mindful of the strong bond the children had developed with their foster parents and could also clearly see the promise of intervention and Sarah's enthusiastic participation in the reunification work. The tension between the risk of removing the children from a loving and stable home, weighed against the benefit of returning them to their biological family, made it difficult to come to a clear resolution. For the judge and mental health professionals on the case, the central questions included: What was the quality of the attachment between the children and their foster family, and between the children and their biological family? How might the twins be scarred by losing their foster home, the only caregivers they have known since birth? Is there a way to preserve the attachment relationships the girls have developed with both sets of parents?


Photo: Marilyn Nolt

**A child who is insecurely attached may avoid contact by looking away or diverting eye-contact.**

## Myths About Attachment

There are decades of research on the construct of attachment, yet some outdated ideas continue to influence parenting practices and decision-making.

### *Myth #1: There can be only one attachment*

Emily and the children's play therapist argued that the children's attachment to Emily was most important because Emily had been the only stable, trustworthy, and primary caregiver in their lives. Further, the play therapist asserted that the reunification visits with Sarah could lead to a major disruption and trauma for the girls. As evidence, he reported that Erin particularly was quite stressed, tense, and clingy during post-visitation play therapy sessions, while Belinda appeared to be fine and unperturbed.

In response, the attachment expert explained that children could enjoy multiple attachments, especially as the girls are getting older. Further, children can enjoy overnights in a family situation where there are multiple caregivers, as often happens in divorce. Before the girls were 2 years old, the attachment-based evaluator would not have suggested overnights (Biringen et al., 2005; Solomon & Biringen, 2005). Moving to a multiple caregiving situation need not mean abandonment and trauma, especially for children more than 2 years old. Further, children are capable of attaching to multiple caregivers and the concept of one attachment, that is, *monotropy* (Bowlby, 1969) is actually outdated. With the current high rate of divorce, the legal system often handles the situation of multiple caregivers. In fact, in some cultures—such as the Efe, a group of forest-dwellers living in Africa, as described by Tronick (2007)—children are raised by many different caregivers, which challenges the traditional notions of attachment theory. For Erin and Belinda, the question put on the table by the legal and mental health professionals was how a sharing of parenting responsibilities, allowing for multiple attachments, might be considered.

### *Myth #2: Quantity of time is not as important as quality*

Although much has been made of quality of time, quantity of time is also important, and to understand the differential mother–child relationships, some similarity in the amount of time spent in those relationships needs to

Photo: Kiwi Street Studios

**Attachment security is an important construct in child development and relationships with caregivers, but it is not easily measured.**

be taken into account. Only then could one compare the relationships and decide which is more optimal. Thus, we (the first author was hired as the attachment expert and the second as a therapist/parent-coach) provided information for the courts about attachment including an explanation that attachment happens over the course of time, and hence, one cannot think about whether or not the girls are attached to Sarah, but about "attachment in the making" (Ainsworth, Blehar, Waters, & Wall, 1978).

### *Myth #3: Children can be attached or nonattached*

Although there is much discussion about the importance of attachment and whether (or not) a child is attached to his caregiver, this type of discussion is not productive and is not based in science. In fact, most children who are raised in home settings (rather than institutions) become attached. Hence, whether (or not) a child is bonded, attached, or nonattached is not the important question, it is whether the child is securely attached to a particular caregiver.

Attachment is an important indicator of how the relationship between a caregiver and a young child is evolving. When a young child is *securely attached* to the caregiver, she seeks proximity, maintains contact in an elaborated way, and is happy to see that person. Secure attachment forms when a young child has received emotionally available caregiving (sensitivity to the child's cues and appropriate ways of guiding and controlling the child's behavior). When a young child is *insecurely attached* (*avoidant type*), she may subtly avoid contact (moving face away, diverting gaze slightly) or markedly avoid contact. Such behavior is associated with a history of feeling rejected by the caregiver. When a young child is *insecurely attached* (*dependent/resistant type*), the child is affectionate toward the caregiver but is also clingy and needy; this type of behavior can often be mistaken by an observer for secure attachment, because the child seems strongly attached to the caregiver, but in fact such attachment has a needy, dependent quality. This type of attachment is created when a caregiver has the capacity for kindness and nurturance, but may be inconsistent in his capability to maintain such care. Thus, the young child receives nurturance, but it may be on a "tune in" "tune out" basis. When the caregiver is preoccupied with other tasks, goals, or moods, such a caregiver may not be attuned to the child, but the child knows in her heart that if she insists on proximity or contact, the caregiver can come through, and hence, this is the main reason why such a child becomes dependent, to keep the caregiver close and more reliably nurturing. A fourth type of category is one that is called *disorganized* and can arise when the caregiver is frightening in some way, or when there are serious affective errors or bizarre behaviors in the communication between the caregiver and young child, or both.

## Evidence-Based Evaluation

The attachment expert (first author) used two evidence-based evaluations (the Adult Attachment Interview [George et al., 1985] and the EAScales [Biringen, 2008]) to provide answers to such questions as: Are the girls attached to Sarah yet, and is that attachment strong, weak, or nonexistent? Is each child's attachment stronger to Emily or stronger to Sarah? What impact would removing them from Emily have on their ability to attach to others? Will they be traumatized if their attachment to Emily is broken?

### *Adult Attachment Interview*

The Adult Attachment Interview (George et al., 1985), is an extensive interview that includes information about a mother's experiences with parents and other attachment figures and about significant losses and trauma in her life. The Interview indicated that Sarah was coping well. Sarah later commented that the Interview helped her think through and understand her troubled past. Sarah participated in the Interview a number of times, with clear indication that she was "autonomous" with respect to attachment, meaning that she was able to coherently reflect on her attachment-relevant experiences about her own parents. Also, although she had had traumatizing experiences with both her own mother and her stepfather, and her own father had committed suicide, Sarah nonetheless had formed a coherent view of these relationships, with a good understanding of why her caregivers acted the way they did. In fact, she had forgiven them. Likely, this working model of relationships helped her in beating the odds against the negative consequences of these life experiences.

### *EA Scales*

Although attachment security is an important construct in thinking about child development and about relationships with caregivers, it is not easily measured in a real-world setting. In contrast, emotional availability is a second-generation attachment concept and, it is important to note, it is measurable in a reliable and valid way in real-world contexts, through the use of the EA Scales (Biringen, 2008; Biringen, Robinson, & Emde). This is a method to rate how the parent is doing with the child and how the child is doing with the parent.

Emotional availability refers to six qualities, four on the caregiver's side and two on the child's side. The four caregiver qualities are: sensitivity, structuring, nonintrusiveness, and nonhostility. *Caregiver sensitivity* refers to the capacity of the caregiver to be warm in a genuine way and to be able to read and respond to child cues in an appropriate, attuned way. *Caregiver structuring* refers to the ability of the caregiver to guide, suggest, and provide a scaffold for exchanges; it is the appropriate form of caregiver control. *Caregiver nonintrusiveness* refers to the ability of the caregiver to be available without being overbearing or interfering; being able to allow the child to lead is key. *Caregiver nonhostility* is the ability of the adult to regulate negative feelings and to be able to stay on an even keel. The two child qualities are child responsiveness to the adult and child involvement of the adult. *Child's responsiveness to the adult* refers to the child's social and emotional responsiveness and how happy the child looks. The *child's involvement* of the adult is the other component of the child's side and refers to the child's interest in involving and engaging the adult in his world, by showing, bringing, talking, and other behaviors that involve the other.

Sarah's therapist/parent-coach used the EA Scales (Biringen, 2008) as part of her parent coaching and individual therapy. The therapy was difficult to conduct, however, because Sarah and the girls had limited time together. Once per week, they came to a university playroom or were seen by the therapist/parent-coach in Sarah's home. The therapist/parent-coach videotaped their interactions and reviewed the tapes at subsequent individual coaching sessions with Sarah.

