The Alarme Distress BaBy scale (ADBB)

USER MANUAL

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The Alarme Distress BaBy scale
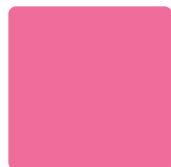## The scale consists of 8 items, rated from 0 to 4.

FACTORS

Tempéramental items

Relational items

Mixed items

ITEMS

(1) Facial expression

(2) Eye contact

(3) General level of activity

(4) Self-stimulation gestures

(5) Vocalizations

(6) Briskness of response to stimulation

(7) Ability to initiate and maintain a relationship

(8) Child's ability to generate and sustain attention

① Facial expression

It is the reduction of facial expressivenessthat is assessed here. The range of facial expressions is more limited in very young children (2 months), but it can be evaluated.

Most children show three emotions at two months of age (Interest, Consent, Distress) and seven emotions at seven months of age (Joy, Satisfaction, Anger, Disgust, Distress, and Sadness), (Izard et al, 1980).

The greater or lesser difficulty in obtaining and maintaining eye contact is assessed in this item.
Even in a very young child, it's generally easy to get a visual contact and the child usually looks for it.

Picture by Colin Maynard from Unsplash
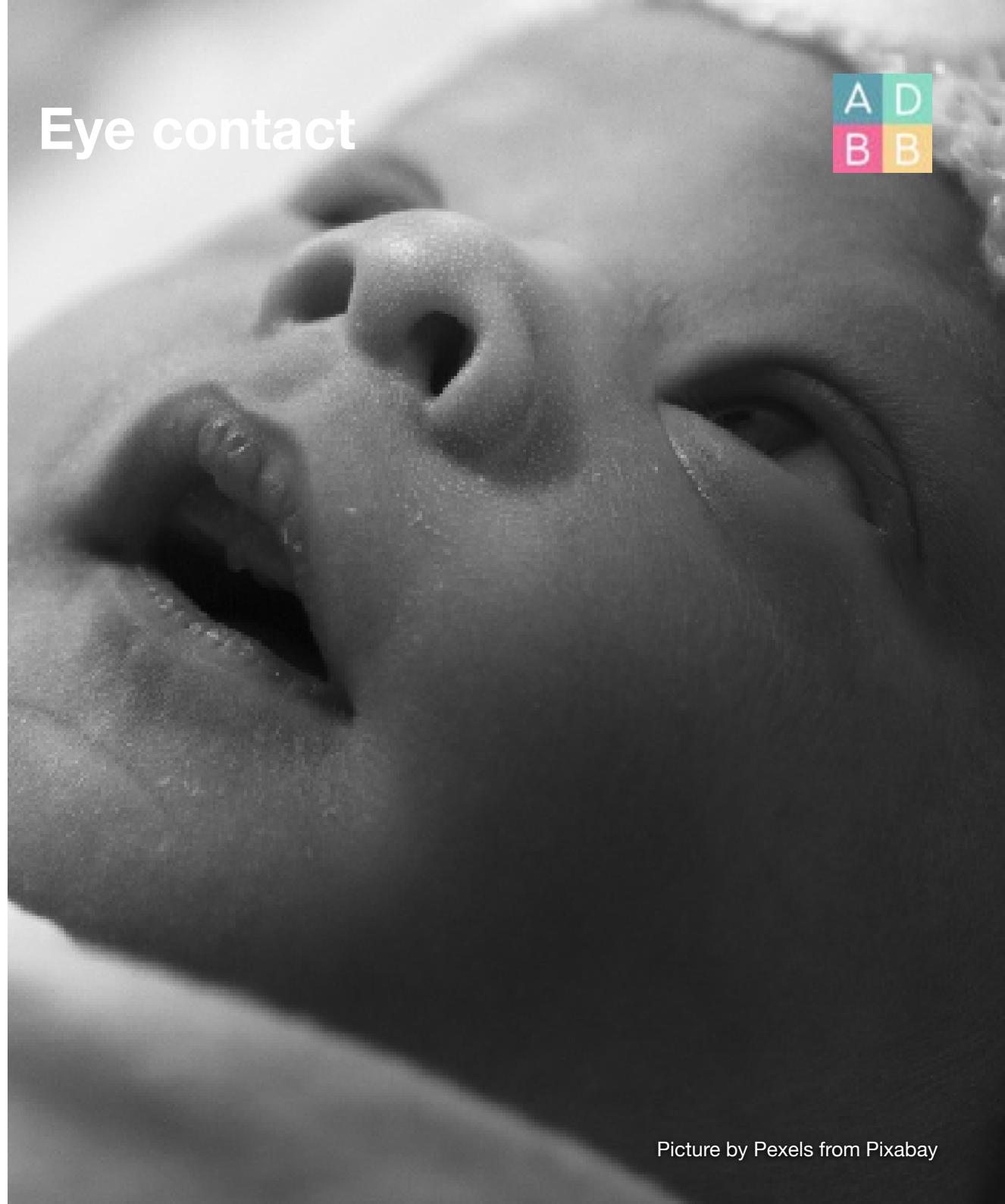
③ General level of activity

