NYC Early Childhood Mental Health TTAC
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A COLLABORATION BETWEEN
NEW YORK CENTER FOR CHILD DEVELOPMENT
McSILVER INSTITUTE FOR POVERTY POLICY AND RESEARCH
NYU SILVER SCHOOL OF SOCIAL WORK

TTAC Webinar Series: An Introduction to Infant/Early Childhood Mental Health Concepts and Practices

Responses to Participant Questions Resource Document

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Module 1

Q: Do you have any thoughts about how to promote caregivers' ability to see physical caregiving as an opportunity for developmental growth?

- **R:** Physical caregiving occurs many, many times each day in the life of a baby and parent and, as Dr. Foley described, is a primary opportunity to engage in the serve-and-return interactions that promote brain development and that also promote emotional closeness between a parent and child. How to approach this depends on the way you are connected to the dyad in question. Are you a friend or relative? Or are you asking in the context of a professional or therapeutic relationship?

  In dyadic therapy there are opportunities to inquire about a dyad's day-to-day life together. When the opportunity presents, you can inquire how the baby likes bath time, if the baby enjoys eating, what their bedtime routine is like, etc. Does the baby like music or singing? As you get to know the child's likes and have a sense of their routines, there may be ports of entry to suggest little songs, games, finger plays, or other things that the parent and child might enjoy together. These are really the pleasures of parenting!

  I am also thinking of the many web and app-based programs available to parents now that give suggestions for turning every day caregiving activities into "brain-building" activities. Do you know about Vroom? It is an app-based program that provides developmental suggestions to parents that can be incorporated into day to day activities that are fun for children and easy for parents. Vroom is just one example. There are many others. Suggestions come right to parents' phones, and are based on the specific age of the baby.

  Some parents do not know how significant they are in their children's development and learning. Once they learn the importance they hold, many are happy to be guided on the

how-to. Look up *Providence Talks*. Once parents learn how they can contribute to their children's growth and development, they are usually on board.

Parents are busy, but incorporating developmental activities and serve and return interactions as you feed babies, dress them, bathe them and put them to sleep are is not only good for babies, but it also makes parenting more fun.

Happy to make this guidance more specific if you want to discuss more details.

- **R:** I don't have a great deal to add to Susan's very thorough and thoughtful response. I think if the caregiver in question is the parent(s) with whom the child is living, a useful tool is Sally Provence's Interview for a Day. Essentially, you ask the parents to describe in detail what a typical day is like at home with the child from the time the child awakens to bedtime and through the night if there are night fears, waking, feedings, etc. In the course of an interview like this you will get a good idea about the activities of daily living (ADL). This can be your port of entry to deepen the discussion of how the ADLs go: what the parent likes best, least; what is most pleasurable and what transpires between parent and child; what might make it more fun, more interactive; what might promote more closeness, etc. This may be an opportunity to give some guidance about how ADLs can be more relational as well as instructive. Analyzing what a child can learn during these times and what the parents might learn, beyond just getting the task done, can be very motivating for some parents. Of course, you would want to build on what the parent already finds pleasurable and given the demands of time etc., start simple, maybe suggest just one activity, let's say bathing if the parent already enjoys that and how it might be expanded or deepened in some way. Videos of parents engaged in ADLs as a developmental affordance, can give the caregivers a concrete model.

  A question I have found useful is to ask the parents if they have any fond and positive memories of times with their own parents around eating, bathing, hand washing, bedtime, cooking, etc. If they can recall some pleasurable times around an ADL, ask them to describe it, what made it special etc. This is your way in to talk about what gift of warm memories they want to impart to their own child-possibly through the same ADL or another.

  Further, remember parallel process. If you do home visits, maybe you could suggest having tea as a part of a visit and bring some goodies and beverage and make that tea a time for conversation, being especially attentive and attuned to the parent. This might be a model for the parents to make meal time more interactive for their own child. Your tea time could be recalled at another visit and explore what the parent remembers of the tea; what they found pleasurable and significant and how some of those same experiences and features could be translated into meal time with their own child and what it might look like. Find out if the parent tried it, what worked, what didn't and what was pleasurable. Be encouraging!

