

Web-Based Radio Show

Healing Relationships

Applying the DIR/Floortime Approach to an Array of Infant Mental Health Challenges

Stanley I. Greenspan, M.D.


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Welcome. Today's topic is going to be how we apply the DIR/Floortime model to infant mental health challenges, both in providing positive mental health and also in helping infants, children, and families where there are a wide range of challenges. For the most part, we've talked in the past about children with biological challenges where there are marked to severe challenges in language, social interaction, motor planning and sequencing, and sensory modulation; and where this derails from the basic ability to attend and engage with others and interact with others and communicate and develop language and develop logical thinking abilities. We've demonstrated how – at least for many children – we can help them get back on a road towards healthy development by starting at the beginning and building those healthy foundations and healthy building blocks.

The same principles apply to the broad array of mental health challenges. We often talk about three groups of challenges. The first group is where the main challenges come from the environment – the nervous system, from a biological perspective is functioning well at birth, but then various environmental challenges derail development because it doesn't provide what we might call the "experiential nutrients," in other words, those emotional and social and intellectual experiences that are the types of interactions that the baby and young child require.

We've also talked about regulatory problems, where there are differences in the way the nervous system functions. Children are either hyper or hypo reactive to things like touch or sound. They may have some mild processing difficulties with sounds or words or with understanding what they see. They may have some challenges in how they plan and sequence their actions, but these are not severe enough to derail the fundamentals of development, such as the ability to engage or interact or communicate or use language or think logically, but they do result in behavioral and emotional challenges, ranging from eating and sleeping challenges to all types of aggressive and defiant and negative and stubborn behaviors.

The third group is where the environment derails development. At the most severe end of the continuum we have what we've termed in the past "multi-problem families." We have a book called *Infants and Multi-Risk Families* (that's available through our ICDL website and from International Universities Press) that describes our program for families where there are severe difficulties in the family. It might be severe mental illness; it might be a history of many generations of deprivation and, therefore, a lack of basic nurturing capacities, and these are where the families have so many difficulties, from alcohol abuse to




other drug abuse, to spousal abuse, to single parents who might have severe mental illness, to a family with patterns of mental illness or patterns of dysfunction so severe that they don't attend to a newborn baby, where babies are even deprived of the warmth and love and nurturance they need to learn to regulate themselves and attend to the world and engage or where, at a more subtle level, the interactions necessary to promote development are not present.

One way to think about these most severe situations is to look at what a baby requires at each stage of development. We know, for example, that babies need to be interested in sights and sounds, so they need a mommy standing alongside the crib or infant seat or to be holding the baby and talking with a lovely voice, and drawing that baby's attention to the left or the right to get that baby interested in sounds and giving big smiles and little facial expressions to get that baby interested in sights. We know that the warmth and nurturing woos and entices that baby into a warm, loving relationship. We know that responding to the baby's emotion cues – their facial expressions and their gestures by four to eight months – helps that baby get involved in two-way communication and get into a continuous flow of back-and-forth continuous interaction. We know that shared social problem solving – helping the baby find a toy, rather than just giving it to him, by exchanging lots of gestures and sometimes playing dumb and saying, “Well, where could it be?” as a 16-month hold and a mommy or a daddy wander around the house together, gesturing to each other to find that toy – promotes lots of communication and also problem solving and also pattern recognition. We know that getting down on the floor with pretend play and talking with your child around their basic needs promotes the use of ideas, and so forth and so on, up the developmental ladder through all stages of functional emotional development.

At each of these stages different families may have different difficulties, so severe abuse and neglect usually affects the most basic level of development, and more subtle difficulties may lead to anxiety, depression, or impulsive behavior because the experiences the child requires aren't present. For example, we've found that where caregivers in those first couple of years of life tend to freeze when the baby shows strong affect and don't provide any nurturing feedback, the child feels kind of empty and there's a low feeling; then we see a little depressive tendency, particularly in a child who is a bit under reactive or where there are over reactive sensations to begin with, so they're extra sensitive to their environment and need their environments more.

