Pathways to
Professional Development

Building Foundations in Infant
and Early Childhood Mental Health

Disorders of Attachment, Anxiety, Activity, and Attention

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Pathways to Professional Development Building Foundations in Infant and Early Childhood Mental Health

Pathways to Professional Development was developed to build workforce competence and to prepare professionals working in the perinatal and birth to 5 periods

- 21 webinars focused on the foundations of Infant and Early Childhood Mental Health.
  - Provided live virtually
  - Recorded for viewing as LMS modules
- Diagnostic Classification of Mental Health And Developmental Disorders of Infancy and Early Childhood (DC:0-5) offered virtually and in-person.
  - View all offerings here→ https://www.ctacny.org/special-initiatives/pathways-to-professional-development/

The aim is to develop a well prepared and competent workforce trained to **identify** and address mental health concerns early, to **promote** awareness of mental health, to **prevent** long-term problems and to **intervene** to help children stay on developmental track.

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Who we are

These trainings are funded by the New York State Office of Mental Health (OMH) and provided by the New York Center for Child Development (NYCCD) in collaboration with CTAC.

- **New York Center for Child Development** (NYCCD) has been a major provider of early childhood mental health services in New York with a long history of providing system-level expertise to inform policy and support the field of Early Childhood Mental Health through training and direct practice.

- **NYU McSilver Institute for Poverty Policy and Research** houses the Community and Managed Care Technical Assistance Centers (CTAC & MCTAC), Peer TAC, and the Center for Workforce Excellence (CWE). These TA centers offer clinic, business, and system transformation supports statewide to all behavioral healthcare providers across NYS.

  - **NYCCD and McSilver** also run the **NYC Perinatal + Early Childhood Training and Technical Assistance Center(TTAC)** which offers ongoing training and technical assistance for those working during the perinatal period to age 5

https://ttacny.org/

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Pathways to Professional Development Webinar Series

Module 5 - Webinar 4 - Overview

This webinar reviews developmental disorders in attachment relationships and problems in emotional and behavioral regulation. We will begin with the ways in which attachment problems can occur and describe trauma-related attachment diagnoses.

There is clear evidence that infants, toddlers and young children can also suffer from clinical levels of anxiety and depression. In this webinar, Regulation (and co-regulation) of mood will be positioned as an essential task of early childhood; and the new diagnosis of Disorder of Dysregulated Anger and Aggression (DDAA) in DC:0-5 will be described.

Symptoms of overactivity and inattention are among the most common reasons for referral to mental health professionals in early childhood. Excessive activity levels in toddlerhood (Overactivity Disorder of Toddlerhood [OADT]) are likely to remain stable through the preschool period. This presentation reviews symptom patterns, co-morbidity and differential diagnoses of ADHD, OADT and Sensory Processing Disorders (SPDs) .

Problems that have similar symptoms (e.g. heightened activity level) may come from different diagnoses (e.g. sensory processing disorder, ADHD, trauma), and require different interventions. Behaviors in infants and young children that concern adults represent attempts by the child to adapt to developmental stressors and as ways of communicating about underlying developmental and relational problems, not only as behaviors to stop.

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Learning Objectives

As an outcome of completing this webinar/LMS, participants will be able to:

1. Identify and differentiate developmental disorders of attachment.
2. State three cardinal features from both the hyperactive/impulsive and the inattention symptom clusters of ADHD and ODT.
3. Describe anxiety symptoms and mood disorders including depression and DDAA.
4. Identify the key differentiating factors between sensory over-responsive disorder (SOD) and ADHD.
5. Identify current recommended assessment and treatment approaches.

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Attachment – Developmental Perspectives

- John Bowlby – An evolutionary view that attachment is a motivational system that balances safety and security with curiosity and exploration
- An IECMH perspective - Michael Trout (and others) – A slow, social unfolding that requires the full participation of both parties. The baby MAKES a contribution, and individual-differences exist.

