

# Behavioral Assessment of Baby's Emotional & Social Style Toolkit

Intervention Strategies for  
Developmental Guidance & Support



Karen Moran Finello | Marie Kanne Poulsen



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ISBN: 978-1-938287-52-7

This publication is available for purchase from the California Center for Infant-Family and Early Childhood Mental Health, separately or as part of a customized training program, at [cacenter-ecmh.org](https://cacenter-ecmh.org) and from WestEd at 888-293-7833 or [WestEd.org/bookstore](https://WestEd.org/bookstore).

Suggested citation: Finello, K. M., & Poulsen, M. K. (2018). *Behavioral assessment of baby's emotional & social style (BABES) toolkit: Intervention strategies for developmental guidance & support*. San Francisco, CA: WestEd.

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# Introduction and Overview

The growing emphasis on home visiting by a variety of early childhood-serving disciplines has prompted a need for easy-to-use tools for developmental and behavioral screening and guidance. The *Behavioral Assessment of Baby's Emotional and Social Style (BABES) Toolkit: Intervention Strategies for Developmental Guidance and Support* was developed to assist early childhood professionals in identifying and helping families address areas in which their infants and toddlers, age birth to 3, may be exhibiting problematic behavior. The *Toolkit* will be useful for home visitors, mental health clinicians, early interventionists, pediatricians, and a wide range of other professionals who support infants, toddlers, and their families.

The *BABES Toolkit* is based on the authors'<sup>1</sup> *BABES* protocol, a forced-choice inventory designed as a quick way to examine a parent's concerns about 24 common issues in infant/toddler behavior (e.g., "Difficult to feed," "Difficulty getting along with others") that may be problematic to the child, the parent, and/or the family. For each of these 24 items, the *Toolkit* provides the following:

- Key background information about the specific behavior.
- Probing questions that the early childhood professional should explore if the parents' concerns about the specific behavior are noted on the *BABES* protocol.
- Potential intervention strategies to address the problematic behavior.

When using the *Toolkit*, the early childhood professional is encouraged to "think outside the box" while exploring possible intervention strategies with a family for the behavior in question.

The final sections of the *BABES Toolkit* provide guidance on general ways to support families; suggestions for determining when a referral for more intensive infant mental health services may be necessary; a list of the protocol items that are related to one another and likely have interconnected concerns and strategies; a list of references; and a list of additional resources. The appendices include the *BABES* protocol in both English (Appendix A) and Spanish (Appendix B), a supplemental information questionnaire that captures demographic information and potential risk factors (Appendix C), and scoring information for the protocol (Appendix D).

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<sup>1</sup> The term "parent" is used throughout this document as an umbrella term to refer to the primary caregiver and attachment figure for the infant or toddler.





# The *BABES* Protocol

This *Toolkit* is designed to complement the *Behavioral Assessment of Baby's Emotional and Social Style (BABES)*, a 24-item protocol that helps early childhood practitioners determine the areas in which families need support with their baby's behavior. (See appendices A and B for the full *BABES* protocol in English and Spanish, respectively). Written using easy-to-understand terminology, the protocol is designed to be family friendly and easy to use. For each of the protocol's 24 main items, parents choose between two different characteristics that are most common in their baby's social style (e.g., "Likes to cuddle" or "Rarely likes to cuddle").

**Measuring babies' typical behavior.** All babies have days when their behaviors or temperament deviate from what they usually exhibit. This is common when they are not feeling well or are experiencing some type of distress, or when their typical routine has been changed suddenly. However, the *BABES* protocol does *not* attempt to capture these "odd" days; rather, the protocol is intended to assess the baby's common reactions on "most" days.

**Understanding parent's developmental expectations.** Parents vary widely in their understanding and expectations related to babies' developmental stages. A parent's answers to the protocol questions can help the practitioner understand the parent's grasp of developmental stages so that the practitioner can suggest appropriate interventions that take the parenting practices and beliefs into consideration. For instance, if a parent indicates an expectation that a 10-month-old should be toilet trained, then the practitioner might want to review typical developmental milestones with the parent and help adjust expectations.

