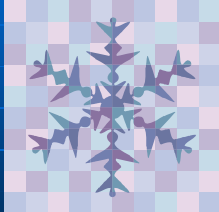


Emotional Development


Opening the mind to The Unfamiliar? Or Just Plain Common Sense....

"Gold standard" = inclusive

- *Dr Jenny Curran*
- Co-presented with *Dr Margaret Kyrkou*
- Supported by Child Youth and Womens Health Services, SA
- Centre for Disability Health, SA



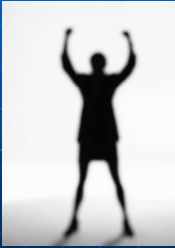
Complex comorbidity



- "Triple diagnoses PLUS"
- Recurrent or episodic crises
- Poorly served by services
- Poorly served by the standard psychiatry approach with modifications

What is required that's missing?

- Comprehensive **developmental** profile
- **Integration** of these findings into assessment
- Fill the "Black hole" .. **Emotional development**



Untapped knowledge reserves?

- Prevalence of DD
- Developmental psychology
- Infant mental health studies
- Clinical experiences



Attachment in children with ID

- Little research
- Similar pattern to neuro-typically developing children but slower and with more in the insecure pattern group compared to 'securely attached'
- if autism present, attachment occurs, but delayed
- Attachment is only one aspect of emotional development
- Self image and self identity
- Motivational factors (Yale group)
- Psychopathology esp anxiety
- Behavioural phenotypes

Key elements of emotional development



- **Self regulation and self soothing**
- **Attachment**
- **Complex sense of self**
- **Recognise and express diverse range of emotions**
- **Developmental anxieties**

CDC-ICDL framework report

- Collaboration by the CDC with ICDL

ICDL

- Founded by Stanley Greenspan and Serena Wieder, the Interdisciplinary Council on Developmental and Learning Disorders has been a pioneer in its work to advance the identification, prevention, and treatment of developmental and learning disorders
- www.icdl.com

- **S Social (based on ADI-R social section)**
- **P Physical including sensory, motor processing, other neurological impairments and seizures**
- **I Intellectual including the executive function skills as well as the more commonly assessed IQ tests**
- **C Communication (based on ADI-R communication section)**
- **E Emotional development (based on SAED)**

CASE STUDY

- How could you go about assessing this emotional capacity?
- What might you expect to find in Troy's case? Give examples of the kinds of behaviours or reactions you might see

SAED for "TROY"

	EC 1	EC 2	EC 3	EC 4	EC 5	EC 6	EC 7	EC 8	EC 9	EC10
Lev 5 Mid ID										
Lev 4 Mod ID	Dev g	Dev g	Dev g				Dev g	Dev g		
Lev 3 Eq. 18 mths to 3 yrs	x	x	x	?			x	x	x	
				7 Sep 'n Anx ty x						
Lev 2 6-18 Months					x				x	x
Lev 1 Less 6 months										

Emotional Development



- **Infant mental health: psychoanalytic, object relations theory, attachment theory, neurobiology, brain research, impact relational trauma**
- **Training???**

**ASSID Conference 2008
November 25th 2008 Melbourne Australia**

Workshop Title

Improving young people's emotional and mental health: Emotional development and addressing the complex mental health needs of people with developmental disabilities

Presenters: Dr Jenny Curran, Disability SA and Dr Margaret Kyrkou, CYWHS, South Australia

Introduction

Since arriving in South Australia about 10 years ago, I have worked towards the development of an interdisciplinary, functionally integrated and developmentally appropriate mental health service for people with intellectual disability, inclusive of those who have more severe intellectual disability and also those with autism spectrum disorders. The ideal or gold standard service model incorporates an understanding of the psychological and emotional development of our clients as well as functional behavioural analysis, since it is important to work with the two areas often labeled as "psychiatric" and "behavioural" together, rather than separating them in to different service responses.

Today, we will explore one aspect of the ideal service model in more depth, that is the assessment of emotional capacities. We will also show how this can improve outcomes in dual disability psychiatry, particularly in relation to the assessment and management of complex comorbidity.

Examples of complex comorbidity include an Axis I psychiatric disorder, such as schizophrenia, occurring in a person with autism and moderate intellectual disability ("triple diagnosis"), or when behaviour consistent past experiences of significant relational trauma (eg sexual and physical abuse), occurs in a person with mild intellectual disability who also lives in poor socio-economic circumstances with disruptive extended family influences.