Q: Can your primary attachment figure switch through your childhood? For example, from a foster parent to parent. Would it switch even if the secondary caregiver is not protective, or would the attachment remain with whomever has protective capacity?

- **R:** Children can develop attachments to different caregivers, either concomitantly (as to a mother and father, or mother and grandmother), or sequentially, as would be the case if a child was reunified with a parent after being in foster care. Children must form attachments to their

caregivers, especially when they are very young, because that is their means of survival! It is the **quality** of attachment that we are concerned about if a parent is not adequately protective or nurturing of the child. Children can develop secure attachments or insecure attachments.

If a child has had a secure attachment with one caregiver, the child will approach new relationships with positive expectations, though of course, attachment disruptions (the loss of a primary attachment figure) are a severe stress for a young child, and the first reaction may be one of grief and bereavement, especially if the first attachment figure disappears. If a child has had insecure attachment to a primary caregiver, that child will be more wary of the new parent, but is capable of ultimately developing a secure attachment if that new parent is very nurturing and has an autonomous state of mind (Thursdays webinar). So yes, we all develop multiple attachments but we vary in the quality of our attachments. And you can have different attachment classifications with different caregivers.

It's a complicated, but fascinating topic. I'd be happy to discuss with you more.

- **R:** Attachments are to a particular caregiver, so a child can have more than one attachment figure. The research suggests they are organized hierarchically. So, yes, a child can have an attachment to a biological parent and another attachment to a foster parent, just as a child can have an attachment to mother and another to father or grandmother. As Susan points out, the quality of the attachment is significant. The child could form an attachment to a figure because she/he is the person on whom the child is dependent but the quality of that attachment may be other than secure. It could be an anxious avoidant attachment or anxious ambivalent attachment or in the worst case, a disorganized attachment. The child could have a secure attachment with one caregiver and an anxious one with another. The qualities of caregiving that are most characteristic of a secure attachment are: **sensitive,** meaning the parent is able to accurately read the needs and emotional cues of the child, for example, for protection, comfort, etc**. ; Responsive,** meaning the parent meets the needs contingently in a way that brings satisfaction to the child more often than not and **Reliable,** meaning that the caregiver is constant and the quality of caregiving is consistent. This does not mean that caregivers need be perfect, only "good-enough." Attachment quality with a particular caregiver can change from secure to anxious, for example, in response to adverse experiences or from anxious to secure in response to emotionally corrective experiences.

Q: What does this mean and how does it apply to children who are removed at birth from mother and moved between homes during their early years?

- **R:** Multiple attachment disruptions are extremely stressful and traumatic for very young children. When children are placed in foster care and then are moved from one foster home to another, they suffer, and can begin to show symptoms, especially if there are multiple moves.

  Foster placements should be as stable as possible and clinicians should work as hard as they can to support foster parents so they can continue to take care of the children they have in their care. Multiple moves in foster care can ultimately impede children's capacity to have secure attachment. It is the single most detrimental thing that the child welfare system can impose on a child.

- **R:** Dr. Chinitz has far more experience with foster care than I. Dr. Provence used to say, constancy of caregiver, consistency of caregiving, and predictability of place, are aims for which to strive. Multiple disruptions of caregiver and place are certainly risk factors which must always

be assessed in relationship to protective factors. Anna Freud suggested that in some cases, the child's capacity for future attachment diminishes with each disruption.

Q: How can we help with social development at this time?

- **R:** Though this is surely an exceptional time and we are all quite limited – especially socially – there still are things we can do to help children with their social development.