For practitioners and parents who need further information about developmental milestones, the authors highly recommend a series of developmental milestone checklists organized by the U.S. Centers for Disease Control, published in both English and Spanish, and available for download at [cdc.gov/ncbddd/actearly/pdf/checklists/all\\_checklists.pdf](https://www.cdc.gov/ncbddd/actearly/pdf/checklists/all_checklists.pdf).

**Identifying the need for further assessment or referral for services.** The maximum possible score for the *BABES* protocol is 48, with a higher score indicating more problematic behaviors. The protocol cut score indicating a need for further assessment and/or referral for services is 36 (see Appendix D for information about how to score the protocol). However, the *BABES* protocol also allows for parent referral based on high needs related to a single item or concern. For instance, if a parent is extremely concerned that the baby cries incessantly, dislikes contact with people, or has a particularly problematic behavior for which the family would like help, further support and intervention is warranted even if the child does not meet the cut score criteria for further assessment and referral.

The *BABES* protocol was developed as a screening tool, not as a formal assessment instrument. As such, it should be used to guide the development of interventions and to open discussions with parents about their baby's development and behavior, the qualities they like most about their babies, and the issues that are troubling to them.

## Sample Research Studies

The *BABES* protocol has been tested and vetted in multiple studies and has been shown to be an effective tool for gauging parental beliefs about their children's behavior. Several formal research studies evaluated the utility of the *BABES* protocol and the most common concerns reported when it was used with families. These studies resulted either in conference presentations or reports within larger studies. Summaries of several of these studies are presented below.

In addition to formal research examining the *BABES* protocol, many providers have used the instrument in clinical programs in hospital settings, child abuse prevention programs, developmental follow-up programs, and home visiting programs as a mechanism to evaluate parental expectations and to provide developmental guidance.

### Original Standardization Sample (Finello & Poulsen, 1996)

Preliminary standardization data were gathered from 15 programs throughout California. Data were examined for 138 children between birth and 36 months of age. In the sample, 44.5 percent were Latino; 28.9 percent Caucasian; 8.6 percent African-American; 3.9 percent Asian; 6.3 percent mixed race; and 2.3 percent identified as "Other." Screening forms were completed in English for 66 percent of the sample and in Spanish for 44 percent. Mean educational level of mothers was 10.3 years (s.d., 3.85, range 0–15). Fifty-eight (58) percent of the children were boys, 37.6 percent were first-borns, and 35.2 percent were second-borns. Mean score for the sample was 26.48 (s.d., 6.41, range 9–45). The behaviors rated most frequently by mothers as problematic included inability to handle upset (37.5 percent), activity level (35.2 percent), temper tantrums (29.7 percent), toileting problems (28.1 percent), whining (25.8 percent), and jumpiness (25.8 percent). Although only 6 percent of the sample met the cut score for referral, 24 percent self-identified as having problems with their child for which they would like help. Of those mothers who identified a problematic behavior that occurred several times per week ( $n=25$ ), 48 percent indicated that they would like help in dealing with the behavior. Neither birth order nor sex was significantly associated with frequency of problem behaviors or a parent's request for help. Typically, young children with milder and fewer problems require less intensive interventions, and the cost of such preventive interventions designed to avoid the development of more serious behavior problems can be minimal compared to the cost of mental health treatment later in life.

### Early Head Start Sample (Shilling, 2001)

Thirty-six (36) teen mothers whose young children were enrolled in an Early Head Start Program participated in this study. All of the mothers had been identified as being in need of intervention to support the parent-child dyad. Mothers completed both the *BABES* protocol and the Parent Stress Index-Short Form (PSI/SF; Abidin, 2012). A Cronbach's Alpha analysis indicated high internal consistency across all items on the *BABES* protocol ( $\alpha=.84$ ). There were significant correlations found between the *BABES* and PSI/SF Difficult Child subscale ( $r=.54$ ) and Total Stress scale ( $r=.44$ ). Shilling provides a method to adjust scores for younger infants when the mother leaves them blank because they are not relevant for the age of the child. This can be useful for agencies relying upon a strict cut score for support and referrals, although the authors of the *BABES* do not recommend sole reliance upon cut scores.

