How Infant Psychiatry Helped Me Know How to Promote Socio-Emotional Development and Resiliency and Know What to do When There’s a Problem
Objectives

- To define socio-emotional development
- To define the concept of resiliency
- To identify classic articles and concepts concerning aspects of infant psychiatry that have helped me to promote resiliency and socio-emotional development.
What are we talking about when we talk about socio-emotional development? The life-long process by which people become socially and emotionally competent and healthy.
What are we talking about when we talk about resiliency?
Definition of Resilience:

“Making lemonade out of lemons”

- A phenomenon or process reflecting relatively positive adaptation despite experiences of significant adversity or trauma. Resilience is a process that is influenced by experience and therefore, is subject to change – for better or worse.

Characteristics of resiliency:

- Personality/temperament of the child.
- Supportive family
- Supportive external milieu

Resilience process involves the interplay between:

a. Significant risk factors/adversity.
b. Positive adaptation defined as “an outcome substantially better than would be expected.”

What is the definition of risk factors?
Those things that increase a person’s likelihood of a maladaptive outcome.
The Unusual Suspects

- Difficult temperament
- Poor intelligence, learning disorders.
- Family disruption/dysfunction
- Divorce
- Caregiver psychopathology (example: maternal depression)

- Poverty and other socioeconomic woes
- Poor access to child care
- Poor quality of child care
- Racism
- Community and media violence
- Poor educational system
The List also Includes Stressors and Trauma
What Types of Stressors Are There?

- **Acute stressors**: implies sudden or rapid onset with a single severe peak of intensity.
- **Chronic stressors**: implies gradual onset, varying intensity levels, and long duration.

- **Note**: there are no clear boundaries between these two. Both can occur at the same time and interact with each other.

- **Traumatic events**: When the stressor overwhelms the child’s/person’s ability to deal with it.
• Not all stressors are traumatic.

• Some stressors can be good!

• All traumatic events are stressors

• Not all trauma is traumatic to everyone!

• **Note:** There is a clear sense that these stressors/traumatic events tend to co-occur and interact with each other in cumulative ways (when it rains, it pours!).
Garmezy and Rutter suggest five categories of stressors:

1. Loss
2. Chronically disturbed relationships
3. Events that change the family status quo.
4. Events that require social adaptation.
5. Acute traumatic events.

• **Note:** Issues of loss, anxiety, and adaptation predominate.
Pittman suggests four interrelated categories of crises:

- **Bolts from the Blue** – Sudden stressor that is “overt, unique, real, specific, and extrinsic.”

- **Developmental Crises** – Universal and expectable “permanent changes in status and function.” Examples:
  - Marriage
  - Birth of children
  - Children starting school
  - Puberty
  - Children leaving home
  - Parental aging and death

- **Structural crises** – Due to “intrinsic” foundational issues in the family, such as caregiver with mental/medical problems.

- **Caregiver Crises** – When members need caregiving and the availability is interrupted.
Pittman feels that crises evolve from core inflexibility or snag points. These are about:

- Communications
- Intimacy
- Roles
- Rules
- Family History
- Goals
- Values

Definition of Protective Factors?

These are conditions in persons, families, and communities that when present, increase the health and well-being of those involved.
The Usual Suspects

Protective factors would include:

- Intelligence
- Easy temperament
- “Good enough” parenting or good relationship with at least one adult.
- Secure attachment
- Social privilege/financial resources
- Good sibling relationships
- Good coping and social skills
- Good quality of child care
- Good quality of education system
- Job availability at fair wages
- Tolerance to diversity
- A society that values families & supports them in their tasks of raising children.
The Main Delivery System of These Protective Factors is Often Felt to be the “Good Enough” Parent

Attributes of a “Good Enough” Parent

1. Able to provide unconditional love and encouragement/reinforcement of the strengths and accomplishments of the child.
2. Makes time for and prioritizes the needs of their children.
3. Able to be emphatic and able to listen and communicate with the child at their developmental level. Has clear and consistent rules and gets key players “on the same page.”
4. Able to discipline consistently.
5. Is a good role model.
6. Gives and teaches responsibility at the appropriate developmental level of the child with goal of fostering independence, individuation, and autonomy. (Don’t argue with spouse or significant others in front of the child).
7. Provides structure and clear boundaries.
8. Able to care for their own needs.
9. Patience and good humor.
10. Treats children with respect due to all human beings.
11. Meets the basic material and safety needs of the child.
12. Changes parenting as the child develops and matures.
13. Teaches appropriate social skills.
Positive Psychology Movement
(AKA The Happiness Movement)
(AKA The Strengths-Based Movement)