These videos of their interactions were also assessed using the EA Scales (Biringen, 2008). The EA Scales are patterned after attachment categories but are rated on a continuum which takes into account gradations of the quality of parenting. The EA Scales provided the first opportunity for anyone to evaluate this relationship without bias. On the basis of feedback from the EA Scales evaluation, the therapist provided feedback to Sarah about how she could nurture an attachment, and make it a secure one.

Initial sessions were a bit awkward. Sarah worked very hard, perhaps even too hard, to show that she was a good mother. She tried so hard in fact that as she took steps forward, the girls, particularly Erin, took steps back, which is what happens in relationships. Sometimes, when people try too hard, they seem intrusive. Thus, Sarah was coached in emotional availability, to let each child come to her so that she could show her own responsiveness to and involvement with the child. As she became just emotionally available without having to do or prove something, we saw over time that both girls began to initiate more and to involve her decidedly more in interactions. Indeed, things were looking pretty good for their relationship! And an attachment was in the making, which was a welcome boon to all who had watched this case go on so long without any neutral evaluation.

## Moving Forward

What is in store for Erin and Belinda? Would it be viable for the judge to consider a joint parenting arrangement with the biological and foster parents sharing the responsibility? Will Emily decide to fight for full custody? Will Sarah have the support she needs to maintain her parental rights? As these issues are under consideration, the information gleaned from using evidence-based assessment tools on the emotional availability of each parent in relationship with the child provides an invaluable piece of the puzzle. As well, learning that Sarah had a coherent and secure view of her attachment relationships from her family of origin (using the Adult Attachment Interview; George et al., 1985) was another important piece of the puzzle, providing information about her internal world. Evidence-based assessment tools can enhance the quality of information available to the professionals in decision-making roles on behalf of children in the child welfare system, and these tools have the potential to make a significant difference in how those professionals determine what is in the best interests of the child.

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**The Emotional Availability Scales provide an opportunity to evaluate the parent–child relationship without bias.**

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# The Family Connection Program

## *Strengthening Relationships Between Parents and Children*

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*You can discover more about a person in one hour of play than in a year of conversation.*
—Attributed to Plato (c. 428BCE–347BCE)

Rachel contacted the Family Connection Program (FCP), a program at the University of California, Davis, for parents and their infants up to 3 years old when her son, Caleb, was approximately 9 months old. She had just been formally diagnosed with severe postpartum depression and was concerned that she had irreversibly damaged her son. She wanted to attend the FCP to learn skills to help her feel connected to her son and for her son to finally have a mother, especially because her own mother died when Rachel was a small child. She said that she was "prepared to fake care and intimacy" until she was truly able to feel close to her son.

## Parent–Child Groups

THE INTERVENTION INCLUDED attendance at the FCP, an 8-week prevention/intervention program for parents and their children from birth to 3 years old. The FCP was designed to demonstrate developmentally appropriate communication and interaction techniques and child-led play and to provide child development guidance to new parents. Families attended the FCP for 1.5 hours per week during each enrollment period. During the FCP sessions, three main goals were developed for Rachel. The first goal was for Rachel to establish a relationship with the program facilitator so she could experience a supportive and attentive relationship and feel connected to the group. The second goal was for Rachel to learn how to see and understand Caleb's cues, including understanding his way of interacting with the world. The third goal for Rachel was to develop her communication and interaction skills and form a stronger relationship with Caleb through observing and participating in child-led play.

### *Session One: Communication Techniques*

During the first session of the FCP, the overall goal is to welcome each family and introduce the basic communication and interaction techniques. The families in Rachel's infant group had infants from approximately 4 months old through 14 months old. The program was conducted in a room designed for infants, with play areas for crawling, climbing, and toddling; sensory play such as splashing in water; fantasy play with toys such as baby dolls; cooking and musical instruments; and objects to explore such as a variety of balls, toys that link, and discovery boxes that reveal surprises when buttons are pushed and wheels are turned. As parents entered the room, they were encouraged to leave their shoes outside and then to come in and sit on the floor. Rachel and Caleb were among the first to arrive. Rachel carried Caleb into the room in a car seat, unloaded

**Abstract**

**Rachel attended the Family Connection Program (FCP) with her 9-month-old son to learn about infant development so she could her overcome the relational deficits of severe postpartum depression. The FCP fostered connections between Rachel, her son, and other participants through presentations about communication and interaction techniques and about infant and family development. Rachel formed connections within her family and with participants in the FCP. Lessons learned from the experience of working with Rachel and her family include the widespread effects of intervention, the importance of the meaning that individuals make of their experiences, and the importance of understanding the foundations of behavior.**

her bulging diaper bag, and sat in one of the most distant corners of the room, away from the program facilitator and the few other families. She sat Caleb on the floor about 3 feet in front of her with his back to her. Of note, Rachel chose an area of the room designed for quiet, one-on-one interactions, with shelves of board books on each side, a few stuffed animals, and a child-sized sofa and chair.

When the program began, each parent introduced himself or herself and the child and then said why they had decided to attend the FCP. As was common with the FCP, many of the parents said that they wanted to meet other parents with babies or felt that, as their baby got older, they needed to provide more activities for him but didn't know what to do. Rachel quietly said that she found being a mother very hard and really had no idea what she was supposed to do. A few other mothers and one father agreed with Rachel, and there was a brief conversation about not fully understanding what it was really like to take care of a new baby. A father, Allan, said that he had already raised three kids as a working father and was now a stay-at-home father of a 6-month-old and lamented that he never knew how hard it was. One parent said that she was interested in learning when her baby, a 12-month-old, would start to understand her and communicate with her. The presentation on communication and interaction techniques followed.

Among the communication and interaction techniques presented was sitting face-to-face to facilitate eye contact, sitting in close range to facilitate physical contact, and using gestures with verbal communications. When the facilitator gave examples of the subtle ways that infants communicate, such as turning their eyes or face away, changing their body posture, or through facial expressions, parents were surprised. Parents were particularly surprised that infants could understand long before they said their first words. To facilitate communications, the facilitator demonstrated a technique called *sportscasting* to assist parents with tuning into their infant's communications. Sportscasting is simply noticing what the child is doing and commenting on it to the child. Rachel sat quietly observing as the facilitator demonstrated, and a few parents tried it out. During free play, Rachel stayed with Caleb in the quiet area. At one point, Rachel put a few books in front of Caleb and a stuffed toy. As the facilitator moved around the room spending a few minutes with each family, she noticed that Caleb hardly moved for the hour he had been there. As the facilitator moved closer to Rachel's area, Rachel picked Caleb up and took him for a diaper change that lasted until clean-up time.


Photo: ©iStockphoto.com/Juan Silva

**Among the communication and interaction techniques presented was sitting face-to-face to facilitate eye contact.**

### *Session Two: Child-Led Play*

For the second session, Rachel arrived early with her bulging diaper bag. She carried Caleb into the room and again sat in the quiet area. This time, she sat Caleb in front of her about 3 feet away, facing her with his back to the room. She got a few books from the shelves and a few small toys that were nearby and put them on the floor between her and Caleb. The facilitator noticed that Rachel interacted with Caleb silently while other parents were sportscasting with their children; for example, "Here, Luke, Let's play with the drum," and "You got that shaker, Clara!" During the greeting time, each parent was asked to reflect on their previous session and the time in between. Several parents said that they felt funny talking to their baby at first but then noticed that the baby seemed to like it. Rachel said she didn't think Caleb noticed she was doing anything different.