**Shilling Age-Adjusted Scores:** Take the total score, divide it by the number of items answered, and multiply this number by 24 (total items on the *BABES* protocol) for an age-adjusted score. For example, a parent answers 20 items and the child's score is 32; 32 divided by 20 is 1.6. Multiply 1.6 by 24 items on the *BABES* protocol. The adjusted score is 38.4.

## California Infant Preschool Family Mental Health Initiative (2003)

The *BABES* protocol was completed for 65 young children who were in the Clinical Services Study sample of this project. Eighty-one (81) percent of the mothers indicated that their child had a problem behavior for which they would like to receive help. In this sample, the mean *BABES* score was 31.55 (range 19–45). A correction was done for missing data; the corrected means were 32.34 (range 24–45). Seventy-five (75) percent of the scores were below the clinical cut score of 36 regardless of score correction. Forty-seven (47) families completed the *BABES* protocol following mental health intervention. There was a slight but significant decrease in the *BABES* score from pre- to post-test (mean post-test score=29.98,  $p=.04$ ). There was also a significant decrease in the number of mothers indicating that they needed help with their child's behavior (from 79 percent to 59 percent).

## Comparison of the *BABES* and DECA Scores (Chon, Liberatore, & Tomazinis, 2006)

To examine construct validity, archived records were examined from a mental health program at Children's Hospital Los Angeles for 99 children with data on both the *BABES* protocol and the Devereux Early Childhood Assessment (DECA). Mean total score on the *BABES* for this clinical sample was 32.48 (s.d., 4.65, range 23–44). A negative relationship was found between the *BABES* and DECA protective scores for Initiative ( $r= -.44$ ,  $p< .01$ ), Self-control ( $r= -.52$ ,  $p< .01$ ), and Total Protective Factors ( $r= -.402$ ,  $p< .05$ ). A positive relationship was found between the *BABES* scores and DECA Behavioral Concerns ( $r=.493$ ,  $p< .01$ ). A factor analysis indicated three interpretable factor structures with principal components analysis with VARIMAX rotation: 1) interaction with others (items 11, 13, 15, 19, 22, 24); 2) emotional regulation through self or others (items 2, 5, 6, 7, 8, 21); and 3) physical regulation (items 3, 4, 10, 17, 18). Factor 1 explained 13.75 percent of the variance, Factor 2 explained 13.0 percent, and Factor 3 explained 10.84 percent. The authors concluded that the *BABES* protocol may be relied upon as a valid screening tool that is simple to use and effective.



# Issues to Consider When Using the *BABES Toolkit*

The *BABES Toolkit* is intended as a practical resource that early childhood professionals can use during home visits or consultations with families in order to learn more about particular problematic behaviors and how to address them. The *Toolkit* can be used as a complement to the *BABES* protocol or as a general guide on its own. A variety of issues should be examined whenever a parent reports concerns about behavior in a very young child. Most importantly, when a parent identifies a problem as being of concern, it should be respectfully addressed — regardless of whether the child's behavior would typically be considered problematic by a professional or whether the score on the *BABES* protocol meets the cut point for referral. Understanding why an issue may be troubling or impacting the parent and family is important.

All developmental and behavioral screening processes should involve identifying and carefully considering the parent's concerns as well as observing the young child in multiple settings. In order to formulate appropriate intervention strategies, it is also essential to pay attention to the baby's current developmental level and to consider a variety of factors that may be influencing the baby's behavior. This section describes various issues to keep in mind when observing families, talking with parents, and identifying potential interventions.

## Factors That May Impact Behavior

Some key factors that can influence a baby's behavior include temperament of child and parent, living arrangements, sensory concerns, sudden changes within the family structure or home, and goodness of fit between the child and the environment, which includes the home environment, early education environment, and child care environment.

### Developmental Delays

An important consideration in understanding a young child's behavior is development — a child who is developmentally delayed cannot be expected to function behaviorally beyond his developmental level. If a 2½-year-old is functioning at the 12-month-old level, behaviors will likely mirror those of other 12-month-olds and not those of other 2½-year-olds. This can be difficult for a family as social pressures, stigmas, and specific behavioral expectations may be attached to the child's size. Helping a family understand development across all areas, not just cognition, is important.

