Infant mental health and child protection

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This is the third article in our series on vulnerable children and young people in New Zealand. This article aims to provide primary care professionals with an understanding of infant mental health, with particular reference to the needs of very young children who may come to the attention of Child Youth and Family

Many infants in New Zealand are taken into state care each year

Early neglect, abuse and parental stress have significant long-term mental health effects for infants and young children. Early assessment and intervention offers the potential for improved outcomes.

In the 12 months from June 2009, 62,543 babies were born in New Zealand. During this time, 166 babies and 502 children aged less than two years came into State care.[1] In 2008 3,456 children aged under two years were found to be physically, emotionally or sexually abused or neglected. An unknown but even larger number of infants will be growing up in less than satisfactory environments. On average 63 children aged under two years are admitted to hospital each year as a result of serious abuse.

Defining infant mental health

The age range used when addressing infant mental health is from birth to a child's fourth birthday.

"Infant mental health is the developing capacity of the child from birth to three to experience, regulate and express emotions; form close and secure interpersonal relationships; and explore the environment and learn – all in the context of family, community and cultural expectations for young children"[2]

Infants can have mental health problems

As adults, we find it uncomfortable to think of babies and toddlers having mental health difficulties and disorders, but they do; and there is a considerable body of knowledge and research in the discipline of infant mental health that is pertinent to assessment and intervention.

It is a myth to assume infants are immune to the impact of problematic care and trauma or to assume that their immaturity in some way constitutes resilience.

Early relationships are critical for an infant's social, emotional and cognitive development. Experiences antenatally and in the first years are pivotal in establishing

the building blocks for ongoing development and may impede or promote development. In recent years the science around genetics, epigenetics and neurobiology highlights the processes of nature via nurture such that nearly all of the elements of early human development are affected by the early caregiver environment, family, culture and community.

Every parent begins with the best of parenting intentions, but for some, "good intent" is not enough. The first months and early years of care giving are critical for a child's development and this is often the time when parents have the highest motivation to "get it right"' with their child. Potentially it is the most opportune time to engage families with multiple difficulties.

It is important to identify those infants and families for whom particular needs and risks contribute to vulnerability.

Adversity, stress and relationships

What looks like a social situation is actually a neurochemical situation

Infants who come to the attention of Child, Youth and Family have generally experienced complex trauma within their care giving environment. They may have had prolonged exposure to trauma (parents who withdraw, are emotionally unavailable or neglect to provide adequate care), experienced multiple traumatic events over time (domestic violence and physical abuse) or experienced different traumatic events at the same time.

Complex trauma has a profound effect on physical, emotional, behavioural and cognitive development. It causes major disruptions in attachment and relationship development. It changes the architecture of the brain and the way it functions potentially resulting in a significantly smaller brain.[3]

Care that is chronically or unpredictably traumatic is experienced by infants as severe stress. Their stress response system (the hypothalamic-pituitary-adrenal [HPA] axis) is over-used. Infants have a highly reactive adrenocortical response to stressors and those responses are regulated within the relationship interactions with their parents/caregivers. The cortisol response is gradually reduced or dampened during an infant's first year, provided they have adequate care. A parent, who is both the source of the stress and unable to respond to regulate the stress, leaves an infant uncontained and overwhelmed. Over time, the infant's HPA axis resets towards a hyper- or hypo-responsive pattern.

Given their age and development, infants have limited behavioural and emotional ways to express their stress – through fight, flight or freezing. All these responses are seen when we observe the infant – caregiver relationship while undertaking an assessment.

Over time it becomes more difficult for young children who have been exposed to trauma to manage normal developmental tasks and their adaptations become more inflexible.

Infants with mental health concerns may:

- Fail to achieve milestones – delayed toilet training, delayed language
- Struggle to master the challenges of regulating their emotions and impulses – prolonged and frequent temper tantrums, severe and persistent separation anxiety
- Be unable to negotiate peer relationships and appropriately play
- Struggle to problem solve
- Struggle to have trust in caregivers – becoming very controlling of them.

The prospective Dunedin and Christchurch Longitudinal Studies and the Adverse Childhood Experiences (ACE) Study (retrospective) have confirmed that adverse childhood experiences are linked to poorer physical, cognitive and mental health outcomes and psychopathology later in adolescence (and continuing into adulthood).

