

# UAIMH Newsletter

Utah Association for Infant Mental Health <http://www.UAIMH.org>

(Issue 11, July-August 2009)

Special Topic: Brain Development



## President's Corner

The year 2008 came and went in a flash, and suddenly it was 2009, with unexpected financial markets and uncertainty in our economic world. Many of us have struggled with this sudden loss of predictability in our worlds. I, for one, think about what I am buying much more than I did in the past. Do I need this? What things are important, and what can I do without? For babies and young children, the research is clear. Sure, it is nice to have lots of cool toys and expensive clothes, but all they really need are predictability, consistently and appropriately responsive caregivers who talk to them a lot, and to feel all the love they have around them. Therefore, in these uncertain economic times, maybe we can leave that "must have" toy on the shelf for another day, which may help us feel more secure and just "be" with our young children. When my daughter was younger, all we needed was Logan Canyon, where we spent so many hours reading books, hiking trails, playing in the water, investigating bugs, making art projects out of the big burrs, and eating our dinners with sticks because mom forgot a fork. We did not have many toys in our house. Moreover, I am proud to say that Bianca must not have suffered too much, as she is heading to Westminster College in the fall on a Presidential scholarship. I guess we did not need those toys after all.

Along the lines of transition and predictability, I am happy to say that UAIMH has the incredible privilege of having Judy Ahrano as the new President. Judy has recently retired from a long and illustrious career, but she seems to have more energy than those 3 year-olds who refuse to take a nap. I, on the other hand, am ready for a nap, even though I have been more like a sloth this year than the normal Tigger that I usually am. Judy is like a breath of fresh air to UAIMH, as she

now has freedom and time, when she is not off sailing to some exotic locale, to think about what she sees as needs in the infant mental health field, and she is ready to learn what is important to others, and to help ensure that those needs are implemented here in Utah. We can be sure that Judy is a visionary leader who will help chart the course of UAIMH for a predictably positive future. Welcome, Judy, and thank you for your selfless service.

Vonda Jump, Ph.D.  
Past President

*"Therefore, in these uncertain economic times, maybe we can leave that "must have" toy on the shelf for another day..."*

We have had a vibrant year under the capable leadership of Vonda Jump Norman, PhD, in 2008-2009. We look forward to her ongoing input and support in the 2009-2010 year. Two newsletters, pregnant with useful information on Sleep Problems and Weight Problems in infancy and early childhood, were published and remain on the UAIMH website (<http://www.UAIMH.org>).

Our Fall Conference, "The Kaleidoscope of Child/Adolescent Weight Problems and Infant/Child Mental Health," held on the morning of October 17, 2008 on the University of Utah pediatric campus, was an excellent presentation by a group of experts in the medical and mental health field, joined by a parent volunteer on a panel of presenters in a clinical problem solving discussion at the end.

Our open Annual Meeting was held April 14, 2009. Vonda presented research and current practice interventions in, "Military Families and Mental Health: Raising young Children in the Face of Uncertainty and Separation." This will be repeated as a poster presentation at the upcoming October 13-14, 2009, Critical Issues Facing

Children and Adolescents Conference.

The UAIMH Board members have worked closely with the Planning Committee for this conference and for the first time there will be an Early Childhood Mental Health track for the full first day of the conference. Ross Thompson, Ph.D., a researcher in early childhood psychology from UC Davis, will give the opening keynote presentation. UAIMH members will receive a

*Keynote speaker at the October 13-14, 2009, Critical Issues Conference will be Dr. Ross Thompson from UC Davis.*

discount on the cost of the conference. The brochure will be available in late August or early September 2009.

Let me introduce myself. I first began working, after earning a Bachelor's degree in Philosophy and Psychology, as a live-in counselor with autistic

and schizophrenic children at the Orthogenic School at the University of Chicago, under the direction of Bruno Bettelheim. After a year, I returned to Atlanta and worked as a personnel counselor for the State of Georgia, taking pre-med science and math courses in the evening. I then graduated from Emory University School of Medicine and completed a residency in Pediatrics at Emory University and Egleston Children's Hospital in Atlanta, Georgia. I practiced general pediatrics in rural North Georgia--the original "medical home" model--for 12 years.

To follow my own love of neurology, psychiatry, and pediatrics, I came to Utah to enter a new fellowship in Developmental Behavioral Pediatrics at the University of Utah under the direction of Dr. Charles Ralston. I subsequently developed the Child Development Clinic at the State Children with Special Health Care Needs Bureau, to serve children birth to five with developmental/behavioral disorders and have practiced as a Developmental/Behavioral Pediatrician in Utah for 20 years.