My own dual disability training in the UK and subsequent clinical experience has repeatedly shown me that where there is a more significant degree of intellectual disability or where there is a multiplicity of factors which can be subsumed under the title "complex" or "high needs", then a more sophisticated framework is required than the straight forward application of a modified general psychiatry approach, particularly as there is a tendency for recurrence of problems over time.

Specifically, the framework most suited to complex cases requires two essential elements in assessment which are lacking in the general approach

- 1. a comprehensive, and in-depth assessment of the person's multiple developmental domains (developmental profile)**
- 2. followed by an active process of integration of the findings of the developmental profile into the broader assessment process.**

The in-depth developmental assessment requires familiarity with the broad range of developmental profiles seen in the population of people with intellectual and developmental disabilities. In Australia psychiatrists and other mental health practitioners generally have little or no opportunity to develop this degree of experience during their training.

The comprehensive nature of the assessment is also a problem for the mental health practitioner since there is no standardized assessment of emotional development unlike other developmental domains which are typically assessed by practitioners, such as speech pathologists, psychologists or occupational therapists, with standardized assessment tools.

By contrast, there is frequently a lack of specific information about emotional developmental and emotional functioning evident in the general clinical assessment of psychopathology. This is perhaps not so surprising given that research in to the emotional development of people with developmental disability behind lags research into social, communication, intellectual and physical development and adaptive capacities of this group.

However, there are a small but increasing number of practitioners who share my concerns about the emotional

development “black hole”. My colleague, Dr Margaret Kyrkou, who is supporting the presentation today, recognizes the importance of a better understanding of emotional development in her work with young people with significant intellectual disabilities and severe behaviour problems. Dr Kyrkou has a background in developmental child health, and in intellectual disability health care including womens’ health, as well as the invaluable personal experience of being the mother of a wonderful young woman with complex disabilities.

In the next section of the workshop, I put forward a basic argument in favour of performing a detailed and integrated assessment of the individual’s emotional developmental profile, as an essential element of psychiatric assessment. This is followed by an illustrative case study, which will involve small group work and take up the main part of the workshop. We end by a short summary and reference to areas of research and practice that can inform our own field in the area of emotional development further.

Mental health assessment in young people with developmental disability with complex dual disability including the assessment of emotional development using the SAED

Despite the early Isle of Wight studies by Rutter and colleagues in the 1970s (Rutter et al, 1970) which showed a link between developmental and neurological disability with psychopathology, the areas of emotional development and psychopathology in children and young people with intellectual disability have been relatively poorly studied, with notable exceptions including the work of Professors Tonge and Einfeld and colleagues here in Australia (Einfeld and Tonge, 1996).

Just as with the adult population, there is mounting evidence that children and young people with intellectual disability or with autism spectrum disorder are at increased risk of emotional difficulties, psychopathology and mental illness. Will mention just 2 review articles that provide good overviews of the dual disability in the youth population.

In his 2008 review in *Current Opinion in Psychiatry*, Kolaitis states that “recent studies indicate that this population (young

people with intellectual disabilities) presents significantly more emotional and behavioural problems than their peers without intellectual disabilities". In the *British Journal of Psychiatry*, eminent researchers Emerson and Hatton (2007) conclude that social risk factors play an important part in the increased risk of mental illness in children and adolescents with intellectual disabilities in Britain, in addition to the intellectual disability itself.

Outside the intellectual disability field, studies in the rapidly growing field of developmental psychology have found links between disrupted socio-emotional development and the increased risk of psychopathology in neurotypical infants and children. Yet there is little sign of interest by the intellectual disability research community in applying these findings to our client group.

In fact it appears that in research terms, the infant mental health and developmental psychopathology research communities have remained relatively isolated from the intellectual disability psychiatry field. The potential for useful cross fertilization between these fields remains largely unexplored. However as clinicians it is apparent that there are many opportunities to examine the application of developmental psychopathology and infant mental health understandings to our own clients emotional and behavioural difficulties.

In my own case, I was privileged to witness the extraordinary psychological birth of a young woman with mild intellectual disability who at the age of 18 years became my patient. She had experienced a long history of severe emotional trauma since very early childhood, had become psychotic in her early teens, and was extremely disturbed when I first met her. However, after treating the psychotic element and lengthy periods of dissociation, it became apparent after a period of 9 to 12 months of living without hallucinations and in an emotionally secure and nurturing environment that she was starting to show attachment behaviours towards the main carer. Her emotional development continued much as one would expect a toddler's would over the next few years, and while I am no longer her psychiatrist, I hear reports that she is doing well in a supported community setting. This and other less dramatic clinical observations encouraged me to search for

a tool to assess emotional development in our clients, just as we assess other developmental capacities such as intellectual capacity or communication skills.