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Attachment – Developmental Perspectives

- From the first moments of life, babies are forming ideas about themselves and the world, through their earliest relationships – Bowlby referred to these ideas as **"internal working models".**
- Attachments are **"relationship-specific"** – meaning that the nature of a child's relationship with one caregivers, differs from their relationships with other caregivers.
- An IECMH perspective - Michael Trout (and others) – A slow, social unfolding that requires the **full participation of both parties**. The baby MAKES a contribution, and individual-differences exist.
- Winnicott – **There is no such thing as a baby**, only a baby and an other! Attachment is necessary for survival.

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Categories of Attachment

Attachment Style	What a child with this attachment style is like	Carers' response style to child	Why the child behaves like they do
Secure	Secure, explorative and generally agreeable	Consistent and attentive to meet baby's needs. Able to soothe child. Can regulate self when child is distressed.	Feels sure needs will be meet so happy to reach out.
Avoidant	Does not readily engage with others. Emotionally distant and withdrawn	Carer is emotionally and physically unavailable for the baby. Leave the baby to fend for self.	Believes that needs won't be met so does not even try to reach out to have them met.
Ambivalent	Anxious, insecure, volatile, angry, 'attention needing', unsettled.	Inconsistent. Sometimes met baby's needs, other times didn't.	Could not rely on needs being met. Might try hard to get needs met.
Disorganised	Angry, hypervigilant, depressed, easily unsettled. Sometimes completely passive.	Extremely unpredictable, scary, unable to regulate emotions, without boundaries or sometimes extremely passive.	Panicked and/or extremely confused about how to get needs met.

RISK FACTORS

Source: https://images.search.yahoo.com/search/images?p=4+types+of+attachment+ainsworth&fr=mcafee&type=E210US739G0&imgurl=https%3A%2F%2Fpracticalpie.com%2Fwp-content%2Fuploads%2F2020%2F04%2Fattachment-styles-Chart-768x771.png#id=87&iurl=https%3A%2F%2Fwww.mollypotter.com%2Fwp-content%2Fuploads%2F2022%2F12%2FAttachment-style-768x436.png&action=click

Disorders of Attachment
(Zeanah, Boris and Lieberman, 2000)

- **Disorders of Nonattachment** – No Preferred Attachment
  - With Emotional Withdrawal
  - With Indiscriminate Sociability
- **Secure Base Distortions –** Seriously Disturbed Relationships
  - With Self-Endangerment
  - With Clinging/Inhibition
  - With Vigilance/Hypercompliance
  - With Role-Reversal
- **Disrupted Attachment Disorder -** Sudden loss of an Attachment
  - Protest, Despair, Detachment

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Attachment Disorder Related Diagnoses

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder

and

- Complicated Grief Disorder of Infancy/Early Childhood

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DC:0-5 - Reactive Attachment Disorder

- A lack of an attachment figure despite developmental capacity
- Pattern of emotional withdrawal and Inhibited behavior which includes 2 of the following:
    - No or reduced interest in social engagement
    - No or reduced comfort seeking when distressed
    - No or reduced response to comfort when offered
    - No or reduced reciprocity with caregivers
- Pattern results from insufficient care (social/emotional neglect) or repeated changes in caregivers.
- Child does not meet criteria for ASD or EAASD
- Typically diagnosed under age 5.
- Prevalence is very low.

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DC:0-5 Disinhibited Social Engagement Disorder

- A pattern of socially aberrant behavior with unfamiliar adults in an infant/young child who has experienced serious social neglect,
- Recurring tendency to approach/interact with unfamiliar adults without hesitation or reticence/caution. Displays at least 2 of the following:
  - Willingness to depart with unfamiliar adult
  - Tendency to engage in age-inappropriate physical (e.g. touching, hugging, etc.) or verbally intrusive interactions with unfamiliar adults,
  - Fails to track or monitor caregiver's whereabouts, not checking or staying close
- Social disinhibition (vs. impulsivity) that is developmentally and culturally inappropriate.
- History of insufficient care(neglect) and repeated caregiver changes
- Prevalence is rare.