  In our everyday interactions with children, we can introduce emotion vocabulary, to help them understand their own feelings, the feelings of others, and how what they do makes others feel. For example, if a child grabs a toy from a baby sibling, a parent can say, "I know you wanted that toy, but it made Max angry and sad when you took it from him". Or, conversely, "look how happy Max was when you danced with him!". Helping children with emotion vocabulary and emotion understanding will help with their social development.
  When you read books to the child or watch a show, you can talk to the child about the situations presented, how the characters feel, and how they might solve problems or predicaments, especially if these involve social situations or other people. Is the child doing web based preschool classes? Can you talk about their friends and think of ways to be in touch?
  Some suggestions may be specific to the child's age or particular circumstances.
  Happy to talk more about this if you would find that helpful.

- **R:** I concur with everything Dr Chinitz said. I would emphasize two-way communication as much as possible. Interaction is the core component of social discourse. Play is a "natural" modality through which children learn social roles and rules, so play can continue through this period with siblings and parents.

Q: I am wondering more about co-regulation between caregiver and child (2-4 years old). How can this skill become a treatment goal? I am wondering in the context of trauma where there is some physiological dysregulation. How can the therapist help their little one develop this awareness about their physiological state?

- **R:** Co-regulation is an important goal to work on and can be done in games and pleasurable activities such as red light -green light, Simon Says, statues. In these games the child is learning to practice inhibition on cue. Before starting an activity, build-in a pause with the familiar: on your mark; get ready; get set-go. Play start-stop games to the starting and stopping of music (musical chairs), practice being loud-soft, fast-slow. All of these involve inhibition, action or modulation of response on cue.
  - Kopp said at its most fundamental, regulation implies the ability to mobilize acts on request (DO) and inhibit action upon demand (DON'T).

  These experiences as games and especially co-regulation in real life situations, daily life, give the child opportunities to practice regulation with the help of caregiver cues and support such as giving more time, or more prompts, talking the child through it, empathizing, gently touching the child to get her/his attention and help the child to slow-down etc. Regulation is more than stop and start and so practicing gradations of loudness, activity level, etc. become important areas for co-regulated practice. Opportunities to exercise cp-regulation occur when the child is dysregulated and the parent offers support to the child to recover to the regulated state, incrementally allowing the child to recover independently and thus supporting the development of self-regulation.

Beginnings of self or effortful control which emerge between 22-33 months are expressed by the following markers: slowing down motor activity, suppressing or initiating activity to signal, lowering of voice, effortful attention, compliance to delay or inhibit of a response on caregiver request with decreasing amounts of external mediation and increasing participatory regulation.

The second part of the question deals with helping a child become more aware of his/her physiological state of arousal. The capacity for self-observation which is the basis for self-monitoring does not emerge until around 18M as evidenced by the rouge experiment. It wasn't until about that age that junior toddlers when peering in a mirror were aware that a dab of rouge had been placed on their noses. Opportunities for the child to observe her/himself in different states in mirrors, video clips and by "mirroring" the child's state through empathic verbal feedback are ways to increase awareness and the development of the self-observing ego. Consistency of feedback and use of the same language are important-"You are getting excited; your body is moving very fast and your voice is very loud; try to slow-down and get still and quiet." A history of trauma tends to render the child hypervigilant and hyper-aroused or muted or dissociated. Therefore, accurate self -observation tends to be compromised and any specific strategies to increase self-observation and monitoring should be a part of a dyadic therapeutic process.

- **R:** Susan Chinitz adds: I am noting that you ask this question about a dyad that has had a trauma history. I would add to Gil's response by reminding that if there has been a traumatic event, both parent and child need to address it directly, have opportunity both verbally and through mutual play to process it, and to generate a mutually constructed trauma narrative that helps the child understand why the event happened, that the mother and child are now safe, and that the traumatic event was not the child's fault. Resolving these common psychological and emotional reactions to traumatic events will support the child's regulation and the parents'.

  CPP provides a lot of guidance for this type of clinical intervention.

  The citations for slide 18 is:

  - Colin, V. L. (1996). Human attachment. Philadelphia: Temple University Press.
  - Winnicott, D. W. (1987). The child, the family and the outside world. London: Penguin. Reading, MA: Addison-Weseley.