- Martin Seligman, PhD
- Instead of focusing on deficits, let’s focus on strengths and virtues that enable people to thrive.
- Focus on:
  - Positive emotions
  - Positive individual traits
  - Positive healthy and health enhancing institutions.
It’s simple! Just accentuate the positives (protective factors, especially “good enough” parenting) and decrease the negatives (risk factors, stresses, and traumas)

This has harder to do in reality or is it?

- Resilient children are not super humans!
- “The most surprising conclusion emerging from studies of these children is the ordinariness of resilience.
- “The conclusion that resilience is made of ordinary rather than extraordinary processes offers a more positive outlook on human development and adaptation.”
- *Where There’s Life (and good rearing conditions), there’s Hope.* “The capacity for developmental recovery when normative rearing conditions are restored is amazing.”
Or Maybe It Isn’t So Simple

How many children have mental disorders?

The System of Halves:

- 20% have disorders that could use help
- 10% could really use help
- 5% could really, really, use help
- 2.5% could REALLY, REALLY, REALLY use help
Question:

Should we focus on the 20% of children with mental disorders that deserve treatment or the 80% who don’t?

Remember that we tend to only see those in the 20%. This may skew perceptions.
If we focus on the 80%, what would they look like?

- They would be competent problem solvers with social and emotional skills.
- They would be curious.
- They would have a push to master their world’s.

- They would have basic trust of others.
- They would be empathic.
- They would be able to communicate their needs, wishes, & emotions.
- They would be able to take pleasure in life.
- They would be able to cope with adversities & “bounce back,” (i.e., resilient).
Note that resilient teens:

- Are reflective and can look inward.
- Have a sense of agency – sense that what they do makes a difference.
  - Similar to Martin Seligman’s concept of Internal Locus of Control.
- Are caring about relationships.
- Have more coherent, integrated complex stories to tell about their lives.
- Take responsibility
- Have learned to handle their affects.
The Kauai Study (Werner and Smith)

Attributes of Resilient Children (at ages 10 & 18 years)

- Better parenting (someone who acted in that role).
- Were more appealing.
- Had better cognitive test scores.
- More positive self-perceptions.
- Greater consciousness.
If we focus on the 20%, which is our jobs, then “apple pie” and motherhood is not enough. What can we do?

What skills and knowledge have I picked up over the years that help me know how to optimize socio-emotional development in the 20% of people who seek my help?
I learned the basics from:

- George Engel’s Biopsychosocial Model
- Infant Psychiatry
George Engel’s Biopsychosocial Model:

- Based on system’s theory.
- Refers to belief that people are best understood when viewed as important, interacting parts of a larger family system that is, in turn, part of still larger social systems, such as peer groups, religions groups, organizations, and cultures.
- Each part of the system is important in its own right and can be studied.
- Each part has its own disciplines that focus on it.
- All parts transact (interactions over time) continually.

Biosphere
Society – Nation
Culture-Subculture
Community
Family
Two –Person

Person
(experience and behavior)

Nervous System
Organs/Organs Systems
Tissues
Cells
Organelles
Molecules
Atoms
Subatomic Particles
Engel proposes that all development (including socio-emotional development) and problems are best understood by looking at the transactions (interactions over time) of biological, psychological, and social phenomena.
Defined as:

- **Biological:** Search for biological and organic correlates of the suspected problem. As what constitutional strengths and weaknesses the child has.

- Consider things such as genetic endowment, predisposition to mental illness, temperament, ability to attach and make relationships, perceptual skills.

- **Psychological:** What and how the child thinks about events. What story do they tell themselves and others? How do they cope? What are their defenses?

- **Social:** The strengths and weaknesses in the caretaking environment, including cultural, societal, and national values.

- Things that stress the caretakers, such as marital problems, mental and medical illness, loss of employment, death of spouse or significant others, and poverty affect their ability to care for the child.
Note that all the risk and protective factors can nicely be attributed to one or more of Engel’s levels and that they interact/transact over time.