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DC:0-5 - Complicated Grief Disorder of Infancy/Early Childhood

- When an infant or young child shows a significant and pervasive impairment of function following the death or permanent loss of an attachment figure.
- Following the death or permanent loss of a caregiver, at least two of the following occur:
  - Persistent crying, calling for or seeking their lost loved one,
  - When encountering reminders of the loss, the infant/young child shows:
    - Detachment, indifference to reminders like photographs, hearing heir caregiver's name,
    - Selective "forgetting" when seeing photos or reminders of the lost person
    - Extreme sensitivity to a reminder or acute distress when a item is touched or taken away.
    - Strong emotional reaction to any separation or change – even games like hide and seek, etc.)
  - Preoccupation with possible death of self or others- wishing death or telling others
  - Cluster of symptoms including depression, poor sleep and eating, self-blame, etc.
  - Causes distress and impairment

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Preventive and Therapeutic Interventions

- Promotion, Prevention and Intervention is the work of all who form relationships with infants, children and families.
- Therapeutic approaches involve the infant/child, caregivers and the nature of the relationships.
- Approaches that focus on behavioral chance in the child without attending to the caregiving relationships fail to address relationship patterns in the caregiver.
- Approaches include:
    - Infant-Parent Psychotherapy (e.g. Fraiberg)
    - Child-Parent Psychotherapy (Lieberman and Van Horn)
    - Attachment and Biobehavioral Catch-up (Dozier and Bernard)
    - Attachment-based Programs with Video feedback
    - Circle of Security

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Attention Deficit Hyperactivity Disorder: ADHD

The following data related to ADHD is based on DC:0-5 (ZERO TO THREE, 2016, p. 25-35)

Age Range: At least 36 M
Duration: Six months
Prevalence: 2%-6% in children 2-6

Symptoms of overactivity and inattention are among the most common reasons for referral to mental health professionals in early childhood.

Behavioral Expression:
INATTENTION CLUSTER
HYPERACTIVE –IMPULSIVITY CLUSTER

It is not ADHD if it appears in only one context or one relationship.

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Inattention Cluster

- Is not careful and is inattentive to details
- Has difficulty maintaining focus in activities or play
- Often fails to attend to verbal requests/demands especially when engaged in a preferred activity
- Often gets derailed following multi-step instructions
- Often has trouble executing age-appropriate sequencing activities
- Avoids activities and tasks that require extended attention
- Loses track of things that are used regularly
- Frequently gets distracted by sights and sounds
- Frequently seems to forget what he or she is doing in common routines

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Hyperactivity-impulsivity Cluster

- Frequently squirms or fidgets
- Usually gets up from seat during an activities when sitting is expected
- Usually climbs on furniture or other inappropriate objects
- Usually seems to make more noise than other children
- Often shows excessive motor activity “as if motor-driven”
- Usually talks too much
- Often has a hard time taking turns in conversation
- Usually has a hard time taking turns in activities
- Frequently intrusive in play

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Overactivity Disorder of Toddlerhood: OADT

Rationale: Epidemiologic data demonstrate high stability of level of activity over development from toddlerhood and early childhood. It is expected OADT will show substantial continuity with ADHD.
Age: Older than 24M and younger than 36M
Duration: 6M
Prevalence: 7%-16% of young children show developmental trajectories of stable high levels of and impulsivity

It is not OADT if it appears in only one context or one relationship.