Vulnerable infants and families

It is important to be supportive of parents and caregivers in their desire to provide appropriate care for their very young children. It is also important to acknowledge openly that for some parents and caregivers this is going to be more difficult and at times additional support and intervention will be helpful.

The attributes that create vulnerabilities to abuse and neglect are well established with accumulating factors increasing the risks for an infant. Multiple factors are associated with an inability to provide adequate care for a child.

The factors that should be considered are:

- Current stressors – poverty, illness, parental conflict, family violence, loss and death. Poverty increases an infants' exposure to multiple difficulties and disproportionately affects Māori and Pacific peoples.
- Maternal or paternal mental health disorders – particularly bipolar affective disorder, persistent depression, alcohol and substance abuse and personality disorder.
- Adverse parental childhood experience – e.g. physical abuse, sexual abuse, neglect, being in foster care, exposure to severe family violence or significant loss and death.
- Teenage parents – difficulties include lack of adequate antenatal care, poor nutrition, negative responses from their families, high levels of depression and stress. Teen parents express less positive and more negative emotions with their infants and support more punitive care giving behaviour, particularly from the second half of the first year.
- Problematic pregnancy or birth – contributing to a parent being withdrawn, hostile or ambivalent about their baby.
- Social isolation – unsupported, abandoned by family or separated from family, or disconnected / alienated from a cultural community.
- Parent criminal history
- Developmentally disabled parents

There is some evidence that caregiving capacity is most disrupted for parents who have been sexually abused in childhood.[4]

In various ways these different factors impede the adult's capacity to read their infant's social and emotional cues and respond appropriately to them or manage their own emotional state - frightening or traumatising the infant.

It is also important to think about the difficulties an infant may have that further complicate a parent's care giving.

These include infants who are:

- Premature, of low birth weight or have medical problems
- Have physical or developmental disabilities
- Are temperamentally "difficult"
- Are physiologically irritable, sensitive to touch, cry a lot or are persistently difficult to console, feed or settle to sleep

Some babies are irritable and difficult to settle as a consequence of the antenatal in-utero environment, e.g. being exposed to high levels of maternal cortisol in the context of domestic violence.

In different ways these infants challenge the capacity of all parents and caregivers to accurately read their cues and support their development.

Recognising symptoms associated with trauma and stress

Given the accumulating evidence around long-term effects of adversity and complex trauma on the developing infant, primary care practitioners need to proactively identify those families with high needs who require extra time for an integrated care approach.

Infants and toddlers cannot advocate for themselves or give a coherent history so observations are essential in addition to eliciting the relevant information from a parent or caregiver.

Infants have relatively limited emotional and behavioural responses. Having eliminated underlying medical causes for distress, it is critical that the health practitioner explore problematic relationships and the potential for mental health disorders. Infant mental health problems are typically complex, requiring time to explore and a recognition that infants function within family relationships. A "whole person" approach is actually a "whole family system" approach with the child's experience kept central.

The most frequent concerns raised by parents or caregivers about infants are:

- Increased aggression and disruptive behaviour
- Sleep difficulties
- Increased separation anxiety

Think carefully about these presentations as all these symptoms may be related to trauma and stress. For example, irritability, tantrums and aggressive behaviour in a toddler may signal depression, anxiety or a traumatic stress reaction. Co-morbidity with problematic care is likely as are significant mental health, alcohol and drug and personality difficulties in one or both parents/caregivers.

What might you hear and need to take notice of:

- A parent who does not feel bonded to their infant
- A parent who fears they may hurt their infant
- A parent who holds a distorted perception or representation of their infant. All parents have negative feelings towards their children at times, however, distortions of perception should be considered when they persist or are developmentally inappropriate such as "he's exactly like my abusive father", [infant of 3 months]; "she hates me" "she's really manipulative", "he's going to end up in jail" [2 year old].
- A parent who feels their toddler is in control – "the boss" of them

What might you observe and need to take notice of:

- Limited or no observations of shared joy in the relationship
- A parent who frightens the infant
- A parent who seems frightened of their infant
- A parent who shows hostility, constant criticism or more worryingly, active rejection
- A parent who is withdrawn, uninvolved, passively rejects, does not respond or is perhaps dissociating, which is highly distressing for an infant
- An infant who is expected to care for the parent, to make them feel better
- An infant who seems perpetually anxious and on edge (hyper-reactive - fight state) and easily becomes dysregulated (e.g. aggressive or whinging and clinging) with minimal apparent triggers
- An infant who appears psychologically numb and shut-down (hypo-reactive - flight state)
- An infant who is aggressive, shaming and coercive of their parent

It is useful to observe interactions when an infant is distressed, hurt or upset. At these times of stress, a child is dysregulated and developmentally requires the care giver to provide care that soothes at both an emotional/ behavioural level and at a physiological level.

