Pathways to Professional Development

Building Foundations in Infant and Early Childhood Mental Health

Interviewing, Screening and Assessment:
The Art and Science of Knowing and Understanding in Infant and Early Childhood Mental Health

Gilbert M Foley, Ed.D., IMH-E

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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Pathways to Professional Development Webinar Series

- **Module I:** Developmental and Psychodynamic Foundations of Infant and Early Childhood Mental Health – 6 Webinars
- **Module II:** Assessment, Diagnosis, Formulation and Professional Development – 4 Webinars
- **Module III:** Risk, Stress, Protection and Resilience – 2 Webinars
- **Module IV:** Through the Lens of Family, Community and Culture – 2 Webinars
- **Module V:** Specific Disorders: A Closer Look: 4 Webinars
- **Module VI:** Helping in Infant and Early Childhood Mental Health – 3 Webinars

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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 Early Childhood Mental Health 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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Overview of the Topic

- An understanding of the child in the context of relationships and culture and from the child's subjective emotional experience are vital features of mindful screening.
- Principles of observation and listening-deeply are foundational to interviewing/history, screening and assessment.
- The principles, practices and nuances of effective parent interviewing and history-taking will be identified and examined.
- The intent, differences and characteristics of developmental monitoring, surveillance and screening will be presented and the aims and components of assessment as part of the diagnostic process will be explored.

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Learning Objectives

As an outcome of completing this learning module, participants will be able to:

- Identify the key principles of effective observation and deep listening
- Characterize the principles and best practices of parent interviewing/ history-taking
- Differentiate and describe among developmental monitoring, surveillance and screening
- Describe the purpose, components and qualitative features of assessment

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"Keen observational skills tend to differentiate a clinician from a technician"

-Glen Aylward

Principles of Keen Observation and Deep Listening

- Uses a variety of settings/contexts, important relationships and varying degrees of structure to collect a representative sample of behavior through the lens of culture, family and community

- Maintains a state of dynamic balance between empathy and distance " an optimal distance"

- Records data systematically and objectively and communicates them articulately

(Foley, 1981)

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Principles of Keen Observation and Deep Listening

- Analyzes the data for recurrent patterns and central themes with attention to transactions among developmental domains, environment and culture

- Uses theoretical frames-of-refence to serve as a guide for interpretation and considers competing hypotheses

- Engages in self-reflection

(Foley, 1981)

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Principles of Keen Observation and Deep Listening

- Listens with full attention –preoccupied with the client
- Listens actively and non-competitively
- Quietens one's own inner dialogue
- Listens with openness, resulting in emotional intersubjectivity and a partial and temporary identification with the client
- Listens with the "third ear"
- Attends to non-verbal cues, off-handed comments; changes in posture, affect, voice, volume, rhythm, rate, complexity of speech and language in association with specific content

(Akhtar, 2012; Makari & Shapiro,1993; Sutanto, 2021)

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Attributes of Keen Observers and Deep Listeners

- Breadth of experience
- Cognitive complexity
- Psychological mindedness/reflective function
- Personal insight

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Types of Interviews

- **Developmental history** refers to the record of a child's physical health, cognitive, motor, linguistic, relational/social and emotional growth and milestones from conception onwards in the context of relationships and culture.

- **An Interview for a Day** refers to a descriptive picture of the child's typical day from the time of awakening through to reawakening the next day (Provence, 1997).

- **Diagnostic interview** refers to the identification of the problems and needs of the individual to formulate a diagnosis, develop goals and objectives, and determine appropriate strategies and methods of intervention and typically includes a history, mental status, and a disposition.

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Interviewing as a Psychological Conversation

Interviewing is most effective as a psychological conversation with an aim:

- To paint an historical developmental portrait of the child from conception to current time
- To gather facts but to go beyond facts
- To find subjective meaning
- To understand historical facts in an emotional, relational and cultural context

Acquiring as much information as possible is **not** the first order of the parent interview/history. In fact, gathering the developmental history is in itself an organic developmental process (Costa & Norona, 2019; Cox, 1999).