The discussion topic for the second session of the FCP built on the communication and interaction techniques by introducing child-led play. The goal was for parents to follow their infant's cues and interests and to become an observer and partner in their child's play without taking over. Some parents commented that it was hard to refrain from playing with the toys. One mother said that she was ready to "really start playing" and didn't imagine that she needed to sit, observe, and join in, which were new concepts for her as she was a doctor and she was used to taking the lead in interactions. During the free-play period, the facilitator connected with Rachel and Caleb. Rachel said, "When I talk to Caleb, he doesn't look at me like the other babies. Maybe it's too late." The facilitator reflected back, "You want to connect with Caleb and you don't feel it has happened yet?" Rachel nodded. The facilitator commented, "Caleb, I see you are putting that rattle in your mouth." Rachel quickly responded, "I think he is teething. He is putting everything in his mouth." The facilitator sportscasted, "Oh Caleb, it feels really good to chew on those hard toys," and Rachel said that she thought the mouthing helped him. The facilitator ended their chat with, "You can see how chewing the rattle makes teething a little easier for Caleb."

### *Session Three: Setting Limits*

For the third session of the FCP, Rachel entered the room with her bulging diaper bag, carrying Caleb in a car seat and holding a teether. Again, Rachel chose to station herself and Caleb in the quiet area. However, this time, she sat Caleb facing her, and the distance between them lessened. Caleb was sitting within reach of Rachel. She could be heard quietly offering him his teether, and he accepted it from her. The third topic of discussion in the program was limit setting and discipline for infants and toddlers. The facilitator talked about early brain development that motivates infants and toddlers to explore everything around them yet limits their ability to control their impulses (Herschkowitz, 2000). A mother of a 12-month-old said that her daughter was getting into everything and got really upset when she took things away from her that were unsafe. The mother said, "She really gets mad at me." Another parent chimed in that she wasn't ready for the terrible 2s but felt that her toddler was already having tantrums. Discussion continued with ideas for understanding their feelings and

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**Parents were particularly surprised that infants could understand long before they said their first words.**

finding ways to prevent frustrations and meltdowns.

The facilitator noticed that, for the first time during the program, Caleb twisted his body from a seated position in front of Rachel to laying on his stomach. During free play, Rachel mentioned that Caleb's teeth hadn't come through yet but that she had bought several more teethers for him as he was constantly chewing on them. She got her diaper bag and pulled out several more teethers and placed them in front of Caleb on the floor, nearly whispering, "Caleb, here are your teethers." The facilitator commented, "I see that Caleb is starting to move about," and Rachel responded sullenly, "I don't have to worry about discipline. He doesn't get into anything." The facilitator noticed aloud that it looked like Caleb might also be getting ready to crawl soon. At this point, the father of the 6-month-old brought his son over to the quiet area. He placed his son on his tummy facing Caleb and said enthusiastically to Rachel, "I'll bet they'll be crawling soon." This was the first interaction anyone had initiated with Rachel, as she always sat in the quiet area. Rachel said, "Do you think so?" Their conversation continued as the facilitator moved to another area of the room.

### *Sessions Four Through Seven: Parenting Education*

The next four sessions of the FCP included guest speakers from the campus, including an infant sleep researcher and a person who spoke about the couple relationship and coparenting. The facilitator noticed that Rachel typically seated herself and Caleb in the quiet area but now were often joined by Allan, the father of the 6-month-old. During the discussion on infant sleep, Rachel said that Caleb wouldn't sleep at night. She said that she tried all kinds of things to help him sleep and that her husband could get him to sleep but for only short periods of time. She said that they were both feeling exhausted and didn't know what to do. The presenter talked about the misconceptions of infant sleep and talked about sleeping arrangements, including co-sleeping. He also talked about how some infants could get back to sleep on their own, whereas others were "signalers" and needed help getting back to sleep (Anders, Halpern, & Hua, 1992). Rachel said that her husband was really getting frustrated with their lack of sleep. Other parents commented that they had heard they would lose some sleep with a new baby but didn't really appreciate what it meant to be sleep-deprived for so long. One mother commented that she felt like she was barely functioning each day and felt like a zombie most of the time.

The facilitator noticed that when the father joined Rachel in the quiet area, he brought some toys from one of the other areas with him. Caleb still sat most of the time but was spending more time on his stomach and now arched his back with his arms and legs extended as if to take flight. Caleb was responsive to Allan, the father who spoke loudly and enthusiastically to him. The facilitator noticed that Caleb raised his face and widened his eyes to look at the father. During free play, the facilitator joined the group in the quiet area, which was slowly becoming less quiet. She said, "It looks like Caleb is interested in you, Allan." Rachel looked at Allan intently. Allan responded, "I tend to be loud and entertaining. I think they like that." He reached down and swooped his son up, raising him high above his head while maintaining eye contact with him. His son, now just over 7 months old, giggled with his whole body and returned the joyful gaze. The facilitator observed aloud, "He really does like that." Caleb turned his head up high, nearly tipping over backward looking at Allan and his son. Rachel continued to watch Allan and his son, missing Caleb's expression of interest.

At the end of each FCP session, families transition from free play to a closing circle with songs and gestures. Although Rachel and Caleb always joined the circle, Rachel's voice was seldom heard singing. The day that Caleb watched Allan, Rachel requested a song for the first time. She requested one of the most active songs, a song about popcorn popping, with babies on their parent's laps bouncing along to Pop! Pop! Pop! Rachel sat Caleb on her lap and bounced him softly. At the end of the session, Allan asked a few of the other parents if they wanted to meet at a park during the week for play dates. Allan invited Rachel, and she agreed to join them.

During the session on co-parenting, most parents agreed that having a baby was really hard on their relationship. Several said that the hardest part was dealing with grandparents who tell them that they will spoil the baby by picking him up every time he cries. Allan shared that he let his older three children cry it out when they were babies and that he wishes he could do it all over again and respond to their cries instead of ignoring them. He said that he felt he was helping his son by responding to his cries quickly and that they had a better relationship because of it. He said, "He doesn't have to cry much because he knows I'll be there when he needs me." Rachel shared that her husband was having a really hard time because Caleb starts crying the minute he gets home and cries frantically through the night. She also noted that he tended to cry a lot on weekends when her husband was at home. She said that things were very tense at home lately. During free play, Rachel spent a great deal of time searching for something in her bulging diaper bag. The facilitator noticed that Caleb flailed on the ground in front of Rachel while she searched the diaper bag. Caleb did not appear interested in playing with toys that day.

Over the next two sessions, Rachel stayed firmly planted in the quiet area. Another mother joined her there one day and said that she missed Rachel at the play date. Rachel seemed hesitant to engage in conversation with the other parents and the facilitator.

She looked about the room with a distant gaze. Caleb sat in front of Rachel most of the time and spent little time on his stomach. At the end of the sixth session, the facilitator mentioned that they had two more sessions remaining, but they always reserve spots for returning families in the next enrollment period. Rachel turned in her registration paperwork for the next enrollment period immediately after the program.

### *The Last Session: Reflection*

At the last session, Rachel entered with her bulging diaper bag and sat with Caleb in another area of the room. She selected the area designed for active play. The setup included a large, round soft pit filled with a variety of balls. She put Caleb in the pit and sat right in front of him. During the discussion time, Rachel presented Caleb with balls without waiting for his response. Discussion was a time of reflection on the experiences of the previous 7 weeks. Rachel said that she had learned a lot but that Caleb's sleep had gotten worse. She said that she would return to the next enrollment period, as did many of the families who participated in the play dates at the park. Some families who weren't continuing said good-bye and exchanged telephone numbers. Rachel was busy digging through her diaper bag in preparation for changing Caleb's diaper.

