Warning Signs for Possible Behavioral Problems in Infants & Toddlers

Guidelines for Mental Health Professionals

Richard J. Pines, D.O.

Saint Alphonsus Behavioral Health Services

Risk Factors Common to Many Mental Disorders I

The interaction of risk and protective factors is very complex and varies from one individual to another.

Risk Factors Common to Many Mental Disorders II

Biological Factors

- Genetic vulnerability due to family history of mental disorders.
- Difficult inherent temperament.
- Prematurity/Low birth weight.
- Chronic physical illness.
- Neurological deficits.
- Uneven intelligence.
- Early language delays/Learning disabilities.
- Male gender.
- Substance abuse.

Nine Inherited Personality Traits

1. Activity Level
2. Regularity
3. Approach or Withdrawal
4. Adaptability
5. Sensory Threshold
6. Mood
7. Intensity
8. Distractibility
9. Persistence

Risk Factors Common to Many Mental Disorders III

Psychological Factors

- Experiencing severe marital discord.
- Physical or sexual abuse.
- Poor family relations and dysfunctional communication.
- Parental mental disorder.
- Experiencing change in circumstances, support status, health, or self-image.
- Experiencing severely traumatic life experiences.

Risk Factors Common to Many Mental Disorders IV

Socioeconomic Factors

- Poverty
- Overcrowding or large family size
- Poor school environment

Risk Factors Common to Many Mental Disorders V

Protective Factors I

- Genetic inheritance with no family history of mental disorder.
- Good health and health care, including prenatal.
- Positive temperament/Sense of humor.
- Above average intelligence.
- Social competence/Ability to get along with others.
- Smaller family size.
- Close relationship with a parent who is responsive and accepting.
- Supportive parents.

Risk Factors Common to Many Mental Disorders VI

Protective Factors II

- Good sibling relationships.
- Adequate rule setting by parents/Constructive discipline.
- Good relationships with peers and adults outside the family.
- Opportunities to function in a variety of settings.
- Sense of being in control of one's life.
- High sense of personal competence and self-esteem.
- Good schools.
- Avoidance of substance use/abuse.

A Child's Stages of Development

Ages 0-1

Developmental Goal:

To Develop Autonomy.

- Independence
- Language
- Ability to explore
- Self Control

A Child's Stages of Development

Ages 0-1

Potential Problem Areas:

- Parental immaturity.
- Chaotic home environment.
- Developmentally delayed baby.
- Baby with difficult temperament.
- Failure to develop basic trust.

A Child's Stages of Development

Ages 0-1

"Normal" Difficult Behavior:

- Child cries in rage until needs are met.

Cries For Help:

- Excessive crying.
- Sleep disturbance.
- Feeding disorders.
- Extreme stranger anxiety.
- Won't cuddle.
- No eye contact.
- No smiling.
- Muscular rigidity.

A Child's Stages of Development
Ages 1-3

Developmental Goal:

To develop basic trust.

- Trust that adults will meet basic needs.
- Trust own body as muscular coordination develops.

A Child's Stages of Development

Ages 1-3

Potential Problem Areas:

- Previous developmental goal not met.
- Stress on family system.
- Changes in environment.
- Child is unable to explore his or her environment due to a physical or mental handicap or too rigid restraint.
- Stressful, chaotic, dangerous, hostile, or abusive environment.
- Child is emotionally neglected and not spoken to.
- Child has a neurological impairment preventing his learning from environment & developing self control.
- Child is not taught to respect limits.

A Child's Stages of Development
Ages 1-3

"Normal" Difficult Behavior:

- Constant exploration involving running, climbing, and getting into things.
- Negativity (Every response is, "No!")
- Clinging to pacifier and/or blanket.
- Thumb sucking.
- Hitting or biting to get attention.
- Curiosity about his own body parts and sexual differences; masturbation.
- Regressing to infantile behavior occasionally.

A Child's Stages of Development
Ages 1-3

Cries for Help:

- Significant sleeping problems, (e.g., night terrors.)
- Eating problems.
- Failure of language development.
- Continual thumb sucking.
- Inability to separate from mother without extreme anxiety.
- Severe temper tantrums.
- Inability to toilet train.

Growth, Weight, and Eating I

- The child is not gaining weight or is stationary (e.g., failure to thrive or growth faltering).
- The child is not growing in stature (growth stunting).

Growth, Weight, and Eating II

- The child shows no maturation in ability to feed, (e.g., eats only liquid food in second year of life.)
- The child looks malnourished, too thin. May have no interest in food.

Growth, Weight, and Eating III

- The caretaker notes the child is not interested in food, has no appetite, or it is hard to feed him or her.

- The child is too picky, a finicky eater, or has excessive selectivity. Food refusal or frequent vomiting.

Irritability and Crying I

- The child is “colicky” after 3 months of life.
- The child cries more than 3 hours in a 24 hour period.
- The child is fussy most of the time.
- The child is constantly irritable and restless.

Irritability and Crying II

- It is hard to soothe the child.
- Once the child starts crying he or she is hard to calm.
- The child has very little patience.