Module 2

Q: What was the name of the person whose video we could get at TTAC website on developmental milestones?

- **R:** Dr. Romina Barros, Developmental Pediatrician, did two webinars on developmental milestones.

Q: Eighteen to 30 months appear to be a very wide range for clinicians to consider. This can be over 80% of the child's life, can you narrow it at all?

- **R:** This is a large slice of developmental life. I do not know why the authors did not divide level V into two separate levels. However, it lends itself to 2 separate periods. Eighteen-24 M could be considered The Early Symbolic or Representational Level characterized by play reenactment of the activities of daily living in which the child plays out caregiving that has been afforded her/him: feeding the doll as she/he has been fed or putting the doll to bed. Typically, these play scenes are enacted with miniature toys- replicas of real- life objects. During this period, there is a significant expansion of the affective array or broadening of the range of affects. As the child has increasing encounters with the real world on her/his own terms, these interactions serve as the stimuli for the differentiation of new affects. A second level form 24-30 M emerges as a separate level and could be considered the period of beginning symbolic play proper. Symbolic play is characterized by: pretense or use of imagination to expand play themes beyond routine and rehearsed experiences; object substitution in which the child is no longer reliant on replicas of the real world but can imagine a block to be a car, for example; socio-dramatic quality which suggests beginning scene organization and interaction with peers and beginning of roles and rules in which the child assumes some job with defined tasks that tend to be rigorously held to with little variance. Level six deepens and expands symbolic play to proto-narrative by connecting play themes in a logical sequence so the narrative play and language approximate a beginning, middle and end.

Q: In regards to language delays, I am wondering does bilingual speech development follow the same pathways as children who are monolingual? Or could it cause a delay in the onset of speech?

- **R:** Growing up equally exposed to two languages may cause early language development to be slightly delayed as the child learns, and sorts, two different codes. But if the child hears both languages in good dosages each, s(he) should acquire both of the languages readily. The first five years are the best years for acquiring, and becoming fluent in two languages. And growing up exposed to two languages, and ultimately speaking two languages, is a gift!

Q: My son has CAPD and was diagnosed at the age of 5, he is now 18 and still struggles socially and with other things. It can be very challenging for parents when dealing with a child diagnosed with this disorder, esp when they are young. Learning the child's strength is extremely helpful!

- **R:** Your story is a good example of how a central auditory processing disorder can, and does, impact the person's functioning in other domains, and other areas of functioning. It also highlights the impact of a child's disability on the experience of parenting. We are sure that it is, in fact the case, that working with the individual's strengths, and building on these while you also address the weaknesses, is the best way to support the person's functioning. Sounds like you have a lot of information that may be very helpful to other parents. Hope others have the benefit of your experience.

Q: From a psychoanalytic perspective, I am wondering if tactile, sensory issues with touch, can be traced back to difficulties in the holding environment-considering Winnicott's theory.

- **R**: Given what is now known about the relationship between nature and nurture, endowment and experience, it is reasonable to assume that most aspects of development have an experiential or developmental contribution to their formation. From animal studies, we know there is a fundamental need for contact comfort mediated through the tactile system. Harlow's baby monkeys preferred the wire mother that was wrapped in soft terry cloth to the wire mother that lactated. Contact comfort is an important feature in attachment formation. It is known from the studies by Spitz, Provence & Lipton and Zeanah, that infants deprived of sensory stimulation through human contact, are at very high risk for developing what we now call **reactive attachment disorder.** Freud suggested that the ego is first and foremost a body ego arising from the surface underlining the significance of the skin and tactile stimulation. Winnicott felt that "holding," literally and figuratively, significantly contributed to transforming the unformed ego into an organized component of the personality. Therefore, tactile sensory issues can arise from failures in "holding' and the provision of stimulus nurturance. Such "psychogenic sensory disorders" would not be considered Sensory Processing Disorders or (SPD) because SPDs are related to the neurological substrate but it is not a leap in my mind that severely sensory deprived infants could acquire a neurologically based SPD secondary to the deprivation of sensory stimulation and relational caregiving which can negatively impact the formation of brain architecture. I have discussed sensory deprivation but sensory overstimulation may be more the concern today in some environments. Excessive and disorganized stimulation may negatively impact sensory function as well as excessive screen time.