## Making a Difference for Caleb

For the second enrollment period, the first three sessions had the same topics. However, returning families asked questions and wanted more information about gesturing and other communication and interaction techniques. Rachel shared that she had purchased a book on baby signs (Acredolo, Goodwyn, & Abrams, 2009) and had been working on learning the signs but had not used them yet. She pulled several books out of her bulging diaper bag. Another parent asked for more information about how to do reflective listening (Rogers, 1951) a communication technique wherein parents notice, try to understand, and talk to their infant about their infant's emotions. A discussion followed, and parents were asked to name some of the emotions they feel. They were surprised that they couldn't come up with the labels for many emotions. The facilitator demonstrated gestures for emotions such as happy, sad, mad, excited, frustrated, and scared with Rachel and Caleb in mind.

During free play, Rachel, sitting in the active area of the room, commented to the facilitator that Caleb didn't really have many cues. She said that it was hard for her to know what he wanted. She said that even her husband couldn't figure him out. She said that he still cried at night, none of them were sleeping well, and that he still wasn't crawling yet. The facilitator listened to Rachel and spent some time observing Caleb with Rachel. The facilitator noticed aloud that Caleb's cues were indeed subtle and could easily be missed or overlooked. During circle time, the facilitator noticed that Caleb's face brightened and his body became energized when they sang the more active songs. At the end of the session, the facilitator mentioned to Rachel what she had observed about Caleb during circle time. The facilitator considered what this would mean for their interactions by saying, "I wonder if Caleb might really feel energized by the singing and hand and body movements?" Rachel paused and then responded thoughtfully, "Oh, I don't know. I can try it."

In another session, Rachel began to use gestures with Caleb. Her voice remained quiet, but her hands and body became more animated as she gestured about the objects around them such as "ball" "duck," and "book." The facilitator noticed that Caleb watched Rachel's hands as she gestured and briefly glanced at her mouth as she softly labeled the objects around them. It appeared that Rachel was also watching her moving hands, but it was unclear whether she saw Caleb's gaze toward her. During the session focusing on child-led play, Rachel commented to the facilitator that she thought that Caleb liked balls. The facilitator wondered, "What is it that you think he likes about them?" Rachel concentrated and replied, "I bounce them for him. He watches them bounce."

When the sleep researcher returned for another session, Rachel spent some time talking with him one-on-one. They talked about reactive co-sleeping, a practice that some parents do unintentionally wherein they want their baby to sleep independently but end up bringing the baby to bed with them occasionally to get some sleep. Rachel said that her husband would bring Caleb into their bed after a few hours of crying. After talking to the sleep researcher, she said that she was going to try putting Caleb to sleep in their bed. Rachel also sought out many different balls for Caleb. Caleb, spending much of his time on his stomach now and even attempting to bring his feet underneath him to stand, seemed to enjoy pushing the balls back to Rachel clumsily.

Over the next few weeks, Rachel reported that Caleb was sleeping much better at night. She also reported that Caleb had started crawling. She said that she still had a lot of trouble figuring out what he needed. She said that he also started crying when she left the room when he had never cried like that before. The facilitator wondered with Rachel about what that could mean. Rachel could not make sense of it and said that she didn't know. She also said that she was attending the play group in the park, and she felt like they were starting to play together as she would push Caleb in the swing and he would smile a little.

Photo: ©iStockphoto.com/wavebreakmedia

**Parents had heard they would lose some sleep with a new baby but they didn't really appreciate what it meant to be sleep-deprived for so long.**

In another session, the discussion focused on where parenting behaviors come from. The facilitator asked the parents to think about how they knew they were loved as early as they could remember. One father, a shy man who was attending for the first time with his daughter, was the first to volunteer that he knew his mother loved him when she rubbed his back when he was sick and when she looked into his eyes when he talked to her. Others said they knew because their parents told them, because of the time they spent with their parents, or because they knew they could tell their parents anything. Rachel said that she knew her dad loved her because he worked and provided for her.

Later in the session, Rachel brought out her diaper bag to share some board books with another mother. She also got out a small, bumpy ball for Caleb, just like the kind used in program. She said to him, "Caleb, here's your bumpy ball. Do you want your ball?" Caleb's eyes brightened and he reached out to take the ball. The facilitator noticed that Rachel was providing for Caleb with all of the things in her bulging diaper bag. The facilitator observed, "Did you see that? I think he really appreciates that you brought his ball for him." There was a quiet moment and the facilitator continued, "You've been working so hard to connect with Caleb. You've provided his teethers, you joined the play group and push him on the swing and you found just the very balls he likes in program, and they are not easy to find in stores." Rachel's eyes welled up

Photo: ©iStockphoto.com/Nancy Louie

**Most parents agreed that having a baby was really hard on their relationship.**

as she looked into Caleb's face with a smile.

After that session, Rachel continued to work on using gestures with Caleb. She began to incorporate gestures for activities and emotions as well. Over the next few sessions, Rachel reported that she learned that Caleb enjoyed active play. Rachel wondered if their 9 months of relative inactivity due to her depression had made him lethargic and unresponsive. She also discovered that Caleb cried when she left the room because he wanted to be with her and interact with her. She felt that she often missed his cues because she had a hard time looking directly at his face because she felt so guilty for missing his first 9 months. She said that she was working on forgiving herself for letting it go on for so long. She also shared that since Caleb's sleep had improved, her relationship with her husband was improving. She said that she thought Caleb had cried a lot with her husband because her husband was tired and impatient with him, when Caleb was just looking for somebody to pay attention to him and to play with him.

Rachel enrolled in a third session of the FCP and selected a weekend session so her husband, Jason, could attend with her and Caleb. The facilitator enjoyed watching Rachel share her experiences in the program with Jason and other new parents in the program. Rachel continued to work on observing Caleb's often subtle cues and joining in active play with him, as he was now skillfully walking up and down a ramp in the play room, as well as rolling balls down the ramp.

By the end of her third enrollment, it was apparent that Rachel truly enjoyed her relationship with Caleb. She was able to make and sustain eye contact with him and share in his joys and understand his sorrows. She noticed his bids for comfort and reassurance and was able to put words to his actions and facial expressions. Following his lead in play enabled her to become energized and understand Caleb's capacity for engagement with her and the world.

Before Rachel left the program, she commented that she finally enjoyed being a mother for the first time. She said that her developing relationship with Caleb also fostered a deeper relationship with her husband, as she said that she was able to really experience true love. Rachel said that she felt the facilitator understood her struggles, accepted her, and helped her to understand Caleb. She also said that hearing about the struggles of the other parents helped her understand that she was not a terrible parent and that she was not alone in her struggles. Rachel especially enjoyed developing a relationship with Allan, someone she viewed as a positive role model. Her husband said that the intervention made a huge difference for their family, as he finally felt comfortable going to work each day knowing that Rachel could meet Caleb's needs on her own. He was happy to have his wife again and see her truly become a mother. Although Rachel continued to experience depression, it was far less severe over time. She believed that she had been mildly depressed for most of her life and then started experiencing severe depression during pregnancy. Rachel reported that she was now able to experience periods of joy and hope for the future.

## *Learn More*

**INFANT/CHILD MENTAL HEALTH, EARLY INTERVENTION AND RELATIONSHIP-BASED THERAPIES: A NEURORELATIONAL FRAMEWORK FOR INTERDISCIPLINARY PRACTICE**
*C. Lillas & J. Turnbull (2009). New York: W. W. Norton.*

**SENSORY INTEGRATION AND SELF-REGULATION IN INFANTS AND TODDLERS: HELPING VERY YOUNG CHILDREN INTERACT WITH THEIR ENVIRONMENT**
*G. G. Williamson & M. E. Anzalone (2001). Washington, DC: ZERO TO THREE.*

## Making a Difference for the FCP

One of the lessons learned from this family was the effect that intervention with one person can have on the whole family through the meanings they make of the behavior and interactions with others. Rachel attended the FCP to help her overcome the relational deficits of postpartum depression and to help her develop a bond with her son. It was clear from the outset that Rachel felt the loss of her own mother over the transition to parenthood. She then felt guilty for denying her son a caring mother when she knew what it was like to miss a close bond with her own mother. She then adopted the practice of doing things for Caleb and providing things for him to substitute for their impoverished interactions. It appeared that Rachel was so focused on learning what to do for Caleb that she lost sight of Caleb in the process. At times, it really seemed that Rachel could not see Caleb, who sat right in front of her.