Relatedness and Communication

- The child appears unfocused.
- The child is unresponsive/not connected with those around him or her or is not responsive to them.
- No eye contact. No smile.

Anxiety or Trauma

- History of major traumatic event, (e.g., domestic violence.)
- The child appears hypervigilant, anxious, excessively worried, or “frozen” at times.
- The child is shaky, tremulous, or easily disorganized.

Mood

- The child appears somber and worried.
- The child appears sad and unenergetic.
- The child exhibits very little joy.

Sleeping

- The child wakes up many times during the night after 6 months of age.
- The child has much difficulty settling at bed time.
- Parasomnias, night terrors, or somnambulism may be exhibited by the child.

Language

- No cooing or attempts to mimic words or phrases.
- After one year, no pointing and/or appropriate use of body language.
- Difficulty in scanning faces.
- No words with communicational intent.

Child: Hypersensitive I

- The child appears hypertonic, rigid, tense.
- The child is too sensitive to noises, being touched, or does not like being held.

Child: Hypersensitive II

- The child is sensitive or uncomfortable in certain body positions.
- The child becomes disorganized during feedings and many other activities.
- The child is unfocused or constantly restless.

Maternal Depression

- Mother looks sad and/or exceedingly tired.
- Mother feels no joy regarding the child.
- Mother states feeling blue, exhausted all the time, or overwhelmed.
- Little partner support for mother.

Parent-Child Relationship

Angry

- Negative statements about the child.
- Malignant attributions of intent toward the child.
- Handles the child in a rough way.
- Loses patience with the child, talks angrily, or without empathy.

Parent-Child Relationship

Underinvolved I

- Poor hygiene in the child.
- No pride in dressing or grooming the child.
- Comes to appointment without any toy or object to entertain the child.
- Comes to appointment without diaper, bottle, or snack.

Parent-Child Relationship

Underinvolved II

- Consistently disregards messages from the child (e.g., crying, vocalizations, signals of distress.)
- Is not attentive toward the child. Does not notice behaviors.
- Forgets the child's feeding, change of diaper, etc.

Parent-Child Relationship

Controlling

- Parent focused mostly on own needs.
- Child has to follow parent's schedule, perceptions, and needs.
- Little empathy toward child's challenges or needs.

Parent-Child Relationship

Poor Fit

- Parent consistently misreads child.
- Parent talks loudly and is too animated with a very sensitive child.
- Parent is too quiet and soft with an undersensitive child.
- Little intimacy and mutual joy.

High Stress in Caretaking

Environment

- Violence in home or environment.
- Few boundaries in home.
- Drug use in the home (cocaine, alcohol, etc.)
- Problems with housing and/or access to health care, mental disorder in family.
- Parent has difficulty in his or her job.

Parental Mental Health I

Increased Aggression in Children:

- Maternal alcohol abuse.
- High frequency of maternal depressive episodes.

Increased Incidence of Conduct Disorder in Children:

- Paternal alcohol abuse.
- Low socio-economic status.

Parental Mental Health II

Children of Alcoholics:

- Increased truancy.
- Increased contacts with police.
- Increased substance abuse.
- Increased school drop-outs.

Parental Mental Health III

Protective Factors in Parental Mental Disorders:

- Having good interpersonal relationships outside of family.
- Having a strong sense of self.
- Having a clear understanding of parent's mental illness.
- Children caring for younger siblings often develop enhanced problem-solving skills and greater adaptability.

Community Nurturing of "At-Risk" Youth I

Children Need:

- A healthy biological inheritance.

Communities Can:

- Educate potential parents about the importance of both parents being in good health at the time of conception.

Community Nurturing of "At-Risk" Youth II

Communities Can (cont.):

- Ensure accessible and affordable prenatal care.
- Educate potential parents that genetic inheritance causes a vulnerability to many physical and mental/neurological disorders.
- Ensure access to adequate medical care during the birth itself.

Community Nurturing of "At-Risk" Youth III

Children Need:

Capable caregivers to provide for physical & emotional well-being.

Communities Can:

Provide education for parents and potential parents regarding children's developmental needs and stages.

Community Nurturing of "At-Risk" Youth IV

Communities Can (cont.):

- Identify parents at high risk for abusive behavior (ideally before the birth).
- Provide education, empathy, and support for high risk parents before an episode of abuse occurs.
- Recognize the importance of a child's having a consistent, nurturing caretaker with whom he or she can form a deep, long-term, secure attachment.

Community Nurturing of "At-Risk" Youth V

Children Need:

- Understanding

Communities Can:

- Increase community understanding of mental/neurological disorders.

- Identify children with mental/neurological disorders.

Community Nurturing of "At-Risk" Youth VI

Children Need:

- Community role models and mentors

Communities Can:

- Interact with youth while modeling positive values and behavior.
- Volunteer time to serve as mentors one-on-one with specific youth.
- Look out for children in the community and accept a nurturing role in caring for them.
- Avoid applying quick labels to difficult youth.