**Remember:** Increase the positive and decrease the negatives!
Many people prefer Urie Bronfenbrenner’s ecological system’s theory which poses 4 systems:

- **Microsystems:** Immediate environments (family, school, peer group, neighborhood, & child care environments).

- **Mesosystem:** A system comprising connections between immediate environments (i.e., a child’s home & school).

- **Exosystem:** External environmental settings which only indirectly affect development (such as parent’s workplace).

- ** Macrosystem:** The larger cultural context (Eastern vs. Western culture, national economy, political culture, subculture).

The newest trend is to speak of GXE. This is the transaction (X) between genetics (G=biology in Engel’s theory) and environment (E=psychosocial in Engel’s theory).

These are, in turn, all versions of the old nature-nurture theory.

Whatever models you choose, the goal is to be systemic!

This level of complexity is needed for the work we do!
More Arrows in the Quiver

Being systemic allows for more sophisticated formulations that yield better interventions, multifaceted plans whether you wish to intervene before a problem occurs (Prevention) or after it occurs.
Infant Work: Systemic to its Core

“There is no such thing as an infant.” Donald Winnicott

Why? Because you can’t think of an infant without immediately thinking of a caregiver.

Rene Spitz:

- Did early work on orphans who died in orphanages even though they had good hygienic conditions & nutrition. It takes more than that!

- Did early work showing the responses of infants to the death of their caregiver.

References:


John Bowlby – British Analyst

- Did work after WWII showing the importance of care giving.
- Influenced by ethnology. He postulated that infants are “hard wired” for attachment to caregivers. This highlights what the infant brings to the relationship and led to modern attachment theory.

References:
What is Attachment Theory?

Attachment theory is a psychological, evolutionary, and ethnological theory concerning relationships between humans; an emotional bond between two or more individuals. The most important tenet of attachment theory is that a young child needs to develop a relationship with at least one primary caregiver for social and emotional development to occur normally, or without this care, the child will often face permanent psychological and social impairment.
Characteristics of Attachment

• **Safe Haven:** When the child feels threatened or afraid, he or she can return to the caregiver for comfort and soothing.

• **Secure Base:** The caregiver provides a secure and dependable base for the child to explore the world.

• **Proximity Maintenance:** The child strives to stay near the caregiver, thus keeping the child safe.

• **Separation Distress:** When separated from the caregiver, the child will become upset and distressed.
Selma Fraiberg – Social worker/analyst

Did some of the earliest clinical work with infants and their mothers. Termed “psychotherapy in the kitchen,” as her “team” worked in the homes of their clients. Fraiberg’s team provided psychoeducation, crisis management, case management, and psychodynamic therapy.

Focus on “Ghosts in the Nursery” (issues from the past that haunt mother’s ability to parent).

► Note links to family of origin work (Bowen), genograms, and multigenerational work.
Did some of the earliest research on the efficacy of infant therapy showing that if the caregiver is helped, that it generalizes to other sibs.

Asked question of whether “depressed mothers” can improve their parenting even while still depressed.

**Reference:**

Richard Bell

Put forth research showing that the problems of infants are not just due to the linear impact of caregivers on the infant, that the infant's behaviors impacts the parents (it is a transaction!)

Reference:
Sameroff & Chandler

Showed that the prognosis of development in disabled infants cannot be predicted by the extent of the pathology alone. Predictions of outcome need to include the quality of the caregiving environment.

They popularized the “transactional model.”

Reference:
The Emergence of the Amazing Newborn/Infant
Barry Brazelton & Bertrand Cramer

- Popularized, along with many others, the abilities of infants; that they are not born “blind, deaf, and dumb” as was once thought.

- Heidi Al’s and Ed Tronick’s work on microanalysis of mother-infant transactions, especially enlightening.

- Infants are not lumps of clay to be molded by their caregivers, but more like seeds that flourish in the right nurturing environments.
References:

The Earliest Relationship. Reading, MA: Addison-Wesley Publishing, 1990. Brazelton’s Touchpoints Center is a wonderful resource for developmental sensitive parenting information. touchpoints@childrens.harvard.edu

► Another such resource is from Zero to Three, which informs, trains, & supports professionals, policy makers, and parents in their efforts to improve the lives of infants and toddlers.