In addition, we learned that it is imperative to be able to observe behavior and understand the roots of behavior. Rachel interpreted Caleb's unresponsiveness as indifference or rejection. In this case, careful observation of Caleb revealed that he became attentive and ready to interact with vigorous stimulation. In addition, it also emphasizes the importance of supporting sufficient sleep as a basic need of each member of the family.

Rachel and her husband felt like they were alone in their dread since becoming parents until they connected with other new parents. As most of the participants in the FCP were college educated and with advanced degrees, they believed that parenting would come easily and naturally. Staff members of the FCP learned about the value of peer relationships for providing understanding and support to new parents. Over the years of the FCP, many of the participants have formed play groups and lifelong friendships that continue to this day.

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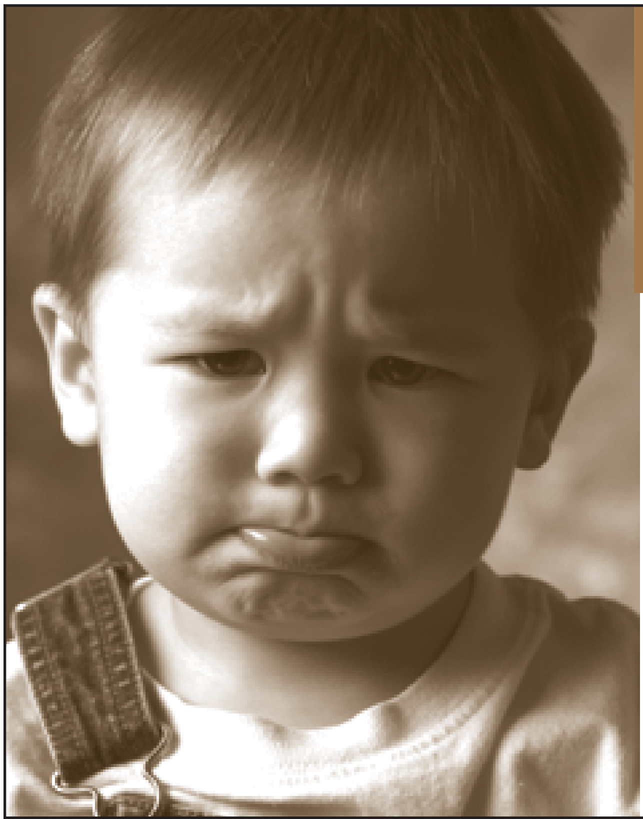

# Notes on a Case of Rumination in an 11-Month-Old Infant

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We got acquainted with Natalie after we undertook a survey of infants in the Women, Infants, and Children (WIC) clinic of our local health department in a city in Kansas. WIC is a supplemental food program for low-income pregnant or postpartum women with children up to 5 years old who are at nutritional risk. The purpose of the survey was to detect feeding problems in infants up to 24 months old in a non-referred population. In the survey questionnaire, Natalie's mother, Roseanne, had written very puzzling information about her little daughter. Natalie is "always hungry" and "eats all the time," however, she also "does not gain weight" she "is underweight" and "makes herself vomit repeatedly."

We called Roseanne and she brought Natalie to the infant mental health service center at the Menninger Clinic, which is a large free-standing mental health resource with multiple services for all ages for evaluation. We had a long collaboration between the Menninger Clinic and the local health department as infant mental consultants and conducting research with infants at risk.

Natalie was 11 months old and had two older siblings who were doing well and eating normally. Roseanne explained the problem: Natalie kept her left thumb in her mouth most of the time, which we could see. She was constantly sucking on the thumb, even during the night. Roseanne thought the purpose of Natalie's thumb-sucking was to feel calm and soothe herself. However, Natalie put her thumb so far into the mouth that she gagged and sometimes vomited accidentally. Roseanne also believed that the baby was trying to make the food come back up from her stomach into her mouth and swallow it again, over and over, but frequently she ended up vomiting.

Roseanne noted that Natalie was always hungry and wanted to eat all day long, and she reasoned it was because of the vomiting that Natalie was hardly full. Roseanne reported that Natalie "throws up several times a day." Natalie's weight was only 16 pounds, which is what she should have weighed at 4 months, and we confirmed with the pediatrician that she had failure to thrive.

Natalie looked very small and was curious about her surroundings. She wanted to catch a glimpse of everything around her. She wanted to stay close to her mother and

**Abstract**

**Rumination disorder is an uncommon condition consisting of the regurgitation of previously swallowed food. The authors discuss how they had to look beyond the information available in the limited literature on this disorder to identify the mechanism and devise a plan of intervention. The treatment consisted of helping the family and child to substitute the problem behavior with alternative outlets for soothing and stimulation. The effectiveness of the intervention lay in the clinicians' ability to question traditional approaches and consider alternative explanations based on direct observation rather than theory.**

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**One suggested intervention was to put lemon on the baby's hand to prevent further sucking.**

seemed cautious of the strangers in front of her. Indeed, she kept the left thumb in her mouth all the time, sucking on it. We asked her mother to try to remove it and Natalie cried very intensely, got very angry, and immediately returned the thumb to her mouth. Roseanne has tried to put salt, spicy sauce, and lemon on it, but Natalie persisted with the thumb-sucking despite these attempted aversions.

We, two child psychiatrists, were baffled about this situation. We wanted to know why Natalie does this with such insistence, and furthermore, what can be done? We proposed to the mother that we would like to visit the baby at home to see how she acted in her "natural" environment.

In the meantime we researched the available information on rumination disorder (or merycism, the technical terms for the problem of bringing up and chewing swallowed food). The pediatric literature suggests that it is most often due to stimulus deprivation and to neglect on the part of the mother (Clouse, Richter, Heading, Janssens, & Wilson, 1999; Hyman et al., 2006; Malcolm, Thumshirn, Camilleri, & Williams, 1997; Thouvenin, Forgeot d'Arc, Baujat, Brousse, & Abadie, 2005). One suggested intervention was to put lemon on the baby's hand to prevent further sucking (Sajwaj, Libet, & Agras, 1974). The information we found was based on anecdotal reports and observations from animals in captivity (Gould & Bres, 1986). Some of the studies were from patients with mental retardation in institutions where there is little interaction with people and thus the patients develop regurgitation as a form of self-stimulation (Kuhn & Matson, 2004).

## The Intervention

Armed with the limited information on rumination disorder, we were ready to look for evidence that Natalie must be deprived and neglected by her mother, and we suspected that surely Roseanne must be quite depressed and this was the reason why the baby stimulated herself in this way. Except that if this was so, why did Roseanne express such concern about Natalie? She also told us that she had taken the baby to the pediatrician several times to find out what she could do to help Natalie. Her pediatrician apparently told her that "babies don't do this," the baby was fine, and the sucking would go away. The pediatrician suggested that the reason for the failure to thrive was due to some failure on the part of the mother to feed Natalie adequately. In a phone conversation with the pediatrician, he repeated these conclusions to us.