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Clinical Features: ADHD

- The neurobiological and genetic underpinnings of ADHD are beyond dispute
- Biomarkers or other objective data to identify ADHD reliably in clinical practice are still lacking
- Comrobidity with other MH disorders is common including: LD, ASD, Developmental Coordination Disorder, Emotion dysregulation disorder, executive function deficits (response inhibition, vigilance, working memory and planning)
- ADHD is 3x more frequent in preterm infants, current research suggests gestational diabetes is a risk factor
- Most common meta-analytic findings suggest consistent alterations in brain activation in the frontal-parietal network for executive functions and ventral attention system for attentional processes

ADHD: Diagnosis

- Clinical interview of parents, developmental history; semi-structured clinical interview of the child containing ADHD assessment (e.g., Connors, CBCL); physical exam
- Cognitive & NP assessments, EEG, neuroimaging are additional tools to be considered
- A diagnosis of ADHD cannot be made SOLEY on the basis of rating scales; Family history is not an essential feature of children who meet criteria for ADHD although there are familial patterns
- TBR-based EEG has just been approved by the FDA to assist in ADHD Dx; Low spontaneous EEG theta/beta ratio (TBR) is associated with greater executive control.
- UK National Institute for Health and Care Excellence recommends a period of "watchful waiting" for up to 10 weeks before delivering a formal Dx of ADHD.
- In younger children, relative age to classmates has to be considered since data indicate the youngest child in a class has the highest probability of having a Dx of ADHD and of being medicated with stimulants.

SPD vs. ADHD

- Do not habituate
- High sensory aversion & withdrawal
- Inhibition of responses
- Sensory aversion and withdrawal reported as most important

- Habituate quickly
- Less sensory aversion & withdrawal
- No inhibition of responses
- Attention and impulsivity are reported as most important

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ADHD: Treatment

- All guidelines over a 10-year period recommend a multimodal treatment approach in which psychoeducation forms a cornerstone of the treatment to all those receiving an ADHD Dx as well as families and caregivers
- Multimodal treatment may include a first-stage of parent counseling; a second-stage that might include individual behavioral Tx possibly combined with a developmental intervention for the child, while the parents participate in parent training followed by a third stage in which stimulant medication may be started.
- School-based interventions including classroom conditions, teacher guidance and for the child self-coping and social-skills to deal with stigma.
- Medication for children under 5-years-old with ADHD should only be given following a SECOND specialist opinion from a service with expertise in ADHD

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EVIDENCE for ADHD Medications

- "The first "gold standard" study of different ADHD approaches alone or in combination found the effects of both pharmacological therapy **and** of multimodal therapy were significantly more effective over 14 M than behavioral therapy alone or the then "standard" therapy of the control group".
- "The multimodal therapy was not significantly superior to pharmacologic therapy alone but did result in significant improvements in ADHD symptoms at a lower dosage of stimulant medication". (Drechsler, et al., 2020, p. 337).

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Anxiety and Mood Disorders

- We now know that anxiety can reach distressing levels in infants and young children, but identifying these disorders can be challenging.
- Developing the ability to regulate emotions and mood, especially negative emotions, is a primary task in the first few years of life, and this process is primarily a "dyadic" process – reliant on the "co-regulation" of the caregivers to help the child develop the capacity for self-regulation.
- There is ample evidence that negative emotions are more closely linked to psychopathology than positive emotions.

We will examine two disorders in Infancy and Early Childhood:

- Depressive Disorder of Early Childhood
- Disorder of Dysregulated Anger and Aggression of Early Childhood (DDAA)

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DC:0-5: Depressive Disorder of Early Childhood

- Young children exhibit depression in ways tat are similar to older children and adults.
- An infant or young child may be suffering from a depressed disorder when
  - A depressed mood or irritability **lasts more days than not for at least two weeks,** as evidenced by a child's direct expressions (when verbal) or by observations of informed caregivers,
  - A child's pleasure and interest in all or almost all activities is diminished, and the child is less engaged, responsive and reciprocal.
  - And 2 or more of these descriptions apply:
    - Change in appetite
    - Insomnia or hypersomnia
    - Agitation or sluggishness,
    - Diminished energy or exuberance
    - Feelings of worthlessness, excessive guilt, self-blame in play and speech,
    - Diminished concentration, persistence, etc.
    - Preoccupation with themes of death, suicide, or attempts at self-harm
- Symptoms cause distress and interfere with normative activities