The only tool designed with developmental disability in mind which I eventually found and which covered the competencies I felt were relevant was the Schema for the Assessment of Emotional Development (SAED), described by Dosen in several publications (Dosen 2005). I have been using Dr Anton Dosen's emotional assessment tool, the SAED, to drill down further with in developmental assessments into the emotional domain as part of psychiatric assessments where there is little clarity about the significance of psychopathology.

At this point, I will very briefly summarise what we know about aspects of emotional development in children with intellectual and developmental disabilities. At its most simple, the research to date suggests that emotional development in children and young people with intellectual disability can be described as following a similar pattern to neuro-typical children, but occurring more slowly and with a greater proportion in the insecure attachment group compared to neuro-typically developing children. If autism is also present, attachment still occurs, although it may be delayed and associated with a greater proportion of insecure attachment patterns than in the neuro-typical population.

Other factors impinge on emotional development, including self image and experience of the reactions and expectations of others, as well as the presence of psychopathology. Zigler's work stresses the importance of motivational factors in determining an individual's actual performance, in contrast with expected performance (Zigler and Hodapp, 1986). The links between negative self image, low levels of goal setting in people with intellectual disability and their experiences in the process of socialization have been studied by the Yale group (Hodapp et al, 1995).

The links between psychopathology and the so-called IQ-performance discrepancy (where IQ stands for the maximal abilities) have also been explored. Pilot studies show a strong correlation between higher rates of psychopathology and larger IQ-performance discrepancies. Of interest, anxiety showed the

strongest correlation with reduced performance from the level of attainment expected (Tasse and Havercamp, 2006).

Studies of behavioural phenotypes show that while there is a general trend to follow the pattern seen in neurotypical development, specific patterns may exist for specific causes of developmental disability. For example, studies of specific genetic causes of intellectual disability with associated behavioural phenotypes have identified a number of genetic or chromosomal conditions which include particular emotional development profiles that are not seen in developmentally delayed children of similar levels of functioning.

An example is Williams syndrome where marked anxiety is often combined with superficially competent social and communication, a pattern which contrasts with the overall population of children with developmental disability.

However, putting behavioural phenotypes aside, let us proceed to identify which might be considered key elements contributing to the domain of emotional development in the contexts of mental health and psychopathology. It is these areas that we must include in assessment in order to determine a person's overall emotional developmental functioning.

Workers in the U.S.A. (Weider and Greenspan, 2003) and elsewhere such as by Dosen and his colleagues in the Netherlands (Dosen, 2007), identify the following developmental capacities as central to healthy emotional development:

- the capacities for self-regulation and attention,
- the capacity for relationships (attachment behaviour)
- the capacity to recognize a complex sense of self
- the capacity to express and recognize a range of emotions in self and in others
- the capacity to experience developmentally appropriate anxieties and to manage these anxieties including by appropriate comfort seeking

The CDC/ICDL Collaboration Report describes a framework for early identification and preventive intervention for emotional and developmental challenges (Cordero et al, 2006). It was produced by a collaboration between the Centers for Disease

Control and Prevention (CDC) in, Atlanta, Georgia, and the Interdisciplinary Council on Developmental and Learning Disorders (ICDL).

The CDC-ICDL framework is based on current understandings of healthy developmental patterns and is designed to detect all possible deviations from those patterns. It uses risk indicators designed to detect a lack of mastery of age-expected emotional, social, and cognitive milestones during a child's first 2 years of life. The authors comment that a child's emotional developmental capacities are "often impaired" when the child also has a developmental disability.

Affective or emotional development is also central to the development of the highest level mental capacities, such as reflective thinking, according to Greenspan and Shanker. They argue that the capacities for these activities only develop fully when infants and children are engaged in certain types of emotional (nurturing) learning interactions, and that children deprived of such interactions exhibit a variety of problems in their social, language and thinking capacities (Greenspan and Shanker, 2007).