### Traumatic Events

Young children who experience traumatic events — or events that they view as disruptive, such as the birth of a new sibling — may exhibit regression in their behaviors. For example, a 3-year-old who has been successfully potty trained and has been using a cup for almost two years may suddenly start

wetting herself,<sup>2</sup> wanting to be in diapers again, and asking for a bottle instead of a cup shortly after the new baby sibling comes home. Another 3-year-old may show these behaviors following parental separation, a move, or the death of someone important in her life. It is critical that all events around the time that problematic behaviors began (“antecedent events”) be examined to better understand what may be causing specific behaviors and how to intervene.

## Temperament

Temperament is a further consideration in understanding a young child's behavior and the parent's reaction to the behavior. The temperament of both the child and parent should be considered as the interaction between them is influenced significantly by what each brings to the interactions. Temperament was first described as a construct by Thomas, Chess, and Birch in 1968, although the dimensions included had long been noted by mothers.

Various dimensions important to temperament may play a significant role in how a child responds to a variety of situations. For example, a child's sensitivity to stimulation can impact how she cuddles, a child's adaptability can influence how she handles change, and a child's activity level and distractibility can be connected to how long she plays with one toy and how long she can stay in one place or sit still. Temperament may also influence which signals the baby uses to express positive and negative emotions, and how the baby experiences her environment.

In addition, temperament influences how a parent responds to a child's behavior. For instance, a parent who has a very active personality (or “temperament”) may have difficulty dealing with a baby who is very quiet and slow to warm up. Therefore, it is important to ask questions about both the young child's temperament and the parent's in order to look at the goodness of fit between them.

Important notions addressed in the construct of temperament include nine dimensions as described by Thomas, Chess, and Birch (1968):

1. Activity level
2. Regularity of biological rhythms
3. Approach/withdrawal in new situations
4. Adaptability
5. Intensity of response
6. Sensitivity to stimulation
7. Predominant mood
8. Distractibility
9. Persistence

Psychologists cluster the temperament dimensions into types, or categories, described as “easy” (or “flexible”), “slow to warm up” (or “fearful”), “active” (or “feisty”), and “mixed.” Research indicates

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<sup>2</sup> In the interest of inclusion and gender non-discrimination, the authors refer to babies and toddlers alternatively in both the masculine and feminine.

that about 40 percent of children fit into the easy, or flexible, group; about 15 percent fit into the slow to warm up, or fearful, group; and about 10 percent fit into the active, or feisty, group. The remaining children show mixed characteristics.

## Sensory Responsivity

Sensory responsivity is another important consideration when examining infant/toddler behaviors and developing possible interventions. A child may be hypersensitive, demonstrating excessive reactions to situations and events, or hyposensitive, not reacting enough to events. If a child's responses are in either range, specific types of supports and interventions may help and others should be avoided so that responses are not exacerbated. In extreme cases, the support of an occupational therapist trained to work with infants and toddlers may be needed.

**Hypersensitivity, or excessive reactivity,** can contribute to many areas in which problems are reported by parents, including cuddling, crying, feeding, sleeping, fussiness, startle responses, and tantrums. In general, hypersensitivity includes sensitivity to such things as close holding, light touch (tickling feelings), and certain clothing fabrics and labels; overreactions to sounds, light, smells, and environmental changes; food sensitivity related to textures (e.g., lumpy foods, crunchy foods), hot/cold food, or mixtures of these; hyper-cautiousness in new situations; and discomfort with changes. This hypersensitivity can create difficulties in providing care as the infant/toddler may demonstrate that he is upset through crying, tantrums, and other angry outbursts, and the parent may have difficulty linking the behaviors to the child's discomfort.

**Hyposensitivity, or underreactivity,** may lead to infants and toddlers being slow to engage in activities such as interactions and play with others, engagement with new toys, and entry into new situations. Sometimes young children seem to show a lack of interest in the world around them, including interest in people and toys. They may withdraw to contain their feelings, prefer to play alone, and not be able to engage others without their parent's support.