My publications include the chapter on "Regulatory

Disorders, Motorically Disorganized," in the DC:0-3 Casebook, A Guide to the Use of Zero to Three's "Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood" in Assessment and Treatment Planning, eds. Alicia Lieberman, Serena Wieder, and Emily Fenichel, 2000.

Out of the UAIMH Board retreat on October 24, 2008, came lofty and realizable aspirations for increased collaboration with related agencies and organizations, including the Intermountain Pediatric Society, the Utah Psychological Association, Utah Association for Play Therapy, Schools of Social Work at the U of U and USU, the Governor's Commission on Early Childhood, the State Office of Childcare, Head Start, Early Head Start, Special Education Preschool, Early Intervention providers and Baby Watch. Other ideas include joining with Zero to Three's military initiative. We discussed setting up a UAIMH Coalition to provide support to Newborn Nurseries for administering Brazelton's Neonatal Behavioral Assessment Scale to newborn infants in their parent's presence prior to discharge (<http://www.brazelton-institute.com/clnbas.html>) and supporting the "Period of Purple Crying" orientation for new parents before hospital discharge.

We would like to make the UAIMH website (<http://www.uaimh.org>) more interactive, providing a consulting pool to enable discussion of clinical problems that arise for providers around the state. We also are considering offering a speakers bureau and a clinical lunch consultation group for general pediatricians. We are thinking about the pros and cons of offering/supporting an Infant Mental Health credentialing program through collaboration with other states/and or offering mini grants for those who wish to pursue credentialing.

Now is an exciting time for early childhood. Just this summer, \$2.2 million in additional funding came into our state to increase early childhood education services, including increasing the number of prenatal to three Early Head Start programs. It is also possible that this country will soon actually have comprehensive health care for pregnant women and children. I am thrilled to

take the helm of UAIMH. It feels like our “day in the sun” is arriving. To work toward fulfilling our lofty goals for the near future we need dedicated workers who will join with UAIMH and help us to solidify the belief in reality that supporting infant mental health is the key to mental health throughout life for a healthier, happier future for the citizens of Utah, the country and the world. Come one, come all and share our camaraderie and our passion!

*Judith Ahrano Kittel, MD  
President of UAIMH*

## News from UAIMH

### *Annual Board Meeting*

We had an exciting and productive Spring UAIMH Board meeting in April. Dr. Vonda Jump, our Past President from Utah State University, presented interesting information regarding the challenges faced by our military families who are experiencing multiple deployments and stressful situations.

Look for some exciting training and conference opportunities through UAIMH in the fall and winter. Also, if you know of an exciting opportunity to promote infant mental health, please let us know and we will be sure to put it in the newsletter.

### *Annual Board Change*

At our Annual Board Meeting in April, a new President took over the reins of UAIMH. We are happy and proud to announce a year of leadership by Judy Ahrano, MD. We are also excited about our new Board member, Susan Dickinson.

**Susan Dickinson** began her professional training and work at The Children’s Center because study of the first years of life for the child was paramount with the goal of effective mental health interventions to change generational family problems. She continued her interest in infant/toddler/preschool mental health and support community partnerships to promote infant mental health

through parent training, support and therapy, as well as basic life-sustaining interventions of proper health care, nutrition, housing, work and education. She currently works for the Utah State Department of Health and serves on the boards of the Utah Parent Center and the Autism Council of Utah.

### *Special Topic:*

## Brain Development and Empathy

As a practicing general and developmental behavioral pediatrician, I have often been astonished by what younger children might say or do, demonstrating a level of social-emotional understanding well beyond what has been credited to them. I have also thought, as have others, that we do not give them full credit for their level of mastery, primarily because they do not always have the language to express their thoughts and feelings clearly. Understanding their level of emotional comprehension requires that we carefully observe and accurately interpret their non-verbal communication.

My 2½-year-old granddaughter provided an excellent example of the complex emotional understanding of a toddler. I was visiting in her home and received a phone call from my mother who told me that my father had fallen the night before and was admitted to the hospital. Naturally, I was greatly concerned and saddened. My granddaughter was hovering around me in the room. As I listened further, my granddaughter came quietly to my side, leaned in against me, put her arm around my shoulders and spoke softly in my ear. “It’ll be all right,” she said, as she patted my back with her hand. As tears welled in my eyes, I was astonished by her heartfelt expression of compassion.