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Aims of the Psychological Conversation

- To compose through sensitive psychological conversation as complete a picture as possible of the caregivers' concerns, the natural history of the problems, the important family life events (including adverse experiences), and the feelings surrounding them.

- To compose a comprehensive portrait of the child's development both historically and currently including strengths and concerns

(Cox, 1999)

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Aims of the Psychological Conversation

- To include in this conversation, explorations of the physical, emotional and genetic health of the child and other family members in relation to associated concerns and feeling
- To portray family interactions as individuals, as a couple, as parents of the child including the caregivers' perceptions and feelings about their child and the role the child has been assigned in the family constellation within the frame of their cultural identity, family beliefs and values
- To compose this portrait with the awareness that the feelings attached to the objective events may be as important, if not more important, than the events themselves. (Cox, 1999).

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Conducting the Conversation

- Establish a **working alliance** with the caregivers by creating an atmosphere of safety, support and a spirit and tone that we are all working together as a **team** in the best interest of the child
- Create a comfortable atmosphere in which the caregivers feel supported and respected for the concern, knowledge, strengths, and coping capacities they bring- find the good
- Recognize parents may feel vulnerable and anxious about their concerns and the implications their concerns may hold for the future of their child and themselves

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Conducting the conversation

- Acknowledge that parents know their child best by putting yourself in the position of a learner, and allow the parents to teach you about their child
- Allow the caregivers to tell their own story, in their own words, from their own perspective beginning where they choose (Costa & Norona, 2019)
- Maintain a stance of calm, attuned-attentiveness and benevolent - availability

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Conducting the Conversation

- When the tone and the time feel appropriate, punctuate the conversation to correct timelines, deepen and expand content, reflect-back, summarize, reframe, contain anxiety and provide developmental guidance.
- When a broad brush picture of the child's developmental journey in the context of relationship, family and culture has been formed, then return to fill in specific details, clarify timelines, ascertain the parents' theory as to the cause of the problem and what they think might help.

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Conducting the Conversation

- As the interviewer, be reflective and connected to your own inner state: fluctuations in physiological arousal, feeling states, emotional triggers and anxieties, among which may be the struggle to stay focused on the caregivers and the press to gather information (Costa & Norona, 2019).
- Being aware of our own vulnerabilities helps to attune with the parents and keep us humble.
- Be a container for strong feelings so that caregivers know that such feeling states are permitted, will not frighten us off and can be managed.
- Beginnings and endings are important. Be planful about the setting, how you present yourself and introduce yourself, how you and the parents want to be addressed, let the caregivers know what they might expect to happen during your time together and be planful in closing the session.

Developmental Monitoring, Surveillance & Screening

Why Developmental Monitoring, Surveillance & Screening?

- Approximately 15% of the pediatric population has developmental problems. Of this subset, 45% have speech or language issues (of these, about 16% who present with an initial language delay 8% will persist), 38% display developmental delay in other domains such as motor or adaptive skills, and 17% have autism or other disabilities (Feldman, 2020).
- The prevalence rate of developmental problems is higher in those born preterm. In fact, of children born at 25 weeks gestational age, only 5% do **not** have developmental concerns (Berry et al., 2017).
- There is essentially an inverse relationship between gestational age and developmental disabilities: the younger the gestational age, the greater the likelihood of developmental problems.

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Types of Developmental Risk

Established risk (e.g., Down syndrome [DS], Rett syndrome, Fragile X)

Medical/biologic risk (prematurity, birth asphyxia, Grade III bleed- a 35-55% chance of disability, Grade IV 90% chance of motor and/or cognitive deficits)

Environmental risk (**ACEs**, Poverty, poor stimulation).