We also find caregivers who overreact to the slightest little upset in their child, so that the toddler's anxiety leads to an escalation, “Oh my!” and the caregiver makes it seem catastrophic to the toddler, and the toddler, instead of being calmed at the moment of distress, gets more upset because the caregiver gets upset and overreacts. Now we find that this, particularly in over sensitive toddlers – toddlers who are sensitive to sound and touch, even if it's not severe enough to be a regulatory problem – can lead to more anxiety.

We know that families having a hard time responding with firm, gentle limits and supporting shared social problem solving in a continuous flow of back-and-forth communication, so the baby can respond to emotional and social gestures, may also see that child remain at the level of the all or nothing reaction – the fight/flight reaction – and be more impulsive because they don't have the back and forth interactions that lead to more subtle regulation of behavior and mood and control of impulses. Where ideas are not promoted – where the preschool child doesn't learn pretend play and doesn't learn how to use words to express their feelings – this also leaves them at the mercy of using their behaviors to communicate and may lead, again, to more impulsive and acting-out behaviors.




So we can see a wide range of difficulties. Now, these are what are typically called infant mental health problems, as opposed to special needs kinds of problems. Some of them were originally described by Spitz back in the 1940's and 1950's when he made his films of institutionalized children who were severely deprived and they failed to develop language and cognitive skills and many failed to develop their motor skills. Others developed motor skills but became very anti-social, and Bulbe describe many of these children, along with Spitz, where the early nurturing and interactive experiences were not present and left them with good motor skills but with an attitude that people were things and they had no sense of shared humanity, no sense of empathy for the human world.

Nowadays we all question the effects of poverty and high stress environments on children. Well, poverty acts by causing stress in the family and we would look at it by looking at the degree to which it derails the necessary experiences to support each stage of development, where the basics are not supported – attention to the world and engagement – if we have the more severe kinds of problems. We see this nowadays, often, with children who are adopted from orphanages where the conditions that Spitz described years ago are still present and there's severe deprivation, but we see severe difficulties in some multi-problem families, right here in the United States, where there is failure to thrive.

Before we go into how to help such children, we should say a word about how this affects the nervous system. Where there's early stress there is mounting evidence that it affects the way pathways are laid down in the brain, the way in which infants and young children develop not only their minds, but their basic ability to organize experience by having pathways that connect to different parts of the brain. So stress affects the brain just like it affects the mind. Deprivation affects the brain just like it affects the mind. So even though children are born biologically well functioning, within a few months of life with severe deprivation and severe stress their essential nervous system – the brain – may already be headed on a pathway toward having severe difficulties. The specific pathways are only partially known. Pre-frontal and frontal lobe functioning seems to be affected; interconnectivity seems to be affected; the hippocampus seems to be affected. The specifics will be worked out over many, many future scientific generations. Very interestingly, recent research on genes showing that there are epigenetic phenomena or biologic events that control genes – that that turn them on or off. For example, the methylation process will turn a gene on or off and you'll have the environment affecting these epigenetic phenomena. In other words, the environment sets in motion these epigenetic phenomena which, in turn, turns genes on and off and regulates the genes. So we may have identical twins that are very different, based on their experiences of the world. So even genetic functioning is very complex; it's not set in stone because the control mechanisms for the genes are controlled by the environment and by these very experiences of stress or deprivation. We've hypothesized that it can get very specific and we've described in our book on mental health problems – a broad range of mental health problems – and in our book on infants and early childhood mental health the specific experiences that are required at each stage of development. We've described this in other books, too – *Building Healthy Minds*, for typical development, and *The Challenging Child* and *Engaging Autism* and *Infants in Multi-Risk Families* – various patterns of derailment and how we've helped families. We would hypothesize that when specific experiences are missing, which are often provided intuitively by many families, it affects brain development in very, very subtle ways. This is a hypothesis that needs to be proven, although we're doing some research now that should support this.

Next we'll talk about how we approach this from a treatment or intervention point of view. When we develop intervention programs for a wide range of infant mental health problems, as well as for children with special needs or children with regulatory challenges, we use our DIR model to basically orient the




intervention program. The goals remain the same, regardless of the nature of the problem – to promote development of the core social-emotional- intellectual abilities, up the developmental ladder, always from attention to reflective thinking, including reflective thinking about emotions and social interactions, as well as academic and intellectual life in the pure sense. The goal is also taking into account individual differences in the child, whether they're mild, as we see in many of the infant health problems; or moderate, as in regulatory problems; or severe, as in children with special needs or an autistic spectrum disorder. So we always tailor it to the individual differences in the nervous system.