When implementing current screening and review for domestic violence, adult mental health and alcohol and other drug use, you should integrate questions about the emotional, social and cognitive development of infants. Remember to ask about experiences of significant loss and death – these tend to preoccupy parents and impede care giving.

Interventions

When the decision is made to place an infant or young child in care (extended family, foster placement) the provision of a different and potentially consistent, empathically responsive carer is a key intervention, irrespective of longer term plans that may include a return home. However, there are considerable challenges for foster parents and traumatised, neglected children in developing new relationships that will potentially support healthy social, emotional and cognitive development.

There are evidence based interventions for supporting foster parents to develop nurturing relationships in this age group.[5] It is appropriate to make referrals to Child and Adolescent Mental Health Services (CAMHS) or Infant Mental Health Services (where they are available) for assessment and intervention when problems persist within the placement beyond three to four months.

Interventions for infants at risk

There are well developed and researched interventions available:

- Assess and intervene (may involve referral) with parental mental health problems and refer for additional intervention around the parent-infant relationship.
- Both maternal and paternal depression are common in these early child rearing years and parental depression has long term effects on children's cognitive, emotional and behavioural development. Just treating a parent will not improve the outcome for children; intervention also needs to address the relationship.[6, 7]
- Refer infants who show significant social, emotional and behavioural problems such as:
  - Persistent aggression
  - Listless, depressed, apathetic infants
  - Failure to thrive (require paediatric review first)
  - Self-regulatory problems as a consequence of disturbed caregiving relationships which may be evidenced in sleep or eating difficulties, prolonged tantrums and self harm
- Refer families where parents identify they are fearful of abusing their child, do not feel bonded, dislike their child or may fear repeating abuse they experienced as children.
- Refer infants exposed to complex trauma:
  - If symptoms have lasted longer than three months and are interfering with functioning
  - If the parent/caregiver is traumatised or compromised (e.g. depression, alcohol abuse] in their ability to look after the child
  - If the trauma involved loss of a parent or significant caregiver

Consider referral to organisations that provide:

- Interventions that decrease social isolation and value connections with parents – e.g. playgroups, playcentre, Kohanga Reo, Pacific Island early childhood centres, kindergartens and other early childhood education services.
- Concrete assistance and advocacy to ensure families living in financial difficulty are able to access resources to assist with parenting and parental relationships – e.g. WINZ, budgeting advice, relationship services and community toy libraries
- Specialised Infant mental health services – in New Zealand these are not yet established in all DHB's but CAMHS are expected to offer assessment and intervention from birth and to work with child health, adult mental health, education and child protection.
- Evidence based parenting programmes including Incredible Years Parenting Programme, Triple P, Mellow Parenting (available in Counties Manukau DHB)
- Community/NGO Early Intervention Programmes including Ministry of Social Development funded home visiting programmes for vulnerable families (e.g. Family First, Early Start, PAFT with Ahuru Mowai).

Further resources:

www.imhaanz.org.nz

The website of the New Zealand Affiliate of the World Association of infant mental health where you will find contact details for the regional infant mental health groups that cover most of New Zealand. These groups, generally comprised of health and early childhood education professionals, are an information source for Infant Mental Health resources in the area.

www.mothersmatter.co.nz

The website of the Postnatal Depression Family-Whānau New Zealand Trust for health professionals and families which is focused on New Zealanders, covers a spectrum of mental health difficulties and up to date medicine information.

www.developingchild.harvard.edu

The National Scientific Council on the Developing Child (NSCDC) is a multi-disciplinary collaboration comprising leading scholars in neuroscience, early childhood development, health and economics. Publications are regularly revised, concise and designed to integrate the science of what is known with what needs to be done.

www.zerotothree.com

This American non-profit organisation informs, trains and supports professionals, policymakers and parents in their efforts to improve the lives of infants and toddlers. The website has numerous resources for parents, caregivers and health professionals.

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