It is important, for this item, to focus only on the movements of the head andmembers, without taking into account those of the hands and fingers. This is because a child may remain motionless and yet have automatic hands and fingers movements, which will be considered in item 4, Self-stimulation.

Most children move around, even though very young children can remain still for a few minutes and even if they usually move by periods.
However, movements often occur spontaneously, or after stimulation ; the observer then notes the movements of the head and eyes, and those of the members.

Self-stimulating gestures

Self-stimulation, is the most difficult to use at first.

Self-stimulation is evident in high-risk populations (orphaned children, children very developmental delay, some non-organic failure to thrive), but it is generally low in non-clinical populations. It should also be recognized that this item has some development with age and that self-stimulation becomes more evident with age.

Training with video documents helps to see what exactly is meant by gestures of self-stimulations, or self-centered gestures.
Any repetitive gesture, which seems separate from the general activity is to be taken into account in this item.
Any activity that does not seem to give pleasure to the child or does not seem to calm the child can be considered auto-stimulation or self-centered.
A child who sucks his thumb-in a regressive movement that seems appropriate and pleasant in context is not considered as a self-stimulation.

It should be noted that the presence of a single clear self-stimulation gesture issufficient to score 1 on this item, while the other items (with the exception of the relationship item) score on the overall observation situation. But if in doubt, please mark 0.

Picture by Jonathan Borba from Unsplash

This item is also complex to rate because it is the quantity of vocalization that is first evaluated, before its positive or negative aspect (pleasure or displeasure vocalizations), and its evolution, but these three aspects (quantity, quality, evolution) will be taken into account to rate this item.

This item will be rated more positively if the crying stops quickly, and if the vocalizations are positive.

A child who screams constantly, or more than 80% of the time, cannot be scored, and will have to be reviewed. This is also the case if the child is very sleepy, has a fever, has an acute neurological deficit, is hungry or needs changing. After a meal or change, observation can be resumed, and the meal or change can even be used as a cotation situation).

But the maximum rating of the vocalization item is reserved for the child who remains silent, who says nothing, does not emit a sound, even in case of painful stimulation, for example an injection for a vaccine.

Finally, we take into account the way vocalizations evolve as the observation progresses.