The home visit was an eye opener. The house was modest but clean and well-organized. Outside playing were Natalie's siblings who looked happy and well-nourished. They greeted the visitors and seemed curious. In the house, Natalie played with a toy stroller for a short time, before she asked to be picked up by her mother and they sat together on the couch where Roseanne fed Natalie, who seemed very hungry. As Roseanne prepared some cereal, Natalie seemed most anxious to start eating, moving her legs and arms as if asking her mother to hurry up. The feeding situation was very unusual: Natalie would open her mouth (like a baby bird) expecting the food, then, as the spoon delivered the cereal she would close her mouth and put the thumb inside with her food. After a few seconds, she would open her mouth again for the next spoonful, remove the thumb, ingest, and then return the thumb to the original position. With every movement, she seemed very eager to eat and if her mother did not rush, Natalie would protest lightly. This sequence occurred many times until the food was gone. Then, Natalie, sitting on her mother's lap, became sleepy, sucking vigorously on the left thumb. She then started to make retching noises. Her abdomen moved as though she were gagging. She regurgitated and re-ingested the food several times, and some cereal started oozing down her left arm, while her eyes were semi-closed, as though she were in a state of quasi-trance. Roseanne said "this is what she does" after every meal. Sometimes she vomited and sometimes she just "plays in this way."

We explored Roseanne's past and her family situation. She had some problems in her teenage years with depression but they had since been resolved. She and her husband had financial problems, but they managed. She said she was not depressed and that she enjoyed playing with Natalie. Indeed, she did not seem depressed.

In a third visit, we were faced with "what to do" after witnessing the same phenomena described above. Natalie seemed to go into a state of self-absorption. There was no indication that her mother was neglecting her or was inattentive, but Natalie seemed to cling to her thumb, the sucking, the retching, and the regurgitations as a possible adaptation in her life. Her state of relative unresponsiveness when she did this maneuver was in contrast with her very attentive and observing eyes and alert behavior at other times. She seemed very aware of the clinicians and their movements.

We started playing with Natalie, using games that involve hand movements such as songs that required clapping, moving her arms, and other activities to keep her hands busy. We imitated what she did with her thumb, using hand motions and retching noises as the clinician introduced his own thumb in his mouth and "pretended to vomit." He then gestured to Natalie that this was not a good idea and "not to do it anymore." We told her to ask her mother for a hug when she wanted to "play the thumb game." Natalie seemed very surprised to see the adult replicating her motions and actions. She also seemed surprised when

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**We started using games that involve hand movements such as songs that required clapping, moving her arms, and other activities to keep her hands busy.**

we told her not to do this anymore and showed her the action of hugging her mother and demonstrated movements where we picked up Natalie's arms and placed them around her mother. We repeated this visual representation three or four times and she seemed very surprised. Her mother was observing closely and told Natalie she would give her hugs instead of the "thumb game." We advised Roseanne to play these games with Natalie and show her with a doll the action of "sucking the thumb" and telling her "no, no, no" in a gentle say. We suggested that she give a massage to Natalie several times a day. The notion behind introducing infant massage was that if Natalie was using thumb-sucking to self-soothe, having her mother use massage as a soothing technique would diminish Natalie's need for and her use of thumb-sucking as a self-soothing behavior.

In a subsequent visit a week later, the mother said the sucking "had gone down a lot" and Natalie had started to gain weight. It seemed that Natalie had allowed her mother to interact with her in a different way, and she seemed to be sucking less. We encouraged her to continue doing the massage and other games with Natalie. Roseanne did not bring Natalie for a follow-up appointment that was scheduled for the following week. When we called her a week later, she said that there was no more vomiting or sucking of the thumb. We were surprised with this quick change and were able to corroborate it during a visit with Natalie, who seemed more able to play and interact and did not keep her thumb in her mouth all the time. In addition to the massage and the games we taught her to use, Roseanne had started to put a sock on Natalie's hand when she could not interact with her and Natalie had to play by herself. She felt the intervention was working and thought no more sessions were necessary. She assured us she was practicing the massage and the games with Natalie and that she seemed responsive to her. She made another appointment, but instead called and said that they could not come, but things were going well and she would call to reschedule. We did not hear from her and could not reach her.

A year later, we encountered Natalie and her mother at the health department by chance. Roseanne was pleased and lifted Natalie's shirt showing her tummy. She reported that Natalie was at a normal weight and she seemed very proud that Natalie had thrived and seemed like a happy, if cautious, child, with no more concerns around eating or her development.

## Lessons Learned

Child psychiatrists have had a long tradition, now fading, of linking a child's problems to the mother's difficulties or poor parenting. In our work with Roseanne and Natalie, we were initially quite willing to attribute Natalie's problems to her mother's depression, only we could not make this link because she did not seem depressed, withdrawn, uninvolved, or indifferent. Rather, she seemed worried, interested, and a "good enough mother" (Winnicot, 1965, p. 49). We were forced to look elsewhere for the mechanism of the problem.

We came to believe that Natalie had "discovered' this strategy of self-soothing and stimulation, perhaps by accident. We have seen infants who suck their fingers or thumbs right from birth, including one that insisted on sucking the same fingers from the time he was 2 weeks old. We have also observed infants resort to pulling their hair, banging their head, or swinging their bodies as maneuvers that calm the child and also are favored because they keep the child aroused and entertained. It is very hard to "remove them" if one does not provide an alternative strategy for soothing and stimulating. Since we worked with Natalie, we have used similar strategies of replacing a problem behavior with another more acceptable alternative in our work with other children. For example, we may advise children to pull the hair of a teddy bear instead of their own hair, hug a stuffed animal instead of swinging their body, or to use calming techniques such as massage or being held.

Even with a fairly young infant like Natalie, one can use visual techniques to show her what she is doing and what not to do, or what to do instead. Some children are highly sensitive to visual information and respond very well to such gestures, showing them in a "theatrical representation" with gestures, puppets, or dolls, what they are doing and how to replace the problem behavior with something else.

There is limited helpful literature available for many of these problems related to self-stimulation, repetitive maladaptive behaviors, and self-absorption during the maneuvers. As the field of infant mental health continues to evolve, there is still much to be learned about situations where the common wisdom does not apply. In this case, most of the literature on rumination suggested that boredom, deprivation, and neglect are the root cause (Gould & Bres, 1986; Hyman et al., 2006). We had to be open to alternative explanations and not try and make the case fit the literature, which would have been an injustice. As a result, we were able to develop an intervention that gave Natalie and her family the tools they needed to successfully manage the problem, and we were able to provide a positive experience of being heard and supported in a meaningful way.

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Photo courtesy C. Li

**Child psychiatrists have had a long tradition, now fading, of linking a child's problems to the mother's difficulties or poor parenting.**

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# Practical Tips and Tools

*Editor's Note:* This resource is reprinted from *Parents and Providers: Sharing the Care*, a set of 7 handouts, in both English and Spanish, that are designed as tools to spark discussion on important child development topics and to support parents in developing the skills of self-awareness, careful observation, and flexible response. Each handout consists of several reflective exercises to guide parents in applying key concepts that support healthy development through their daily interactions with their young child.

## Why Is My Child Acting Like This?

Challenging behavior means different things to different parents. One mom sees her toddler, who wants to do everything by himself, as oppositional and defiant. Dad, on the other hand, sees this behavior as positive—that his son is capable and independent.

A child's challenging behaviors are a normal part of development. Sometimes, though, they come up so often or are so intense that they get in the way of a child's ability to learn or to form relationships. If you think your child is having struggles like these, talk to a trusted professional to get the support and guidance you need.

Listed below are some of the most common challenging behaviors during the first 3 years. Circle the ones that you have had to handle. You might also want to put a star beside the ones that are currently concerns for you:

- Crying that is difficult to soothe.
- Tantrums.
- Sleep problems.
- Separation anxiety.
- Feeding challenges.
- Toilet training issues.
- Hitting, pushing, or biting.
- Not listening or cooperating.
- Social withdrawal—a child who is very shy to the point of it being painful.

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### Behavior Has Meaning

All behavior has a purpose. Babies and toddlers are not able to put their thoughts and feelings into words very well, so they communicate by using actions. A baby may cling and cry because she is fearful of new people and places. A toddler may bite to keep another child from interrupting her play. Understanding what your child's behavior is telling you helps you find supportive ways to respond to her and teach her better ways to express herself.