Types of Developmental Risk

- Cognitive problems often first present as language delays
- For children born with extreme prematurity (less than 28 weeks) mean group IQ/DQ decrease by 1.2 to 2.5 points per week below 32 weeks
- More than 75% of extremely premature infants experience deficits in visual-motor integration and writing
- There is a risk for low-average to borderline cognitive abilities due to IVH, disruption of brain development associated with extreme prematurity and continued low grade hypoxia caused by BPD (need for supplemental oxygen after 36 weeks gestational age)
- A toddler who was born extremely premature is at risk for “high prevalence /low severity” dysfunctions (e. g. ADHD, learning disabilities)

(Aylward, 2020)

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Developmental Monitoring

- *Developmental monitoring, typically conducted by parents/caregivers,* tracks how a child grows and changes over time and whether the child meets the typical developmental milestones within expected time parameters. A brief milestone checklist may be used.

Developmental Surveillance

Developmental Surveillance is an important way for clinicians to identify children at risk for developmental delay and should occur during every health supervision visit with special attention at the 4-5 year visits in preparation for school entry.

Developmental surveillance consists of:

1. Eliciting parent's concerns
2. Obtaining a developmental history
3. Observing the child
4. Identifying risks, strengths, and protective factors
5. Maintaining a record
6. Sharing opinions and findings

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Developmental Screening

- **Developmental screening** is the practice of systematically looking for and monitoring signs that a young child **may** be delayed in one or more areas of development using a parent-report or observational instrument with empirically derived norms and established validity and reliability.

- Screening is **not meant to establish a diagnosis** for the child, but rather to help professionals determine whether more in-depth assessment is the next step

- **Red Flag** behaviors/patterns that are not a usual part of typical development warrant further investigation, even if the developmental screen is negative.

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Red flags

At all ages:

- Avoids or rarely makes eye contact with caregiver
- Concerns about sleep
- Eats inedible objects (more than rarely)
- Has chronic or frequent diarrhea or vomiting
- Has growth problem in height or weight
- Engages in self-hurting behavior
- Has unusual number of injuries
- Is apathetic or listless
- Is under or over-active
- Is often hard to comfort or satisfy
- Excessive use of head banging or other self-stimulating behavior
- Rocks Excessively
- Cries excessively

Check also after 18 months:

- Is overly aggressive or combative (e.g. hits, bites pushes, kicks, etc.
- Engages in frequent ritualistic or stereotypic behavior (e.g. body rocking, marching in place, crossing and uncrossing legs, etc.)
- Is indiscriminately friendly with strangers
- Has difficulty separating from caregivers or parent(s) on a regular basis (province, et al., 2016)

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Some Commonly Used Screening tools

Parent-report developmental screening instruments

- Ages & Stages Questionnaires, 3rd Ed. (ASQ-3) (PDF)
- Parents' Evaluation of Developmental Status (PEDS) (PDF)

Observational developmental screening instruments

- Battelle Developmental Inventory 3rd Ed. Screening Test (PDF)
- Brigance Early Childhood Screens III (2013) (PDF)

Minnesota department of Health (2021)

M-CHAT-R (Modified Checklist for Autism in Toddlers, Revised)

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Timetable of Developmental Screening

The American Academy of Pediatrics (AAP) recommends developmental and behavioral screening for all children during regular well-child visits at these ages:

- 9 months
- 18 months
- 30 months

In addition, AAP recommends that all children be screened specifically for autism spectrum disorder (ASD) during regular well-child visits at:

- 18 months
- 24 months

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Developmental Assessment

Developmental Assessment

A **developmental assessment** is a comprehensive and systematic evalution of the child's functional status across developmental domains in the context of relationships and culture to differentiate between delay and disorder, make a diagnosis and guide appropriate intervention and support.