*“...We do not give [younger children] full credit for their level of mastery...”*

What do we know that allows us to accept without question that this child was not just imitating behavior of adults that she might have witnessed? We now know that

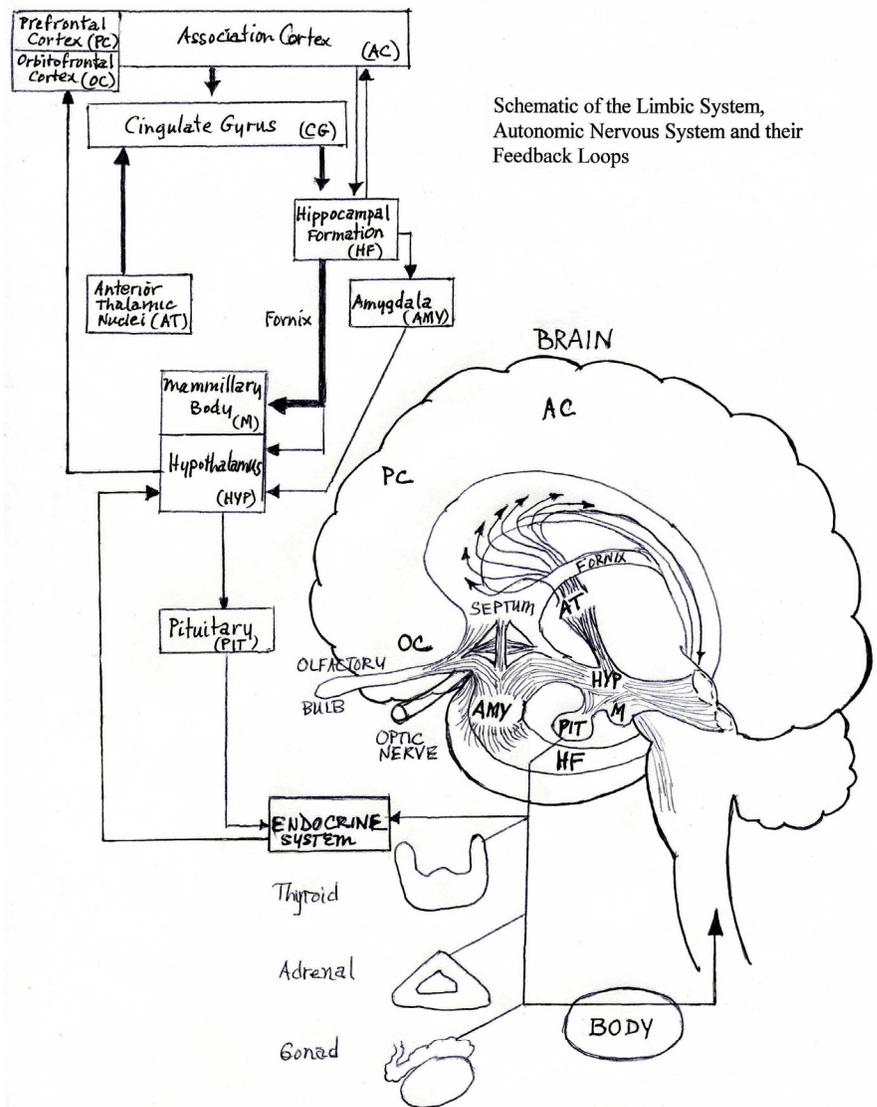
she is capable, at her age, of recognizing and correctly assessing another person's emotional state. She is capable of turning that emotional understanding into an empathic act. Knowing the neurodevelopmental basis for the social-emotional complexity of the toddler helps us embrace such a compassionate act as authentic.

What has neuroscience research taught us? We know that the period of most rapid and complex brain development is the first three years of life. We know that an essential requirement for optimal brain development is a reasonably emotionally healthy and securely attached relationship, integrated with genetic, nutritional, experiential/educational, and environmental factors. We also know that there is a quality of plasticity in brain development that allows for compensation when there are deficits, via the development of complementary skills. We know that young children learn best when they are active participants, experientially and emotionally. Optimal learning comes through play and independent exploration. Learning is maximally supported in the context of a securely attached relationship that is caring, comforting, protective, attuned, and facilitating.

Let us first review what takes place in the brain through the fetal period into the early childhood years. Anatomically, the nervous system begins with the neural plate after conception. A neural groove forms at about 18 days gestation and begins to close together to form a complete neural tube by 28 days. Already the forebrain, midbrain and hindbrain are developing and by the 23 days of gestation the optic outpouchings are occurring. By 33 days the lateral outpouchings appear to form the early cerebral hemispheres. Internally the tissue begins to proliferate, as a layer of neuroepithelial cells differentiates

into neuroblasts. These neuroblasts migrate outward in waves to form the cortical mantle layers. At 10 weeks the cerebral cortex is quite thin, with only one outer layer formed. Neuronal cells are added, with the majority of those present by 4-5 months gestation. During the same time, the cerebellum is going through its major formative period.