► www.zerotothree.org

► Infant Mental Health Journal (Wiley Publishers)
Mary Ainsworth

Worked at the Tavistock Clinic as did Bowlby.

Attempted to do research on parenting across cultures. To do so, she created and researched “The Strange Paradigm,” a set protocol of steps to test the relationship of infants and their caregivers.

Involve videotaping varying sequences with infants playing in a observation room while caregivers and strangers enter and leave.
The Protocol

1. Parent and infant are introduced to the experimental room.
2. Parent and infant are alone. Parent does not participate while infant explores.
3. Stranger enters, converses with parent, then approaches infant. Parent leaves inconspicuously.
4. First separation episode: Stranger’s behavior is geared to that of infant.
5. First reunion episode: Parent greets and comforts infant, then leaves again.
6. Second separation episode: Infant is alone.
7. Continuation of second separation episode: Stranger enters and gears behavior to that of the infant.
8. Second reunion episode: Parent enters, greets infant, and picks up infant; stranger leaves inconspicuously.

From: Wikipedia (Mary Ainsworth)
Four aspects of the child’s behavior are observed:

1. The amount of exploration (e.g., playing with new toys) the child engages in throughout.
2. The child’s reaction to the departure of its caregiver.
3. The infant’s anxiety when alone with the stranger.
4. The child’s reunion behaviors with its caregiver.

From: Wikipedia (Mary Ainsworth)
From observations, Ainsworth and colleagues hypothesized 2 main categories of behaviors/attachments:

- secure
- insecure

They hypothesize 3 sub-categories of insecure attachment.

- Anxious – resistant insecure attachment
- Anxious – avoidance insecure attachment
- Disorganized/disoriented attachment.

The researchers hypothesize that the secure attachment is the foundation of healthy, adaptive socio-emotional development and resiliency.

They hypothesize that insecure attachments put infants “at risk” for problems with their socio-emotional development and non-resiliency.
Mary Main – Ainsworth’s Colleague

Created the Adult Attachment Interview (AAI) which studied caregiver's recollections of their own upbringings/attachments to see if they correlated with their infant’s attachment category.

Caregivers who could see their own parents in a realistic, objective light tended to have infants with secure attachments. Those that had overly subjective views of their past (denial of problems, over-idealization of parents, ongoing overtly conflict with parents), tended to have infants with insecure attachment.
Note: this researches the concept of the “Ghosts in the Nursery” of Fraiberg.

The Importance of Affects/Emotions

- Research and theorizing on the importance of affects in development including the concept of emotions as a communication within systems.

Ongoing Research on the Wider “Context”

If mother’s are important, then so are father’s and siblings.

The importance of alternate/complementary/supplemental care giving systems.

- Grandparents
- Relatives
- Daycare
- NICU/hospitals

Back to Engel’s system’s model
The Importance of Families

If Mother’s, Father’s, and sibs are all important, then surely there is value in studying how they interact with one another, hence, family therapy/systems theories and therapies.

A Main Question:

How do families impact development?
References:

Patricia Minuchin; “Families and Individual Development:” Provocations From the Field of Family Therapy.”


References: (cont.)


As an infant psychiatrist, I deal with problems in the infant-caregiver system.

- My goal is to assist caregiver-infant systems to better create environments that will enhance the socio-emotional development of all members of the system.

- To assist, one must have a sense of what is “good enough parenting” and normal development in infants.
I was greatly influenced in my clinical work by Nadia Bruschweiler-Stern and Daniel Stern’s article:

The Model Consists of Four Transacting Elements

- Infant’s overt interactive behavior (BI).
- Mother’s overt interactive behavior (BM).
- Infant’s representation of the interaction (RI).
- Mother’s representation of the interaction (RM).
The infant’s overt behavior together with the mother’s overt behavior constitute the interaction.