Developmental Assessment

A comprehensive developmental assessment is:

- **Multidisciplinary**
- **Multimodal** (employs multiple means of collecting a **representative sample** of behavior and evaluating function including but not limited to: record review, health status, interviews, observations, report measures and administration of structured test items)
- **Multisession** (DC:05 recommends a minimum of 3-5 discrete sessions)
- **Multi-contextual** (e.g. home, school)

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Developmental Assessment

A developmental assessment is :

- **Relational and family focused** (active participation of parents/caregivers and significant others identified by the family)
- **Culturally informed** (cultural identity, primary language, etc.)
- **Trauma informed**
- **Strength-based**

Developmental Assessment

A Developmental assessment is likely to include the following components:

1. Use of caregiver report and participation
2. Integration of the child and family history
3. Direct observation of behavior, milestones and patterns of relating/interaction
4. Administration of structured test items

Developmental Assessment

Formal assessment methods typically include:

Broad-band measures (e.g. Bayley-4, IDA-2)

Narrow-band measures typically apply to specific developmental domains and may be discipline specific (e.g. Sensory profile-2, preschool Language Scales-5)

Employing:

Naturalistic observation

Structured observations (e.g. Crowell)

Report measures (e.g. CBCL, Sensory profile)

Administration of test items/eliciting behavior (e.g. Bayley-4)

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Developmental Assessment

As part of clinical assessment **qualitative aspects** of behavior are important with young children:

Areas of importance include (a) vision (aberrant eye position [esotropia, exotropia], uncoordinated eye movements); (b) excessive tone/decreased tone that is obvious in execution of motor tasks; (c) asymmetries in arm or leg use; (d) poor motor modulation (reaching, letting go of objects); (e) strongly established hand preference at an early age (< 12 months); (f) very short attention span, excessively high activity level, or increased impulsivity for age; and (g) emotional dysregulation (Aylward, 2020, p.-95).

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Developmental Assessment

In assessment of young children:

- Patterns of behavior are more meaningful than single abnormal “signs”
- The functional impact of atypical findings (i.e. degree of “impairment”) is critical in assessing the significance of abnormal findings
- Identifying behaviors that are key components of higher-order or more complex skills are of particular significance, such as selective attention, habituation or ability to inhibit are early indicators/predictors of executive function (Bayley & Aylward, 2019)

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Developmental Assessment is the portal to the distinct but interrelated components and process of diagnosis and formulation

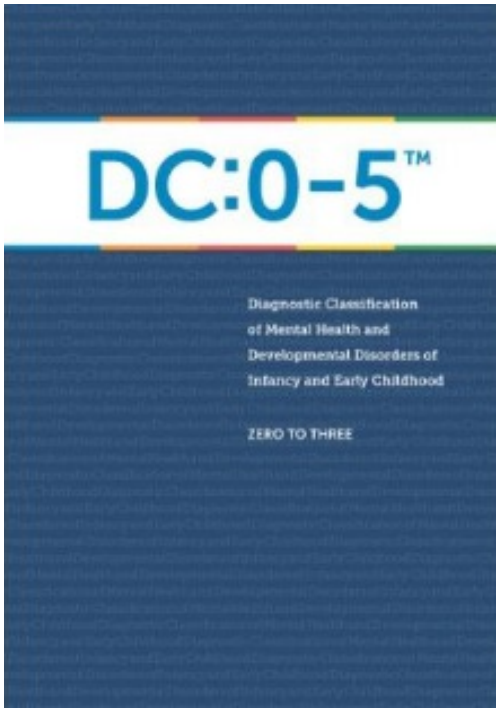
The Diagnostic Process

Assessment
Gathering data from record reviews, observations, and perceptions from caregivers

Diagnosis
Identification and classification of disorders

Formulation
The way in which the infant's/young child's clinical presentation is understood in the context of biology, relationships, social network, and culture

DC:0–5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood



- DC:0-5 was developed since existing classification systems such as DSM V did not adequately reflect the unique developmental and relational experiences of infants and young children.
- DC:0-5 is a multi-axial system that considers a child's clinical disorder only after issues such as the child's health, development, psychosocial stressors, and culture as well as the nature of the child's relationship with important caregivers have been assessed.
- The NYS Office of Mental Health (OMH) has been actively collaborating with the NYS Department of Health (DOH) to work toward making the DC:0-5 the recommended diagnostic tool for the birth to age 5 population in New York State.
- Sign up for a DC 0-5 Training here: https://www.ctacny.org/special-initiatives/pathways-to-professional-development/

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