Q: The focus is usually on the relationship between mother and child. What happens in those families where there are two fathers or a father who is more involved than the mother?

- **R:** Mothers are most referred to in the literature because most the attachment research was conducted with mothers and infants given the social norms of the day. Infants can form attachments with caregivers other than their biological parents or figures of any gender. The key factors are having a caregiver who is sensitive, responsive and reliable in care and constant over time. I often say, it is every infant's birthright to have an emotionally competent caregiver with whom to fall -in -love.

- **R:** Yes, you are right! We do speak and read about mothers more than fathers in the literature on parenting. I think that in the past, that used to be the case because there was, in fact, an expectation that mothers were, most often, children's primary caregivers. Now, I think that the use of the word, mother, is almost just shorthand. Increasingly, the field of infant mental health appreciates that children are raised by diverse kinds of caregivers including fathers who are primary caregivers, same sex couples who co-parent, grandparents or others. And, just as importantly, the field of infant mental health acknowledges that while children need a primary caregiver who is emotionally committed to them and able to provide nurturing parenting that is reliable, sensitive and as consistent as possible, who plays that role is less important than the fact that this relationship is unique, and not interchangeable. The research on child outcomes suggests that while fathers parent differently than mothers, there is no adverse impact on

children for being raised primarily by a father, or by two fathers or two mothers. The language in the literature should change to reflect this changing reality and the results of these studies.

Q: I know trauma responses can mimic ADHD. Can a child develop ADHD without any attachment problems or trauma history?

- **R:** Yes, for sure. I would venture to guess that many, if not most children who qualify for a diagnosis of ADHD do not have attachment problems or histories of trauma. ADHD is a research-backed, and fairly common childhood disorder that has varying levels of chronicity or duration. It is usually evident by the time a child is a preschooler though some diagnoses may not occur until the child reaches elementary school. It may get better as the child gets older, but in some cases the diagnosis is still applicable in adulthood. ADHD can accompany other childhood disorders, like learning disabilities, but it often presents as a single condition or the only problem for which a child needs support or intervention.

- **R:** ADHD is a neurodevelopmental disorder. It is not caused by psychosocial factors. However, the behavioral manifestations of ADHD can both precipitate psychosocial challenges and be exacerbated by psychosocial challenges. ADHD can make parenting more stressful and the child with ADHD may find social and school adjustment more difficult, placing the child at risk for social-emotional complications. Less than good-enough parenting does not cause ADHD but a lack of sufficient structure, for example, can make manifestations of the disorder more complicated. It is important to be aware that ADHD can be comorbid with other developmental or mental health disorders of early childhood.

Q: **Speak on children regression to previous behaviors of aggression and irratibility, fears, mood changes; dis. disruption in family nucleu**

- **R:** The circumstances that are connected to disruption of the nuclear family are very variable so it is hard to describe a typical pattern of reaction. However, if a child has lost a primary attachment figure when the family disrupts, or if there was a traumatic event that was connected to the disruption, the child is likely to show some symptoms, including all of the behaviors you indicated. The support available to the child is a critical factor. Are the adults involved mindful of the impact of the family disruption on the child? Can they keep the child's emotional needs front and center? Has anyone explained to the child why the family is no longer together, and especially, that it wasn't his or her fault? The symptoms you describe are definitely imaginable in the context of traumatic family disruptions or sudden loss of attachment figures. But strong support, and parents' capacity for reflective functioning, could alleviate the impact

Module 3

Q: Please touch on how as professionals we can build resilience in young children and parents.