## Household Environment

A range of environmental factors may also influence both behavior and caregiving. These can be as simple to understand as household size and composition or as complex as caregiving arrangements involving multiple households, differing child expectations, and differing parenting practices and beliefs. Cultural practices and beliefs are interwoven into all of these factors and must also be considered.

Households may be composed of two committed parents living in a three-bedroom house of their own with one child; a single unsupported mother living with a childless aunt in a spotless two-bedroom adult-designed apartment; a single father living with his parents, four siblings, and his two children under age 5 in a three-bedroom house; a couple with an extremely irritable premature baby living with a friend who works a night shift and sleeps during the day when the baby is awake; or any number of other household and living configurations. Each size and composition presents its own challenges in examining antecedents of behavior in the young child, why a parent is using specific consequences for certain behaviors, and why certain interventions may not work for the family.

## Cultural Beliefs

Cultural beliefs and parenting history play a major role in child rearing and parenting expectations. For example, in many cultures, children are expected to share their toys and other belongings from an early age — often, this is before developmental specialists would expect young children to be able to share. In such cases, it is important to respect and address the parental concerns and expectations of their child's behavior, even while understanding that such behavior may not fit within standard developmental milestones. Thus, any discussion of young children's behavior must include a conversation about the beliefs and practices of the parent(s) and other adults living in the household. If any of these practices are harmful, they must be addressed despite cultural beliefs. However, if the practice is not harmful but it does not seem to be working well with the child, it can be useful to partner respectfully with the parent to figure out why the practice may not be working and to strategize about alternate solutions.

## Parenting Practices

Parents differ in how they raise their children, and there is no “right” or “wrong” way to parent. The following are two of the main approaches to parenting:

- **Infant demand** (also called attachment parenting or proximal care) refers to parenting that aims to be responsive to infant needs at all times — including feeding quickly, responding immediately to cries, and holding and sleeping with the baby.
- **Structured care** refers to parenting that involves structured routines such as feeding and putting babies to sleep at regular times.

These are both parenting approaches rather than adaptations to changing infant needs and competencies. The reality may be that some forms of parenting are more effective than others during different developmental periods and may depend on how easily babies complete developmental transitions. Newer research (St. James-Roberts, 2007) looks at parenting as either an “external regulatory environment” for infant regulation or as a “scaffold” to support an infant's own learning. Clearly, these two concepts do not cover all aspects of parenting but do allow measurement of effects.

- Studies indicate that proximal (infant-demand) styles of parenting are associated with low amounts of fussing and crying in the first three months and with night waking that continues beyond three months.
- Structured parenting leads to more overall fussing and crying in the first three months, but less night waking and crying after that.
- No differences seem to exist by parenting style for infants with unsoothable crying (which may be due to neurodevelopmental processes rather than parenting style).
- Structured parenting does seem to prevent infant sleep problems by providing learning “scaffolding” for sleep patterns and settling at night. Infants who experience structured parenting remain settled throughout the night at earlier ages.



## When Is a Referral Needed for More Intensive Infant–Toddler–Family Mental Health Services?

There are times when the issues reported by the parent are due to her own interpretation of the world and may stem from serious psychopathology or dysfunction. The parent may have diagnosed but untreated mental health concerns or may have serious mental health concerns that have never been diagnosed. In addition, due to the stigma around mental health treatment, many individuals who could benefit from mental health services refuse such services. Infant–family and early childhood mental health specialists often see parent–child dyads for treatment when the parent would never seek treatment on her own. Referrals on behalf of the baby are commonly accepted by parents who are eager to do what is best for their young child, and great progress is often made, sometimes leading to individual therapy for the adult. If a parent's belief systems or expectations are the concern, and the parent is resistant to the concept of mental health services, discussion about referral to a specialist who will focus on the baby with the involvement of the parent should definitely occur.

In other cases, developmental and family interventions around an issue of concern may not be sufficient to treat the problem. If intervention has been tried for a significant length of time without change, referral to a competent specialist in infant/toddler mental health should be made.