Postnatally, neuronal cells continue to be added, although most are present at birth. In the first six months of postnatal life, most of the cells added are myelin producing glial cells. Myelin forms the sheath which coats nerve fibers, enabling electrical signal propagation between nerve endings and cells throughout the brain



Schematic of the Limbic System, Autonomic Nervous System and their Feedback Loops

Adapted and modified by Judith Ahramo Kittel, MD from McEwen (1989), MacLean (1990), and Kandel (1991), in Schore, 1994.

and body. This progressive myelination is reflected in the “head to toe” direction of motor development observed in the first year of life. Brain growth is almost complete by two years and, at that time, the brain is approximately 80% of adult size. During the first 3 years of life, axonal fibers begin their most marked proliferation of connections/synapses between nerve cells and nerve endings. This enables rapidly advancing brain function. The subsequent firming or pruning of these associative connections, based on learning and experience, continues to finely hone these *associative tracks*, which are essential for integrated brain function. This process continues through life (Jones, 2006).

During the very early period of fetal cellular brain development, external substances and maternal stressors can permanently impact later functioning of different neural cells and can alter the cell migration pattern in ways that may interfere with an otherwise genetically preordained path. Examples are exposure in utero to nicotine, alcohol, cocaine, and amphetamines. Severe emotional stress, as in trauma, experienced by the mother during pregnancy, increases exposure of the prenatal brain to stress hormones, glucocorticoids. Research has indicated this may cause aberrations in fetal brain development (Wellburg, 2001). Exposure of the fetal brain to these substances, during the first three weeks of pregnancy, can alter the capability of neurotransmitter production by neuronal cells. It can also disturb the migration of those cells to their proper anatomical locations, altering the pattern and function of connections with other cells.

Let us now review major anatomical elements of the brain, and their functions, related to the development of the emotional life of the fetus, newborn, infant, and toddler. The basic life support system includes the *brainstem*, the *hypothalamus*, and the *pituitary*. These, together, sustain life, growth and homeostasis. They provide the body’s chemical response to a primitive experience of emotion via the autonomic nervous system with its sympathetic (energy mobilizing) and parasympathetic (energy conserving) response capabilities.

The *amygdala*, located in the mid brain, takes in information from the sensory organs (olfactory, visual, auditory, tactile, and gustatory) and attaches an experiential emotional energy value to each experience, laying down *implicit* memory tracks. For example, the newborn has a built in ‘homing’ capability at birth (Stern, 1985) to locate its own mother through smell, via the olfactory nerve, and sound, via the auditory nerve. This homing capability does not require conscious purpose or thought. Implicit memories alone are not modified by cortical, cognitive judgment. Implicit memories, generated by trauma, can be reactivated and re-experienced, set off by a trigger that is not necessarily consciously recognized. An example is a “flashback” in post-traumatic stress disorder, which brings a “gut level” re-experiencing of the implicit memory, without attendant cortical modification and without the trigger even being recognized consciously (Siegel, 1999).

There is a *mirror neuron system*, located in the lower premotor and parietal cortices, that enables self-other *motor action matching*, accompanied by *matching of affect and cognitive intent*. The newborn “mirrors” the actions of a parent/caregiver with attunement to the emotional state of the partner and the developing infant gradually begins to recognize the intention of the partner. This matching capacity serves an important role in the development of social cognition and empathy and continues to be active through adulthood (Lepage, 2007).

The information captured by the amygdala is transferred to cortical areas from the hypothalamus, via the thalamus, to the *anterior cingulate gyrus* of the *hippocampus*, a horn shaped structure in the lower cortical area of the brain. All these structures have been referred to as the limbic system. Information is sent from the limbic system, via connecting fibers, to higher cortical areas, where there is integration and modification of experiential, implicit, and emotionally labeled memory. The cortex adds cognitive *emotional value* and *judgment*, converting implicit memory to *explicit memory*, which is then embedded in the cortex for further association and recall.