- **R:** Although there are innate factors which are associated with resilience, such as physical robustness and flexible temperament, environmental factors play an important role. A key

variable is having a significant relationship with an adult by whom the child feels uniquely understood and cared about. This may be the parents but not necessarily; It can be a teacher, aunt, neighbor, coach and so forth. Resilience is associated with a feeling of competence -social, academic, practical. It is important that children have opportunities to accomplish skills and feel a sense of mastery. Living in a family with developmentally appropriate expectations, structure, support, balanced discipline and ties to extended family promote resilience. Having a sense of one's cultural and self -identity and a social support system are among the environmental factors that promote resilience. As a professional, supporting a child in a therapeutic relationship, holds resilience building potential. Supporting competence and mastery in the child through consultation with the school to optimize learning and skill building; supporting the child in extra -curricular activities and participation in organizations that promote skill building and physical/athletic and social competence are ways for professionals to support resilience. Further, working with the family to nurture the characteristics identified above has resilience building potential.

Q: Can you please recommend readings for sensory processing disorders in autistic children?

- **R:** I would recommend reading the DIR Model (Development, Individual difference, relationship-based) literature (Greenspan & Wieder) as a good place to start, since so much of the sensory is built in to the theory and practice. The Profectum website has an excellent parent tool kit which addresses sensory factors in ASD. The work of Lucy Miller, although not specifically about children on the spectrum, but SPD more broadly, is an excellent introduction to the topic both through scholarly articles and her book for parents and professionals: "Sensational Kids." The research of Liz Torres at Rutgers on sensorimotor processing in ASD is leading-edge. A book by Williamson and Anzalone, "Sensory Integration and Regulation in Young Children," was ground breaking. Although not specifically about ASD, it is an excellent introduction with applicability to ASD.

Q: What ideas do you have for teachers and supportive teams that have limited interactions with parents/caregivers?

- **R:** This is always challenging. I think the first question to ask is, "why is there limited interaction with families; what are the roadblocks and how can they be remedied?" Making home visits, having extended hours and weekend availability often help. With COVIOD, we are learning a great deal about phone and virtual interaction and I think these will be continued effective ways to reach out to families. Conducting in-home team meetings or now virtual ones may stimulate family motivation and participation. Having a comment notebook that goes back and forth between team and family is another stay in touch link.

Q: Can you speak about effects of over involvement and emotionally intrusive parenting?

- **R:** Over involvement and emotionally intrusive parenting may result in the child's insecure attachment because the parent's responses to the child are neither sensitive nor contingent. If the intrusive parenting is also frightening, the child may develop a disorganized attachment.

The concern is a real one and the dyad might benefit from dyadic psychotherapy if you are in a position to make that recommendation and referral.

Q: How can therapists best advance their training in infant mental health?

- **R:** If you are psychodynamically oriented, there is a local (Manhattan-based) post-graduate program, Parent Infant Psychotherapy (PIP), at the Columbia University Center for Psychoanalytic Research. It is a two-year program for licensed mental health clinicians that meet once or twice a week in the late afternoon and evenings.

  The Parenting Institute at Adelphi University in Garden City has a 2-year post-graduate program in infant mental health that Gil helped to develop and was on the faculty of. That mostly takes place in Garden City on Long Island, and meets one evening per week.

  The University of Massachusetts in Boston has a part-time, post graduate program, the Infant Parent Mental Health Fellowship/Post Graduate Certificate Program, that has an excellent faculty and reputation. Classes are held over a 3-day weekend every other month. Lots of my colleagues in NYC have found this to be accessible and worthwhile even though it's in Boston.

  These are programs that immediately come to mind. There are also clinical programs around the city that take interns and other trainees that could probably support this learning go

Q: Does Medicaid reimburse for ICD 11 complex trauma dx?

- **R:** Yes, ICD 11 lists this disorder as Complex PTSD. Since it is a recognized disorder in this system, Medicaid should reimburse for services for it.

  The complicated part of this is probably obtaining an evaluation that can help the individual qualify as having that diagnosis. There are guidelines for what such an evaluation should include. They are on the website for the NYS Office of Mental Health.