**Take a Look**

> *Shayla, mother of 15-month-old Jaden, is very frustrated. After just a few bites at mealtime, Jaden pushes the spoon away and cries, "No!" Shayla offers another spoonful, and Jaden again rejects it. Shayla takes away the bowl, figuring Jaden is just not hungry. But then Jaden begins to scream and bang on the high chair. Shayla thinks, "Okay, so you are hungry," and spoons up more applesauce. Again, rejection. Jaden shouts, "No, no, no, no, no!" Shayla is feeling very frustrated when she turns to see that Jaden has picked up the spoon and has happily started feeding himself. "Aha", thinks Shayla. "Go figure!"*

*continued*

## Decoding Your Child's Behavior

As you think about the challenging behaviors you have dealt with, keep in mind that children behave differently with different people and in different places. Nina, 18 months, frequently hit and bit other children in her previous child care center. The center did not provide much structure and had only two caregivers for a class of 15. In her new family child care home the children follow a consistent routine each day, and Nina is one of just five children cared for by a loving provider. In this new setting, Nina has been much less aggressive.

***Think about one of your child's behaviors that you find challenging. Then ask yourself the following questions to try to figure out what the meaning and purpose of this behavior might be.***

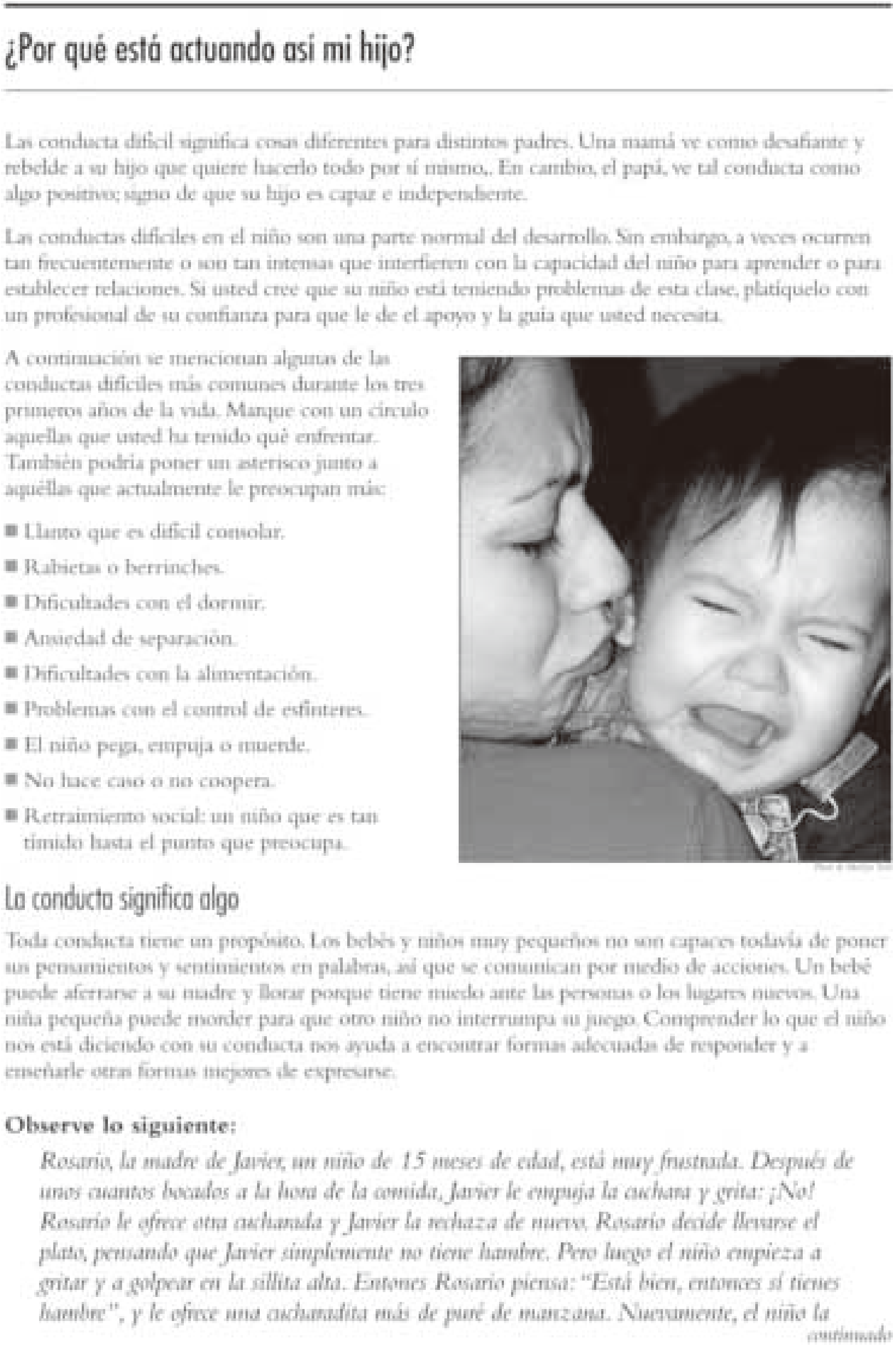
- When does the behavior usually happen (e.g., When your child is tired or hungry? When he is in a loud, noisy place? When he is in a new situation)?
- What usually happens right before this behavior?
- Right after?
- What is the result of the behavior?
- What do you think your child is struggling with when acting this way? (For example, might she be having a difficult time suddenly with separations because a family pet recently died? Is she refusing to brush her teeth because she is sensitive to touch and does not like the way the brush feels or the toothpaste tastes?)
- Next, think about your typical reaction to this challenging behavior. Is this response working? If not, thinking about your responses to the questions above, what might you do differently?

## Wrapping Up

There will be moments when your child is having a difficult time. Despite all of your efforts, sometimes nothing seems to work. You might simply have to put your child in a safe place—such as his crib—to take a short break while you cool off. This can actually turn out to be an effective strategy to help your child calm down, too. What's important is to hang in there and keep trying. Think about the big picture and remember that what your child is learning through your thoughtful responses is that you will always be there for him, no matter what.

# Practical Tips and Tools

*Nota del editor:* Este recurso ha sido reimpreso de “Padres y proveedores: compartiendo el cuidado”, una serie de siete hojas de trabajo en inglés y español diseñadas como herramienta para fomentar el diálogo sobre temas importantes de desarrollo infantil para apoyar a los padres a desarrollar las habilidades de la autoconciencia, la observación cuidadosa y la respuesta flexible. Cada hoja consiste en varios ejercicios de reflexión para guiar a los padres sobre cómo aplicar conceptos clave que apoyan el desarrollo sano mediante interacciones diarias con su niño pequeño.



## ¿Por qué está actuando así mi hijo?

Las conducta difícil significa cosas diferentes para distintos padres. Una mamá ve como desafiante y rebelde a su hijo que quiere hacerlo todo por sí mismo,. En cambio, el papá, ve tal conducta como algo positivo; signo de que su hijo es capaz e independiente.

Las conductas difíciles en el niño son una parte normal del desarrollo. Sin embargo, a veces ocurren tan frecuentemente o son tan intensas que interfieren con la capacidad del niño para aprender o para establecer relaciones. Si usted cree que su niño está teniendo problemas de esta clase, platíquelo con un profesional de su confianza para que le de el apoyo y la guía que usted necesita.

A continuación se mencionan algunas de las conductas difíciles más comunes durante los tres primeros años de la vida. Marque con un círculo aquellas que usted ha tenido qué enfrentar. También podría poner un asterisco junto a aquéllas que actualmente le preocupan más:

- Llanto que es difícil consolar.
- Rabietas o berrinches.
- Dificultades con el dormir.
- Ansiedad de separación.
- Dificultades con la alimentación.
- Problemas con el control de esfínteres.
- El niño pega, empuja o muerde.
- No hace caso o no coopera.
- Retraimiento social: un niño que es tan tímido hasta el punto que preocupa.