There are particular areas of the frontal cortex, which perform specialized functions. The *prefrontal cortex*, which lies just above the orbitofrontal cortex and directly behind the forehead, performs the special task of regulating attention, inhibiting impulses, and following rules in response to incoming experience. It is the director of *self-regulation*. The *orbitofrontal cortex*, located behind the eyes and below the prefrontal cortex, is the seat of *executive functioning*-higher level cognitive decision making. Decisions are made regarding what action should be taken in response to a stimulus, based on the cognitive assessment of its *risk and reward* value. These value assignments are used to adjust and correct emotional response, providing regulation of the body and directing motivation and regulation in social emotional behavior.

The emotional value and experiential information is transferred to both *right and left cortical hemispheres* so there is coherent coordination. These cortical hemispheres further integrate incoming experiential information. The *right hemisphere* is the nonlinear, holistic, nonverbal thinker and communicator and has social awareness. It is infused with intense emotion, and body sense. It holds images, themes and a sense of personal self, existing across time. The *left hemisphere* is concerned with more logical, cause/effect reasoning, verbal processing, and linear thinking, and strives to create logical meaning. It also assigns words to wordless feeling states and perceptions. All of these assessments and judgments are stored in the cortex as explicit memories, to be retrieved when they are relevant. Thus a growing cortical memory bank of valued experience has been created for use in problem solving and interpreting new information (Schore, 1994; Siegel, 1999).

A reciprocal circuit then transmits modulated experience back through the limbic system, to the autonomic nervous system, which supplies appropriate energy, excitatory (sympathetic) or inhibitory (parasympathetic), for responsive action. In other words, the limbic system acts as a 'grand central station' communicating with higher cortical neurons and attaching emotional and

rational value to experience. Response is thus modified and synchronized by cognitive judgment (Schore, 1994; Zero to Three, Jan. 2009).

Many of these areas of the brain take in information before birth as the baby begins learning in the womb. Experiments have shown that if a mother reads a story to baby while in the womb, the baby will preferentially attend to that story after birth rather than another story (Meltzof, 2008). Humans are a social species and the very survival of infants is based on protection, nurturance and emotional attachment of infant and caregiver. There are built-in reciprocal emotions and biological facilitators that bring together babies and their caregivers in human and in other animal species, even before birth, to foster this "womb" of continued support. Love and compassion are necessary for nurturance and protection and ultimately survival (Dalai Lama, 2008). Thriving of adults, including their ability to support the succeeding generation, continues to be influenced by their individual early experiences of being nurtured, protected, and attached.

Now let us turn to the development of empathy in the context of the development of social competency. Early brain development, with its expanding capability for learning and responsiveness from fetal to preschool age, in concert with the quality of a reciprocally responsive nurturing environment, provides the substrate for the development of successful social interaction. Successful social interaction depends on the development of social competency and social cognition. Social competency is a composite of emotional understanding, emotional regulation in relationship, and emotional expression. Empathy is the ability to place oneself in the mind of another, to experience what the other feels, then conveying that understanding to the other through emotional expression. The following table is a schematic condensation of the progression of the development of emotional expression and empathy from birth into early childhood.

*"Love and compassion are necessary for nurturance and protection and ultimately survival."*  
(Dalai Lama, 2008)

## Stages in the Development of Emotional Expression and Empathy (cumulative)

Age	Emotions expressed	Social referencing	Empathy	Brain
<b>Birth</b>	Distress, pleasure, interest, attention	Attunement	Attunement to caregiver	Amygdala
<b>3 mos.</b>	Joy, sadness disgust	Discriminate active facial expression in primary caregiver	Mirror emotion of primary caregiver	Mirror neurons
<b>4-6 mos.</b>	Anger, surprise, apprehension	Distinguish negative and positive emotions of primary caregiver	Averse to mismatch of face and voice	Hippocampus
<b>6-8 mos.</b>	Fearfulness	Distinguish negative and positive emotions of others	Uses gaze to share interest; learn to approach or avoid by cues	Orbitofrontal cortex, and prefrontal cortex
<b>9-12 mos</b>	Recognizes feelings of others	Read facial/vocal cues	Notice more subtle expressions of emotions of other	Right brain
<b>14-18 mos.</b>	Self/other distinction	Recognizes different feelings and intentions of others; points to share	Beginning to use words to identify feelings	Left brain
<b>18 mos. - 2 yrs.</b>	Can describe own internal states with words: "happy, sad mad, scared	First emotional words, feel the pain of another, comprehend others' intentions	Expresses empathy using words to label emotions of others	Integrated brain
<b>2-3 yrs.</b>	Use own words to meet own need and influence others	Obtain comfort, support, or attention to meet own needs	Influence other's emotions using language	Integrated brain
<b>&gt; 3 yrs.</b>	Answer questions about feelings; rich emotional language	Build corrections with others using emotional understanding	Processes social/emotional information from others and situations	Integrated brain

Adapted and compiled by Judith Ahrano Kittel, MD (2009) from : Henderson, Gerson, & Woodward (2008), Schore (1994), Thompson (2008), Warren, Denham, & Bassett (2008).