BI + BM = The interactions
Together these four transacting elements constitute the relationship
THE RELATIONSHIP

Subjective Experience of Interaction as Represented by the Infant | Objectifiable Interactive Behavior | Subjective Experience of Interaction as Represented by the Mother

R_I ←→ [B_I ↔ B_M] ←→ R_M
Source of Clinical Information (S)

Locus of Therapeutic Action (A)
Different Therapeutic and Theoretical Approaches Focus on Different Elements of the Relationship
The Psychoanalytic Approach Viewed Schematically.
The Interactional Coaching Approach Viewed Schematically.
The Family Therapy Approach Viewed Schematically.
These concepts learned from Engel, infant mental health people, and family/systems therapists, have served as the foundation for how I conceive all work with infants, children, adolescents, and adults.
A good therapist, mental health worker, or case manager needs to be a developmentally skilled biopsychosocial expert who can be a “good parent” via supporting parents and the systems they are embedded in to facilitate the development of their children and themselves.
If successful, what would the good enough therapist look like:

• They would be competent problem solvers with social and emotional skills.
• They would be curious.
• They would have a push to master their worlds.
• They would have basic trust of others.
• They would be emphatic.
• They would be able to communicate their needs, wishes, and emotions.
• They would be able to take pleasure in life.
• They would be able to cope with adversities (stresses and trauma) and “bounce back.”

Note: *this should sound familiar.*
The basics of socio-emotional development and resiliency are the same regardless of age.
Attachments
<table>
<thead>
<tr>
<th></th>
<th>Social</th>
<th>Self-Help</th>
<th>Gross motor</th>
<th>Fine motor</th>
<th>Language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>Responds positively to feeding &amp; comforting</td>
<td>Alert, interested in sights &amp; sounds</td>
<td>Kicks legs &amp; thrashes arms</td>
<td>Looks at objects or faces</td>
<td>Cries</td>
</tr>
<tr>
<td>1 mo.</td>
<td>Social smile</td>
<td>Responds to voices; turns head towards a voice</td>
<td>Raises head &amp; chest when lying on stomach</td>
<td>Follows moving objects with eyes</td>
<td>Cries in a special way when hungry</td>
</tr>
<tr>
<td>2 mo.</td>
<td>Recognizes mother</td>
<td>Reacts to sight of bottle or breast</td>
<td>Holds head steady when held sitting</td>
<td>Holds objects put in hand</td>
<td>Makes sounds – ah, eh, ugh - laughs</td>
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<tr>
<td>3 mo.</td>
<td>Recognizes most familiar adults</td>
<td>Increases activity when shown toy</td>
<td>Makes crawling movements</td>
<td>Shakes rattle</td>
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<td>4 mo.</td>
<td>Interested in his/her image in mirror, smiles, playful</td>
<td>Reaches for objects</td>
<td>Turns around when lying on stomach</td>
<td>Puts toys or other objects in mouth</td>
<td>Squeals - Ah-goo</td>
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<tr>
<td>5 mo.</td>
<td>Reacts differently to strangers</td>
<td>Rolls over from stomach to back</td>
<td>Picks up objects with one hand</td>
<td>Makes razzing sounds – gives you the “raspberry”</td>
<td></td>
</tr>
<tr>
<td>Age</td>
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<tr>
<td>6 mo.</td>
<td>Reaches for familiar persons</td>
<td>Looks for object after it disappears from sight. For example, looks for top after it falls off tray</td>
<td>Rolls over from back to stomach</td>
<td>Transfers objects from one hand to the other</td>
<td>Babbles</td>
</tr>
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<td>7 mo.</td>
<td>Gets upset &amp; afraid if left alone</td>
<td>Anticipates being lifted by raising arms</td>
<td>Sits without support</td>
<td>Holds two objects, one in each hand at the same time</td>
<td>Responds to his/ he name, turns &amp; looks. Makes sounds like da, ba, ga, ja, ma</td>
</tr>
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<tr>
<td>8 mo.</td>
<td>Plays “peek-a-boo”</td>
<td>Feeds self cracker or cookie</td>
<td>Crawls on knees</td>
<td>Uses forefinger to poke, push, or roll small objects</td>
<td>Makes sounds like ma-ma, da-da, ba-ba</td>
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<tr>
<td>9 mo.</td>
<td>Resists having a toy taken away</td>
<td></td>
<td>Pulls self to standing position</td>
<td>Picks up small objects using only finger and thumb</td>
<td>Imitates speech sounds that you make</td>
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<tr>
<td>10 mo.</td>
<td>Plays “patty-cake”</td>
<td></td>
<td>Sidesteps around playpen or furniture while holding on, or walks</td>
<td>Picks up two small objects in one hand.</td>
<td>Understands single words like bye-bye &amp; nite-nite</td>
</tr>
<tr>
<td>Age</td>
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<td>11 mo.</td>
<td>Shows or offers toy to adult</td>
<td>Picks up spoon by handle</td>
<td>Stands alone well</td>
<td>Puts small objects in cup or other container</td>
<td>Uses mama or dada specifically for parent</td>
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<tr>
<td>12 mo.</td>
<td>Imitates simple acts such as hugging or loving a doll</td>
<td>Removes socks</td>
<td>Climbs on chairs or other furniture</td>
<td>Turns pages of books a few at a time</td>
<td>Says one word clearly</td>
</tr>
<tr>
<td>13 mo.</td>
<td>Plays with other children</td>
<td>Lifts cup to mouth &amp; drinks</td>
<td>Walks without help</td>
<td>Builds tower of 2 or more blocks</td>
<td>Shakes head to express “no.” Hands object to you when asked</td>
</tr>
<tr>
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<td>14 mo.</td>
<td>Gives kisses</td>
<td>Insists on feeding self</td>
<td>Stoops &amp; recovers</td>
<td>Marks with pencil or crayon</td>
<td>Asks for food or drink with sounds or words</td>
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<tr>
<td>15 mo.</td>
<td>Greets people with “hi” or similar</td>
<td>Feeds self with a spoon</td>
<td>Runs</td>
<td>Scribbles with pencil or crayon</td>
<td>Says 2 words besides mama or dada. Makes sounds in sequences that sound like sentences</td>
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<td>18 mo.</td>
<td>Sometimes says “no” when interfered with</td>
<td>Eats with a fork</td>
<td>Kicks a ball. Good balance &amp; coordination</td>
<td>Builds tower of 4 or more blocks</td>
<td>Uses 5 or more words as names of things</td>
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<tr>
<td>21 mo.</td>
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<td></td>
<td>Follows a few simple instructions</td>
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By 3 Months: Regulation and Interest in the World