In order to emphasize emotional development with the whole developmental profile, I identified the Emotional domain as a separate developmental domain, with in the context of the more familiar developmental domains, making the acronym SPICE

Figure 1: The SPICE profile: a communication aid

S Social (based on ADI-R social section)

P Physical including sensory, motor processing, other neurological impairments and seizures

I Intellectual including the executive function skills as well as the more commonly assessed IQ tests

C Communication (based on ADI-R communication section)

E Emotional development (based on SAED)

When I apply the SPICE profile (Fig 1), I base the "Social" and "Communication" domains on the Social and Communication

sections used with in the Autism Diagnostic Interview, ADI-R (de Lord, Rutter and LeCouteur, 1994). The “Intellectual” reflects the commonly assessed neuro-psychological domains, but also includes some form of assessment of executive functioning. The “Physical” domain is made up of several unrelated developmental areas including the regulation and processing of sensory information, motor disorders of typically developmental origin such as dyspraxias and cerebral palsy and seizure disorders. Temperamental traits can be included with in the emotional domain or if more appropriate in another domain such as social.

In summary, the mnemonic SPICE is a rough and ready tool, less based on any consistent or scientifically rigorous classification system, and more on its ease of recall and utility when explaining individual profiles of development to those who are unfamiliar with autism, intellectual disability, sensory processing disorders, complex seizure disorders and impairments in emotional development which are often seen in dual disability clients.

In spite of the relatively arbitrary nature of the domain divisions with in the SPICE profile, the total information that it covers provides an extremely comprehensive and in-depth developmental picture that is amenable to providing a basis for shared discussions across the user-provider boundary, as well as between sectors of service providers.

The Profile can then be integrated into any other assessment process such as a functional behavioural analysis, a person centred plan, an educational support plan or a psychiatric assessment. We can use the developmental information to help identify developmentally appropriate interventions particularly of an emotional nature, to add to the “intervention tool box”.

Using this approach, we often find that a first step typically may be to intervene with the environment, so as to optimise the developmental “fit” between the person and their social-emotional environment, or sensory and communication features of the environment instead of moving directly to medication for a symptom or diagnosis.

The acronym SPICE appears to be particularly valuable in facilitating communication with carers, other professionals

with little knowledge of development and with more able clients about their developmental strengths and weaknesses, to emphasize the importance of emotional development as part of the overall picture. Experience has demonstrated that the same message given in words or writing alone, such as in a report for carers (and also a range of professionals with little developmental experience) is more often than not poorly understood compared with the use of the SPICE profile as an additional visual prompt.

The following case study illustrates use of the SAED, as well as the SPICE profile as an aid to communication, and offers an example of how psychopathology can be interpreted through developmental perspective.

CASE STUDY "TROY"

Developmental psychopathology, infant mental health and early intervention: where does the SAED fit?

Infant mental health is relatively new to psychiatry, although the areas of knowledge that inform this field are many and have long histories. In the first clinical textbook dedicated to this field, *Clinical Skills in Infant Mental Health*, (Mares et al 2005) the authors describe a collection of influences on the development of the infant mental health. They identify important influences as psychoanalytic theory, object relations theory, attachment theory and developmental psychology. In addition the recent advances in neurobiology and brain research have offered insights into the links between the quality of attachment (developmental psychology) and the infant's brain growth and development.

Even having had a 3 year training in psychodynamic psychotherapy which covered the influences noted above and also included psychotherapy with patients with developmental disability, I find that carrying out and interpreting a SAED assessment is still a complex and challenging clinical skill.

For the future, it is necessary to take the next step in researching the psychometric properties of the SAED in comparison with other emotional developmental assessment tools. In terms of practitioner skills, further training in the

areas identified with in developmental psychology as part of emotional development should be pursued. The ICDL centre provides some online opportunities. Others need to be explored.

To conclude, I have argued that the impact of a child's emotional development, and the related issue of the affective component of any learning situation are becoming recognized as having a more significant role in overall development than previously thought. Research directed to examining the affective component of the infant caregiver relationship is crucial, in both neurotypical and in developmentally delayed children. The links between emotional development and psychopathology in youth with developmental disability is a potentially rich area for research.

Seeing nurturing relationships as the greatest of our developmental resources may be common sense, but we need to ensure that our clients are included in the research on emotional development. As Winnicott, a pioneer in infant mental health, famously wrote

"There is no such thing as a baby...if you set out to describe a baby, you will find you are describing a baby and someone. A baby cannot exist alone, but is essentially part of a relationship"

(Winnicott, 1964)

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