Q: Are there different ways for these traumas to be handled for each child?

- **R:** Although there are standard guidelines in trauma treatment for very young children (for example, that therapy should include the child's primary caregivers, and that it should deal directly with the fact that a traumatic experience has occurred), treatment is individualized to account for the unique circumstances experienced by each individual child. The primary caregiver works with the therapist to develop a "trauma narrative" – the story of what happened - that is accurate, age appropriate and reviewed with the child. Also, the therapist may cultivate a collection of specific toys that provide opportunity for the child to use play to show what happened or to express feelings about. Treatment is, thereby, individualized but occurs within a framework that is reasonably standardized. Child Parent Psychotherapy, for example, has fidelity measures to be sure that clinicians are providing therapy as they are trained to do.

Q: Where I can find and print the screening for early care and education?

- **R:** Ages & Stages Questionnaire and Ages & Stages: Social-emotional are published by Brookes but can also be accessed on-line. The MCHAT (screening for autism spectrum disorders) is available on-line. So is the PHQ-9 for screening for depression in adults.

  The DECA tools have to be purchased from the Devereux Center. The Short Sensory Profile -2 can be downloaded from the internet.

Q: Can you speak to cultural considerations with regard to the parenting types?

- **R:** Culture impacts many aspects of childrearing and family life, such as feeding, sleeping, toilet training, discipline practices, and songs, activities and ways that parent teach children, and play with them. It also affects lines of authority in families, how they understand the problems children present, and how they seek help outside the family, their belief systems, ceremonial practices and gender roles as examples. Understanding the impact of a family's culture is critically important in assessing and working with children and families.

  The initial work on defining children's attachment classifications was actually done cross culturally, including in Uganda. The literature still reflects some discussion and debate about the intersect between culture and attachment research.

Q: Parents are reporting more depressive symptoms for themselves, children and teenagers because of COVID-19 limitations and disruption in family routines; statements such as "feeling trap".

- **R:** This is a very difficult time for everyone, and a disastrous time for too many. By now, with restrictions in place for almost two months, everyone is stressed, and worried, and sometimes even depressed. It's important to differentiate when those feelings/responses are in the typical or expectable range for the circumstances, or whether the response, or behavior, seems excessive, or to require clinical attention.

  This is sometimes particularly hard to discern in teenagers because they tend to be private or confide more their friends than their parents. But with adequate amount of social support, personal resourcefulness and community support, most people will cope adequately and survive this pandemic emotionally and physically. There is a lot of information on the internet now about mental health support, self-care, and ways to cope with this crisis. If there is someone you believe needs clinical intervention, this is still available via tele-health at many clinics throughout the city.

Q: Can the DECA assessment be done on all children or only autistic children?

- **R:** The DECA assessments that I am most familiar with are the DECA-C (for clinical assessment) the DECA – Infant, and the DECA - Toddler. None of these is specific to children with autism spectrum disorders. They are applicable for general populations of children. The DECA-C is particularly helpful when there are concerns about a child's behavior or social emotional

development. We like it because it addresses children's strengths/protective factors, as well as behavioral concerns.

Q: What was the name of that clinical interview-the Crowe?

- **R:** The Crowell Assessment Procedure

Comments:

I suggest adding racism to factors in cumulative risk.

- **R:** I think you are right, Julia. We are increasingly recognizing that racism is a chronic stressor that takes a toll on its victims in all ways – physical health, psychological and mental health, interpersonal, financial, self- image, and world view to name a few. I appreciate your suggestion; I will add this to my notes for future presentations.

I can appreciate this presentation because I grew up in foster care and I was one of the lucky ones to have the same foster parents my whole life. I am a number one advocate for consistency g that one person in a child's life that they can trust. Thank you for the great insight excellent presentation these last 3 days!

- **R:** I am happy to hear that you had a stable experience in foster care. All children should be able to say that, but too few can. So happy to see you are working in the field. Lived experience goes a long way in this work! Thank you!