This is an amazingly complex and completely natural process. These aspects of emotional development have been investigated for decades and, with new testing paradigms and neuroimaging techniques, our understanding is continually being supported, refined, and enhanced, as is our awe at the natural process. The capacity for empathy is defined as the ability to experience and join with the feeling state of another and to offer comfort. Its expression is at the center of social interaction success. Healthy emotional development and social interaction success are established by the end of the preschool years and predict success in adaptive functioning throughout life for each child (Warren et al., 2008).

There are many situations and conditions, which can interfere with the development of empathy for self and other, as with any developmental process. Young children at risk are children who have experienced abuse and maltreatment, mental illness in caregivers, or chronic illness. Children who live in poverty are at risk, as are children with developmental challenges. Children with genetic predispositions to anxious, fearful, or shy temperaments are also at risk. However, research has shown that one consistent positive attachment relationship, even in the life of a child at risk, can influence that child's outcome in a positive way (Lieberman, 2008; Raikes & Thompson, 2006).

It is clear that young children have a sophisticated level of social understanding and capacity for empathy. This implies that we can raise our expectations for success of those with difficulties by making appropriate interventions. We have not dealt specifically with emotional regulation in relationship here, though it is an essential component of social competency. For infants, toddlers and young children, successful interventions with behavioral issues must include addressing children where they are, with knowledge of their needs, their individual levels of social understanding, their emotional development, and their ability to express themselves. This means, first, understanding their behavior, as language, tuning into their internal state, and then empathically teaching them how to replace their reactive behavior with verbal expression of emotion. In this way, they will learn to regulate their own intense feelings.

If parents and caregivers, supported by professionals, are empowered with this information and understanding, and can tune into the internal world of the child, joining the child empathically as the basis of intervention, the child will develop compassion for self and others. Very early intervention, for the fetus, infants, toddlers, their families, and caregivers—especially for those at risk—provides our greatest hope for preventing lifelong maladaptive social interaction patterns and increasing successful adaptive functioning.

Judith Ahrano Kittel, MD  
Developmental Behavioral Pediatrician  
President, UAIMH

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## Attachment and Autism

In the DSM-III (APA, 1980), the definition of autism was “Failure to develop normal attachment behavior”. In the DSM –III-R (APA, 1987) “Attachment of some autistic children is bizarre; no or abnormal seeking of comfort at times of distress.” Currently in the DSM –IV-R, the above ideas have been removed from the “Reactive Attachment Disorder of Infancy or Early Childhood” category, except as exclusion. I myself have wondered previously about the validity of autism causing attachment issues or vice versa

At this year’s excellent Bridging the Gap conference, Dr. David Oppenheim shared exciting new research on attachment and autism. Dr. Oppenheim’s study utilized the Standard Strange Situation Procedure, an A/B/C/D classification system (Mary Ainsworth, 1978) to evaluate response to separation and reunification of parent and child in a new training program for parents of children newly diagnosed with autism. The ADI and the ADOS (measures to identify autism) were both used to confirm the clinical diagnosis of autism. The subjects were a relatively large sample of males, including both high and low-functioning children. I was very impressed with the emphasis Dr. Oppenheim placed on the importance of confirming that the children in his study had autism. They had all been previously diagnosed with autism, yet for the validity of his research and his presentation of the validity of his research, Dr. Oppenheim wanted to confirm the diagnosis.

After identifying that each child in the study had autism, the Strange Situation was employed to identify “secure” or “insecure” attachments of the children to their caregivers. The results were phenomenal! 50 % of the children with autism/PDD had secure attachments. This rate is a bit lower than with “typically developing children” at 60%, yet still an incredible find. Dr. Oppenheim found that the children with a more strict diagnosis of autism were more insecurely attached and that the higher the child’s mental development, the more secure the child’s attachment was.

Another couple of pieces of this attachment/autism puzzle that Dr. Oppenheim looked at were (1) maternal

sensitivity to their children with autism and (2) their own insightfulness. It may be difficult for parents to hear that their perfect child, the love of their lives, the roots of their love, their prodigy, has autism. In the past, many parents (mothers in particular) were blamed for doing something wrong that damaged their child. Sadly, many mothers internalized this “fault.” This in itself may impact their child’s attachment style. If this fierce battle does not come to a resolution within the mother (parents), it may be difficult for the family to successfully function and attach to their child with autism. For secure attachment to form, a resolution to this heart breaking news needs to occur first. It is important to know that “Insecure attachment does not cause autism and a secure attachment does not cure autism” (Oppenheim, 2009).