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DC:0-5: Depressive Disorder of Early Childhood

- Young children with depression are much more likely to have depression in later childhood.
- Anxiety in young children aged 3-5 also predicts school-age depression.
- Young children of parents and grandparents with depression are at risk for early onset depression.
- A young child's experience of chronic illness, multiple adverse health conditions, and pain are also associated with increased risk of early childhood depression.
- Early childhood depression occurs across all cultures and economic groups.
- Depression can occur in relationship-specific disorders

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DC:0-5: Disorder of Dysregulated Anger and Aggression of Early Childhood (DDAA)

BACKGROUND

- This is a new diagnosis in the DC:0-5 and is rooted in the empirical evidence that concurrent dysregulation of emotions and behaviors has been observed and studied extensively in young children, 3-5 years old, differentially conceptualized as Oppositional Defiant Disorder (ODD), comorbid mood/anxiety disorders, Disruptive Behavior Disorder, or irritability.
- Young children, 0-6, have often been diagnosed with ODD and Conduct Disorder.
- DDAA emerges out of research on early childhood emotional and behavioral dysregulation and on "Disruptive Mood Dysregulation Disorder" in older children and adults.

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DC:0-5: Disorder of Dysregulated Anger and Aggression of Early Childhood (DDAA)

- **A primary emphasis in DDAA is the focus on irritability and dysregulation of anger as expressions of emotional dysregulation that lead to dysregulated behaviors, including temper tantrums.**
- **Research indicates that emotional dysregulation, not simply dysregulated behavior, is a critical feature of the current definition of ODD.**
- **DDAA views the "misbehavior" as a symptom of the mood dysregulation. Treatment that focuses on behavioral change alone does not address the "internalized" mood dysregulation – and may exacerbate the mood difficulties.**

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DC:0-5: Disorder of Dysregulated Anger and Aggression of Early Childhood (DDAA)

DDAA would be indicated when all of these criteria are met, **more days than not for three months, and are present in more than one setting, and ore than one relationship**:
The child demonstrates a pervasive/persistent pattern of mood and dysregulation as evidenced by three symptoms from of these four cluster:

1. Substantial anger and temper dysregulation(e.g. difficulty calming down when angry, angers easily and irritable, intense temper outbursts, verbally or physically aggressive towards self or others when frustrated or if limit setting occurs.)
2. Noncompliance and rule breaking (e.g. arguing with adults, defiance, not following routines/directions, daily breaking rules when adult is watching, taking things from other people or stores when it is forbidden.)

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DC:0-5: Disorder of Dysregulated Anger and Aggression of Early Childhood (DDAA)

3. Reactive aggression when angry, upset, scared, etc. (hits, bites, throws things at caregivers or younger children, breaks things on purpose at least weekly).
4. Proactive aggression (e.g.is coercive and controlling in play, excludes peers from play, says or does things that hurt other people's feelings with understanding, physically or verbally frightens others, starts physical fights, uses or threatens use of an object to harm others

Specify if guilt, remorse, concern or empathy is/are lacking

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Summary and Take Away Messages

- Attachment relationship are essential in human development.
- Regulation of mood is an essential task of early childhood and is primarily formed through relationships with primary caregivers.
- Anxiety and mood disorders can be identified in infants and young children.
- Dysregulation of emotions can lead to behavioral dysregulation including anger and aggression. Treatment must address the emotional/mood dysregulation
- Symptoms of overactivity and inattention are common reasons for referrals to mental health professionals.
- Clinical levels of overactivity can be identified in toddlers.
- Activity problems can be related to sensory processing disorders.
- Problems behaviors can often be understood as attempts by young children to help themselves.
- Interventions must include child's caregivers.

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