**Developmental Goals**

- Can be calm.
- Recovers from crying with comforting.
- Is able to be alert.
- Looks at one when talking to.
- Brightens up to appropriate experiences.

**Clinical Observations**

Shows an interest in the world by looking at (brightening) or listening to (turning toward) sounds. Can attend to a visual or auditory stimulus for 3 or more seconds.

Can remain calm and focused for 2 or more minutes at a time, as evidenced by looking around, sucking, cooperating in cuddling, or other age-appropriate activities.
By 5 Months: Forming Relationships (Attachments)

**Developmental Goals**
- Shows positive loving affect toward primary caregiver (and other key caregivers).
- Shows full range of emotions.

**Clinical Observations**
- Responds to social overtures with an emotional response of pleasure (e.g., smile, joyful vocalizations).
- Can display negative affect (e.g., frown, negative vocalizations, angry arm and leg movements).

By 9 Months: Intentional Two-Way Communication

**Developmental Goals**
- Interacts in a purposeful (i.e., intentional, reciprocal, cause-and-effect) manner.
- Initiates signals and responds purposefully to another person’s signals.
**Clinical Observations**

Responds to caregiver’s gestures with intentional gestures of his/her own (e.g., when caregiver reaches out to puck up infant, infant may reach up with own arms; a flirtatious caregiver vocalization may beget a playful look and a series of vocalizations).

Initiates intentional iterations (e.g., spontaneously reaches for caregiver’s nose, hair, or mouth; uses hand movements to indicate wish for a certain toy or to be picked up).

**By 13 Months: Developing a Complex Sense of Self**

**Developmental Goals**

Sequences a number of gestures together and responds consistently to caregiver’s gestures, thereby forming chains of interaction (i.e., opens and closes a number of sequential circles of communication).

Manifests a wide range of organized, socially meaningful behaviors and feelings dealing with warmth, pleasure, assertion, exploration, protests, and anger.
Clinical Observations

Strings together three or more circles of communication (interactions as part of a complex pattern of communication. Each unit or circle of communication begins with an infant behavior and ends with the infant’s building on and responding to the caregiver response. For example, an infant looks and reaches for a toy (opening a circle of communication); caregiver points to the toy, gestures, and vocalizes, “this one?”; infant nods, makes a purposeful sound, and reaches further for toy (closing a circle of communication). As the infant explores the toy and exchanges vocalizations, motor gestures, or facial expressions with the caregiver, additional circles of communication are opened and closed.