Picture by Jenny Friedrichs from Pixabay
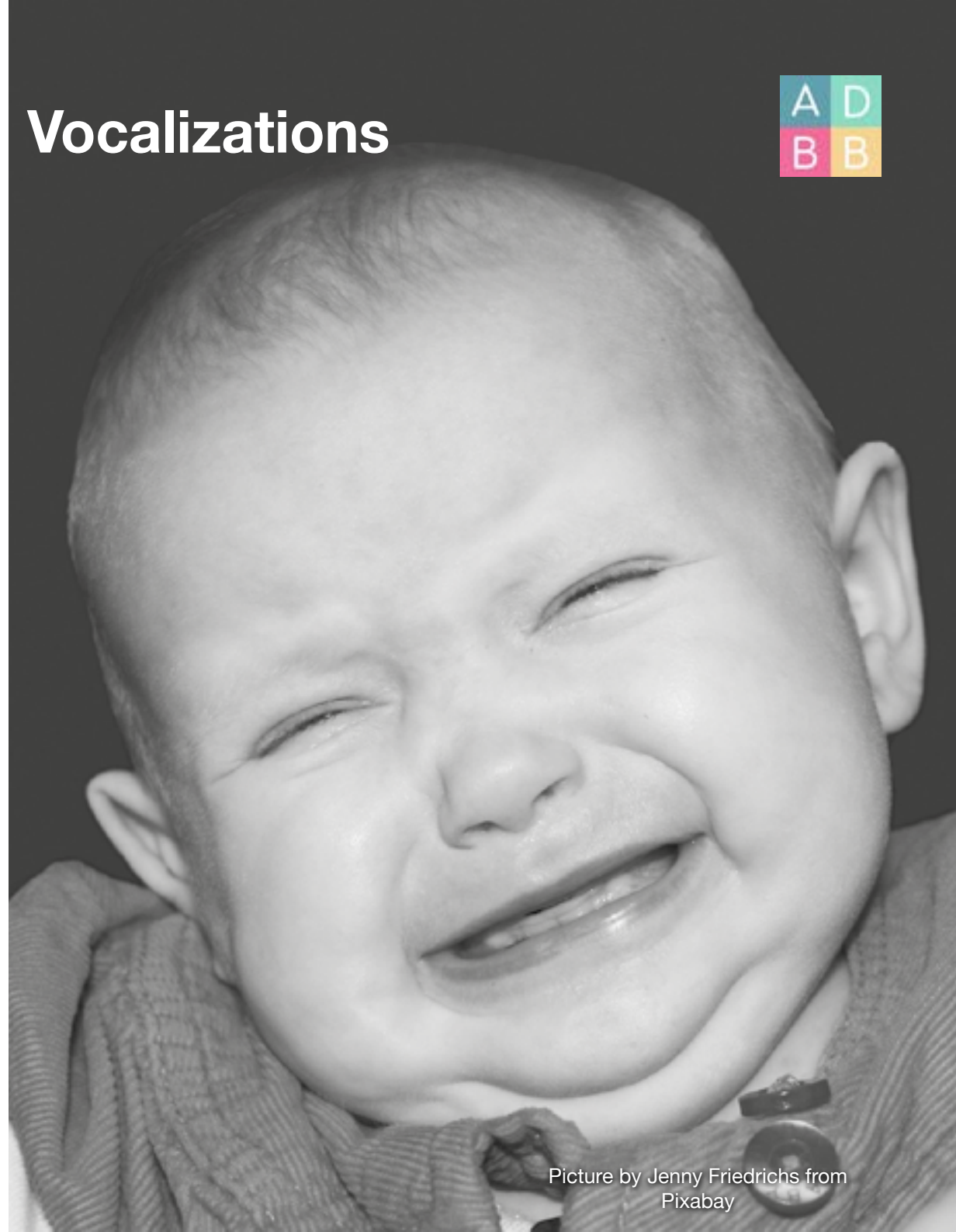
Briskness of reaction to stimulation

The vivacity or speed of the response is measured by the delay between stimulation and response.

Is there a feeling of delay in responding?

It is very important to pay attention to each stimulation that is given to the child (looking at him, talking to him, touching him, responding to auscultation, measurement, examination of the ears, a injection). It is therefore necessary to be prepared to evaluate this speed of response to stimulation, without which this information will be lost.

The key point is that it is the delay (or lack of delay) in response that is assessed here, not the magnitude of response to stimulation.
And for this reason, the vivacity of the response cannot be assessed in the absence of any response.
The maximum can only be rated (absence of any response if the stimulation is to lead to an expected response, e.g. a shot).

Otherwise, the absence of a response cannot be equated to a withdrawal. In very young children, the reaction to strong stimulation, such as the introduction of an otoscope, can lead to brief freezing reaction.

The reaction to stimulation can also be very subtle at this age, and is limited to a blink.

Picture by Bennet Robin Fabian from Unsplash

Ability to engage and maintain the relationship

The assessment of how the child accepts to engage in the relationship with the observer and/or clinician is done without considering the relationship with the parent.

Does the child engage in a relationship and support it?
Is this relationship barely established, through eye contact, or does it develop during the examination?
Does the child take the initiative?

Again, the existence of a relationship is more important than whether it is «open» or «closed», positive or negative.

An anxiety towards a stranger is in fact a proof of relationship, with a mixture of attraction and fear. The evolution of this capacity to enter into a relationship over time must again be taken into account.

Picture by Lawrence Crayton from Unsplash

⑧ Attractivness

This last item is not a judgement on the charmor physical appearance of the child.
It measures the effort or lack of effort that the observer must make to maintain his or her attention on the child throughout the examination.

Children without withdrawal easily attract attention, and arouse a feeling of pleasure, without effort or concern on the part of the observer, from the beginning to the end of the observation, the child remaining in the centre of general attention, because of their initiative and their quality of contact.

With others, we are first attracted, then we realize that this interest does not last, and that we must make an effort to keep our attention on the child. Elsewhere, in front of a child in withdrawal, the observer may feel a lack of pleasure in the contact, or even feel held at a distance by the child.

To evaluate this item, it may be important to take into account one's own subjective feelings of the length of the observation, of the slow passage of time and that nothing happens, which is the case when the child is withdrawn; on the other hand, a child without withdrawal gives the feeling of an easy, pleasant observation, to follow a small story.