The big difference with infant mental health problems is we're often working much more with the "R" part of DIR – the relationships and the family patterns. In severe multi-problem families we're providing lots of outreach and family support in helping caregivers and family members get proper mental health treatment, as well as dealing with problems in relationships in the family. We describe that in a number of case studies, in both our book on infants and early childhood mental health and our book on infants and multi-risk families, where the problems are more subtle, with helping toddlers control impulses by helping prevent the development of anxiety or depression through fostering the type of interactions in terms of reading and responding to the baby's or toddler's emotional signals and fostering imaginative play to foster the use of ideas to deal with a wide range of feelings. There we're involved in counseling family members, often, who are with the baby – caregivers, mom, dad, and it could be extended family members – to help them overcome their challenges. They may have difficulties with a certain emotion – with aggression, for example, or sadness or loss – and it's hard for them to interact, either in pretend play or just in reading or responding to the baby's gestures, around those emotions. So, a baby, for example, who every time he looks sad or looks angry doesn't get an interactive response, may not learn as a toddler to express that feeling or experience it in the full sense because there's no reciprocal response – no back-and-forth interaction around that feeling, even before he can use ideas, even before labeling the feeling becomes important. So he may not develop a feeling of appreciation of that feeling and then it's obviously hard for him to label it, once he becomes more verbal. Once he gets to pretend play, he's just having discussions because how can you say, "I'm sad" if you haven't experienced the interactions around sadness or loss or disappointment, or anger, for that matter?

So at each of the levels of development there are certain interactions that help babies and toddlers develop a wide range of emotional experience and become comfortable with that range of emotional experience, learn to express it with gestures, and experience it in themselves and read it in others so they can empathize, eventually, and then use words and ideas to label it and discuss it, and then go up the ladder until they can reflect on it. But where that's not forthcoming, again, you can have challenges, so a lot of the work will be coaching parents, not just on how to interact, but also on their own feelings about their baby's or toddler's or preschooler's or child's feelings. So they often have an opportunity to grow, along with the child.

With parents who are derailed at the beginning stages of forming that first relationship of setting up a regulating environment that fosters attention, safety, and security, often we're helping whole families move up the developmental ladder together – the parents with the baby. It may involve homemakers at home with extensive outreach and it may involve coordination with Social Services and Protective Services. We can't go into all the details of that work, except to say that an infant mental health specialist – a person who's well-versed in these principles – needs to organize and guide such an effort, or else the agencies can work at cross-purposes. We've had many cases where there were 10 agencies involved, and each agency was working at cross-purposes – one taking the baby out of the home, one putting the baby



back in the home – and you have the caregiver who’s still not on medication or not dealing with his or her mental health problems, so you need to get all the agencies and all the helpers working together with a common goal. Our DIR/Floortime model provides a model for this.

When it comes to the children with regulatory and biologically based problems, obviously, there is also work being done with the environment, but here we’re doing a lot of work with helping family members who may be functioning quite well learning to tailor their actions to the baby and toddler’s individual differences, which may not be obvious or self evident or intuitive. We’ve described that in books like *Engaging Autism* and *The Challenging Child*.

No matter what the problem, we need to be working on the D, the I, and the R part, where the R becomes more and more important in the vast range of infant and early childhood mental health problems. Where we can see not just abuse and neglect and severe derailment of development, but we can also see anxiety, depression, impulsive behavior, and other types of difficulties, ranging from moderate forms of stubbornness to clear negativism and defiance. We can see eating and sleeping and feeding problems. Here it’s important to work in a comprehensive model, one that embraces the principles we’ve been talking about. Again, there’s mounting evidence now from our neuroscience colleagues that such approaches help develop not only the mind, but the brain also, and that early stress of the type we’ve been describing will affect both the mind and the brain. So we can think of what we’re doing when we take a broad infant and early childhood mental health approach as helping foster healthy mental development in all ways.