### La conducta significa algo

Toda conducta tiene un propósito. Los bebés y niños muy pequeños no son capaces todavía de poner sus pensamientos y sentimientos en palabras, así que se comunican por medio de acciones. Un bebé puede aferrarse a su madre y llorar porque tiene miedo ante las personas o los lugares nuevos. Una niña pequeña puede morder para que otro niño no interrumpa su juego. Comprender lo que el niño nos está diciendo con su conducta nos ayuda a encontrar formas adecuadas de responder y a enseñarle otras formas mejores de expresarse.

**Observe lo siguiente:**

> *Rosario, la madre de Javier, un niño de 15 meses de edad, está muy frustrada. Después de unos cuantos bocados a la hora de la comida, Javier le empuja la cuchara y grita: ¡No! Rosario le ofrece otra cucharada y Javier la rechaza de nuevo. Rosario decide llevarse el plato, pensando que Javier simplemente no tiene hambre. Pero luego el niño empieza a gritar y a golpear en la sillita alta. Entones Rosario piensa: “Está bien, entonces sí tienes hambre”, y le ofrece una cucharadita más de puré de manzana. Nuevamente, el niño la*

*continuado*

*rechaza. Javier grita. "¡No, no, no, no, no!" Rosario se siente frustrada cuando se da vuelta y descubre que Javier ha tomado la cuchara y muy contento ha empezado a alimentarse él solo. "Miren", piensa Rosario. "¡Quién iba a adivinar!"*

## Descifrar la conducta de su hijo

A medida que piense en las conductas difíciles a las que se ha enfrentado, tenga en cuenta que los niños se comportan en forma distinta con diferentes personas y en lugares diferentes. Irma, una niña de 18 meses, a menudo pegaba y mordía a otros niños en el centro de cuidado infantil al que asistía antes. El centro no estaba muy organizado y sólo había dos cuidadoras para un grupo de quince niños. En su nueva guardería los niños siguen una misma rutina todos los días e Irma es una de sólo cinco niños que atiende una cuidadora cariñosa. En este nuevo sitio , Irma ha mostrado una conducta mucho menos agresiva.

***Piense en una de las conductas que haya presentado su hijo o hija y usted encuentre difíciles. Luego hágase las siguientes preguntas para intentar encontrar cuál puede ser el significado y propósito de esa conducta.***

- ¿ Cuándo ocurre generalmente esa conducta? (por ejemplo: ¿cuando el niño está cansado o tiene hambre, cuando se encuentra en un lugar bullicioso o ruidoso o cuando se halla en una situación nueva?)
- ¿Qué ocurre justo antes de esta conducta?
- ¿Qué pasa poco después?
- ¿Cuál es el resultado de esa conducta?
- ¿Con qué cree usted que su hijo está batallando cuando actúa de esa forma? (Por ejemplo: ¿cree usted que tal vez está manifestado ansiedad de separarse de pronto porque una mascota de la familia murió recientemente? ¿Se niega a lavarse los dientes porque es muy sensible al tacto y no le gusta la sensación del cepillo o el sabor de la pasta de dientes?)
- A continuación, piense en su reacción típica ante esta conducta difícil. ¿Le ha dado buen resultado su respuesta?
  Si no, piense en sus respuestas a las preguntas anteriores y considere ¿qué cosas podría hacer de modo diferente?

## En resumen

Va a haber momentos en que su hijo tendrá problemas. A pesar de todos sus esfuerzos, a veces nada parece ayudarlo. Tal vez usted tendrá que poner al niño en un lugar seguro, como su cuna, para darse usted un respiro y mientras usted también se calma. Esta podría resultar ser una estrategia eficaz que le ayude al niño a calmarse. Lo que es importante es persistir y seguir intentando después. Tome una perspectiva amplia de la situación y recuerde que lo que su niño está aprendiendo por medio de sus respuestas adecuadas es que usted siempre estará siempre disponible, para todo.

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# *Jargon Buster*

Given the multidisciplinary nature of our work with infants, toddlers, and families, we often come across words or acronyms that are new or unfamiliar to us. To enhance your reading experience of this issue of *Zero to Three,* we offer a glossary of selected technical words or terms used by the contributing authors in this issue. Please note that these definitions specifically address how these terms are used by the authors in their articles and are not intended to be formal or authoritative definitions.

| *Phrase* | *What it means* |
|---|---|
| **Developmental Individual-Difference, Relationship-Based (DIR) Model** | The Developmental, Individual Difference, Relationship-based (*DIR®/Floortime™*) Model (Greenspan & Weider, 2006) is a framework that helps clinicians, parents, and educators conduct a comprehensive assessment and develop an intervention program tailored to the unique challenges and strengths of children with Autism Spectrum Disorders and other developmental challenges. (Find it in Wieder, page 5) |
| **Emotional Availability Scales** | Emotional Availability (EA) is a research-based, scientifically driven way of understanding the quality of communication and connection between a parent (or caregiver) and child (Biringen, 2000). The Emotional Availability (EA) Scales have been in existence since 1987, and are now in the 4th edition of the system. (Find it in Biringen & Allender, page 36) |
| **Neurosequential Model of Therapeutics (NMT)** | The Neurosequential Model of Therapeutics (Perry, 2006) a way to understand how the child's ecological history (including genetic, epigenetic, and environmental factors) has impacted the young child's current functioning, in order to plan for the best suitable therapeutic procedure and process. (Find it in Zarnegar, page 26) |
| **Potential Space** | Potential space is an intermediate and protective area of experiencing, an experiencing that lies somewhere between outside and inside, between fantasy and reality (Winnicott, 1971). In potential space, a toddler develops the capacity for symbols and selfhood through a dialectical process of oneness and of separateness. (Find it in Ostler, page 10) |
| **Rumination** | Rumination disorder, also known as mercyism, is the regurgitation of previously swallowed food. The cause is often unknown, and the syndrome has been linked to lack of stimulation and family stress. (Find it in Maldonado-Duran & Karacostas, page 46) |
| **Selective Mutism** | Selective mutism is a type of communication disorder related to social anxiety in which a child who is normally capable of speech is unable to speak in given situations, or to specific people. (Find it in Shott, Warren, Stuck, & Wright, page 15) |

Biringen, Z. (2000). Emotional availability: Conceptualisation and research findings. *American Journal of Orthopsychiatry, 70*, 104–114.

Greenspan, S., & Wieder, S. (2006). *Engaging autism: The Floortime approach to helping children relate, communicate, and think*. Cambridge, MA: DaCapo Press/Perseus Books.

Perry, B. D. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children; a Neurosequential Development Model of Therapeutics. In N. Boyd Webb. *Working with traumatized youth and child welfare* (pp. 27–52). New York: Guilford.

Winnicott, D. W. (1971). *Playing and reality.* New York: Basic Books.

## UPCOMING ISSUES

September: Professional Development
November: Challenging Behavior
January: Conversations With the Experts

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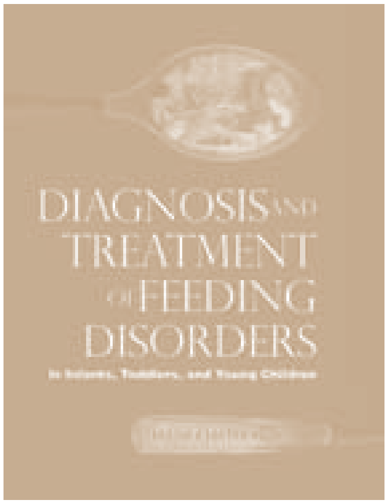

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