*“In the past, many parents (mothers in particular) were blamed for doing something wrong that damaged their child.”*

This study was done well and was presented clearly. Yet as with all studies, this study did not go exactly as planned. A deviation from the standard Strange Situation to a modified Strange Situation was required to obtain safe and accurate data, and the A/B/C/D/ system was used only 2 times, and 1 time an A/B/C system (an older version of the Strange Situation) was used (Gottfried et al, 1998).

This study confirms earlier findings in a 1991 study by Sally Rogers, PhD, Sally Ozonoff, MA, and Christine Maslin-Cole, PhD from the University of Colorado and Colorado State University who conducted a matched control study of attachment behavior in children with autism and children with other developmental or psychiatric disorders, also using a modified Strange Situation. Their findings were that there were no differences in the security of attachment in young autistic children and young children with other psychiatric diagnoses, if all were on the same cognitive level. Within the groups, cognitive level seemed to mediate attachment security within the autistic group, but not in the group of children with psychiatric diagnoses. This

needs to be investigated further.

Continuing ongoing research in this area is needed to better define and address the specific difficulties posed for autistic children and to know how to support them and their parents in the development of secure attachments. I am a bit biased regarding attachment theory and the need for continued research. I believe that with research based early support for families with young autistic children, the percentage of secure attachments in relationships can be improved even further and I personally hope to take part in that work.

Thank you Dr. Oppenheim for your diligent passion and study of attachment. Thank you to the Children's Center for their always awesome Bridging the Gap conference! Thank you to the incredible UAIMH (Utah Association Infant Mental Health) board (of which I am honored to be a member) and our members. Come on in, join the fun!

*April A. Hewes, MSW, 2009*  
*University of Utah School of Social Work*

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## Journal Review

“Challenging Behavior,” *ZERO TO THREE*, January 2009, Volume 29, No.5 Journal of ZERO TO THREE: National Center for Infants, Toddlers and Families.

The theme of this edition of “ZERO TO THREE,” Challenging Behavior, is explored from different perspectives (systems to dyad) and provides neurodevelopmental, biological and dynamic understanding, assessment tools and interventions from research and clinical practice.

In her introduction, Stephanie Powers, Editor, stresses the need to address the complexity of challenging behaviors and presents the disturbing statistics of increasing preschool expulsions.

This edition provides solutions to what parents report as challenging behaviors. Rebecca Parlakian and Claire Lerner in “Facing the Challenge: What Mother's Have to Say About Their Young Children's Difficult Behaviors” present online survey data from mothers of children birth to 4 years. Challenging behaviors were defined and rated as: tantrums (29%) sleep problems (16%), power struggles (13%), eating (12%) and talking back (12%). Some of the challenging behaviors when child is playing with another child were sharing, hitting and mess making. Over 40% of parents requested information about eating/mealtime, controlling one's anger and setting limits and over 30% want bed/sleeping information.

Amy Hunter and Amy Louise Hemmeter, in their article “*The Center on the Social and Emotional Foundations for Early Learning: Addressing Challenging Behavior in Infants and Toddlers*,” present a framework of recommended practices to help ECE programs support social, emotion competence of young children, through a pyramid model for an effective workforce, practical leadership strategies and practical staff suggestions. Training modules and other resources for promoting social and emotional competence of infants and toddlers are provided (<http://www.vanderbilt.edu/csefel>).

In “*Meeting the Needs of the Youngest Infants in Child Care*,” the authors report phone survey data that childcare providers did not talk about the priority care needed for the 6 weeks to 4 months old. Neither does training stress this critical period. Most centers have too high of a ratio of infants to caregiver. Typically, workers are not allowed extended time with one baby, yet babies learn self-regulation through the relationship with the familiar, responsive adults, who provide immediate consistent care. Administrators and caregivers need education in critical period of 6 weeks to 4 months old.

In “*Stories From the Fussy Baby Network*” the authors describe how the core program was expanded to better meet the needs of the Latino community. The Erikson Fussy Baby Network (<http://www.FussyBabyNetwork.org>) provides phone call support (warmline), home visits and consultation with a developmental pediatrics to parents for support in caring for their crying baby. To better connect with the Latino families, a community-based program was developed in a local church. What started as an effective drop-in center to ask questions about a fussy baby, developed into nurturing, connected relationships within the context of a regular playgroup for parents and babies. Poignant stories of parents gaining confidence and babies feeling comfort were described.