By 18 Months: Increasingly Complex Sense of Self

Developmental Goals

Comprehends, communicates, and elaborates sequences of interaction that convey basic emotional themes.
Clinical Observations

Has the ability, with a responsive caregiver, to open and close 10 or more consecutive circles of communication (e.g., taking caregiver’s hand and walking towards refrigerator, vocalizing, pointing, responding to caregiver's questioning gestures with more vocalizing and pointing; finally getting caregiver to refrigerator, getting caregiver to open door, and pointing to the desired food).

Imitates another person’s behavior and then uses this newly learned behavior to convey an emotional theme (e.g., putting on daddy’s hat and walking around the house with a big smile, clearly waiting for an admiring laugh).

By 24 Months: Representational Capacity of Emotional Ideas

Developmental Goals

Creates mental representations of feelings and ideas that can be expressed symbolically (e.g., pretend play and words).
Clinical Observations

Can construct, in collaboration with caregiver, simple pretend play patterns of at least one “idea” (e.g., dolls hugging or feeding the doll).

Can use words of other symbolic means (e.g., selecting a series of pictures, creating a sequence of motor gestures) to communicate a need, wish, intention, or feeling (e.g., “want that”; “me toy”; “hungry!”; “mad!”).

By 30 Months: Greater Representational Elaboration of Emotional Themes

Developmental Goals

Can elaborate a number of ideas in both make-believe play and symbolic communication that go beyond basic needs (e.g., “want juice”) and deal with more complex intentions, wishes, or feelings (e.g., themes of closeness or dependency, separation, exploration, assertiveness, anger, self-pride, or showing off).

Creates pretend dramas with two or more ideas (e.g., dolls hug and then have a tea party).

Uses symbolic communication (e.g., words, pictures, motor patterns) to convey two or more ideas at a time in terms of complex intentions, wishes, or feelings. Ideas need not be logically connected to one another.
By 36 Months: Emotional Thinking

Developmental Goals

Can communicate ideas dealing with complex intentions, wishes, and feelings in pretend play or other types of symbolic communication that are logically tied to one another.

Distinguishes what is real from unreal and switches back and forth between fantasy and reality with little difficulty.

Clinical Observations

In pretend play, involves two or more ideas that are logically tied to one another but not necessarily realistic (e.g., “the car is visiting the moon: (and gets there) “by flying fast”). In addition, the child can build on an adult’s pretend play idea (i.e., close a circle of communication). For example, the child is “cooking a soup” and then adult asks what is in it. The child says “rocks and dirt” or “ants and spiders.”

Engages in symbolic communication that involves two or more ideas that are logically connected and grounded in reality: “No, go to sleep... want to watch television.” “Why?” asks the adult. “Because not tired.” Child can close symbolic circles of communication (e.g., child says “Want to go outside.” Adult asks “What will you do?” child replies “Play”).
By 42-46 Months: Emotional Thinking

Developmental Goals

Is capable of elaborate, complex pretend play and symbolic communication dealing with complex intentions, wishes, or feelings.

Clinical Observations

Engages in “how,” “why,” or “when” elaborations, which give depth to play and communication. (Child sets up castle with an evil queen who captured the princess. “Why did she capture the princess?” “Because the princess was more beautiful.” “When did she capture her?” “Yesterday.” How will the princess get out?” “You ask too many questions”).

Deals with casualty in a reality-based dialogue. (“Why did you hit your brother?” “Because he took my toy.” “Any other reason?” “He took my cookie.”).

Distinguishes reality from fantasy. “That’s only pretend,” “That’s a dream. It’s not real.”).
Uses concepts of time and space. (Caregiver: “Where should we look for the toy you can’t find.” Child: “Let’s look in my room. I was playing with it there.” Caregiver: “When do you want the cookies?” Child: “Now.” Caregiver: “Not now, maybe in 5 minutes.” Child: “No, Want it now!” Caregiver: “You can have the cookie in 1, 2 or 5 minutes.” Child: “Ok. One minute.”).

Bibliography