Danis and Wakschlag, in their article “*In the Eye of the Beholder*,” introduce the Disruptive Behavior Diagnostic Observation Schedule (DB-DOS), a semi-structured diagnostic observation tool, to distinguish normative misbehavior from clinically significant disruptive behavior syndromes and disorders in children ages 3 to 5 years old. Two core facets of disruptive behavior are behavioral regulation and anger modulation. Modeled after the Autism Diagnostic Observation Scale (ADOS), the DB-DOS uses challenging tasks to elicit behaviors with different people and with the deliberate levels of support from the examiner to assess the child’s capacity to self-regulate.

Tarullo, Obradovic, and Gunnar, in “*Self-Control and the Developing Brain*,” describe the brain regions essential

for self-control development. Factors, which impact neurodevelopment, are discussed: home environment, negative parenting, temperament, culture, genetics, prenatal exposure to drugs and alcohol; sleep disruption, poverty and maltreatment. The authors purport that preschool curriculum can help the child develop self-control, a skill needed for social, academic, social and emotional success. *Tools of the Mind* curriculum is reported to improve cognitive control (Diamond, Thomas, & Munro) with online supplemental materials: ([www.sciendmag.org/cig/content/full/318/5855/1387/DC](http://www.sciendmag.org/cig/content/full/318/5855/1387/DC)).

Attention Skills Training Program (Rueda, Rothbart, et al.) helps to improve control of attention (free download at [www.teach-the-brain.org/learn/downloads/index.htm](http://www.teach-the-brain.org/learn/downloads/index.htm)).

In “*Solving Sleep Behavior Disorder in Infants and Toddlers*,” Mechthild Papousek, using both a developmental perspective and systematic transactional approach, links sleep problems to other regulation problems and provides diagnostic assessment criteria and clinical intervention steps.

The authors of “*Sensory Food Aversions in Infants and Toddlers*” present diagnostic criteria, describe the natural course of picky eaters (increases at 4 to 24 months) and provide treatment steps: parent reflection and behavioral steps with the infant/toddler.

Elizabeth Pulsifer-Anderson, in “*Helping Families Understand and Manage Pediatric Gastroesophageal Reflux*,” describes how early childhood professional can help families better cope with this medical problem effecting healthy children and over half of special needs children. Colic and reflux are delineated. Diagnostic and testing guidelines are discussed and Gerd treatments are reviewed. A three-step parent plan is suggested: to understand symptoms to track; to learn homecare techniques and to express ways support can be provided.

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## Mark Your Calendars UAIMH and other Activities

### *Children's Center Relocation*

The Children's Center is pleased to announce that the eastside center has now relocated to our newly renovated home at 350 South 400 East. With more than 40,000 square feet, The Children's Center will grow to serve 2,500 clients annually. This will be accomplished with the expansion of services such as the Therapeutic Preschool and individual and group therapy. In addition, The Children's Center is planning new programs to increase services for emergency trauma treatment, infant mental health, and children who have autism spectrum disorder. Recently, The Children's Center partnered with Easter Seals to provide Occupational Therapy. This new program will enhance our comprehensive mental health care services.

### *Easter Seals*

Easter Seals Northern Rocky Mountain also provides autism services to families along the Wasatch Front and South East Utah. Crystal Emery and Gayle Hill are P.L.A.Y. (Play and Language for Autistic Youngsters)

Consultants, providing parents with in-home training to help their children gain skills in communicating, relating, thinking and problem solving. Both Crystal and Gayle have a strong background in infant mental health. For information on Easter Seals NRM programs call Janet Wade: 801-633-2091

### *Critical Issues Conference*

“Save the date! October 13-14, 2009 plan to attend the “Critical Issues Facing Children and Adolescents” Conference in Salt Lake, which this year will offer an Early Childhood track for the entire first day. Ross A. Thompson, PhD, from UC Davis, author of “The Psychologist in the Baby” in the May 2008 issue, “The Developing Mind” of the Zero to Three Journal, will give the keynote address on the first day. Members of the Utah Association of Infant Mental Health will receive a discount on the cost of the conference. Don't wait to join the wonderful network of support of fellow professionals and parents by going to [www.uaimh.org](http://www.uaimh.org) and completing the brief information form for membership!”

**UAIMH Newsletter by Judith Ahrano-Kittel, April Hewes, Susan Dickinson, Janet Wade, Vonda Jump, Mary Ellen Heiner.**

<http://www.UAIMH.org>