Picture by Colin Maynard from Unsplash

Important point

All items, except 4, Auto stimulation, are evaluated on the whole observation: the score on each of these items is therefore an average, which means that the whole examination is taken into account, and compared towhatis expected of a baby in this situation, in this cultural context, and at this age.

How to score ?

Each item is rated from 0 to 4. It is important to keep in mind the meaning of the 5 possible ratings, summarized at the top of the scale. If you are uncertain between two items, you should refer to them, rather than looking for the definition of the item that «fits» best.
- 0 = means completely normal.
- 1 = means slightly abnormal.
  If in doubt, select 0.
- 2 = means clearly abnormal.
- 3 = means very clearly abnormal.
- 4 = means massively abnormal.

We thus choose the rating of each item by deciding between 0 (surely no problem with the item), 1 (very discreet but present), 2 (net), 3 (obvious), 4 (massive).

In case of doubt, we do not rate 1 (which would give a total of 8 if we gave 1 to each item), but 0. All items are totalled and an assessment is made as to whether the result is consistent with the overall assessment:
- 0-4 : below threshold,
- 5-7 : slight clear withdrawal,
- 8-10 : net withdrawal,
- 11 et plus = Above 15 obvious withdrawal.

How to do it in practice ?

It is not necessary to memorize the scale ; it is not necessary to keep each item in mind when evaluating a child. On the contrary, it is important and sufficient to maintain your usual attitude during a clinical examination or observation.

However, it may be useful to quickly note some reactions, such as self-stimulation gestures, vocal reactions, or responses to a stimulation, as these elements are important to evaluate items 4 (self-stimulation), 5 (vocalizations), 6 (briskness of response to stimulation).

It is essential to retain your judgment until the end of the examination, and not to constantly seek to confirm your first

impression.

The rating is best done immediately after the observation or consultation. The scores are then selected, using the scale.

The «film» of the observation must then be replayed, taking into account all that was witnessed, with particular attention to what changed during the examination, in one direction or the other.

A child who is slow to set off can appear very withdrawn at the beginning ofthe observation, and be very open at the end: such a child will be rated as not withdrawn.

On the other hand, the attention paid to the development of things will make it possible to realize that a child who seems very present at firstsight remainsin fact on the same register, and showslittle diverse emotional reactions. Also check that the withdrawal is stable over time and repeat the assessment one to two weeks later.

You can rate the different items in the order you want; it is good in practice to rate the easiest itemsright away: items 3 and 6 for example, then self-stimulation, then the itemsmostrelated to the relationship (7 and 8), then those that are also related to temperament factors (facial expression, vocalization).

It must be realized that the scale is little more than an aid to observation. But the score reflects an interpretation of the child's behaviour in a given situation by the observer. It is therefore important to think about what we think about the child's behaviour.

It is suggested to start by putting a note at each item, first. Then, we look at the total score obtained, and we decide if we think that the child's behaviour is generally normal, below the threshold, or if there is a moderate, clear, or massive withdrawal.

We then return to each item, we adjust the score of each item and we make the total.

Picture by PublicDomainPictures from Pixabay

How long should the observation be ?
What types of situations can be used ?

This observation al sample should be long enough, but not too long,so that the child is allowed sufficient time to warm up or to calm down, and show the display of his/ her affective reactions in the situation.

Literature suggests that the best chunk of time to work with is about 10 to 15 minutes.

The situation of observation has to be as structured as possible,so that comparison between children becomes possible.

Routine pediatric examination, be it by a nurse or by a pediatrician or a general practitioner is well fitted for assessing withdrawal behavior, since it is quite structured, with a lot of quite strong stimulations in a brief period of time and done more or lessthe same way everywhere in the world.

The inconvenient of this situation is that some infant learn quickly about it and may appear withdrawn, at least at the beginning of the examination, just because of the fear of being examined.

Some other situations are possible: developmental testing (Bayley, Brunet-Lézine, or any validated developmental testing), feeding situations (Feldman & al), Murray & Fiori Face to Face situation, Ainsworth's Strange Situation, free play situations, Crowell assessment situation, use of strange toys, or even home videos.

Should the child be assessed with her mother ?

The assessment isthe one of the child within his her relational environment.Most ofthe time,the child isseenwith hermother, being her his main caretaker.
Therefore, one has to realize that any assessment of the withdrawal behavior will be made within this relationship. If a child shows withdrawal behavior within this relationship, it will be important to check if this is true within other relationships as well.

Is there any influence of age of the child in the assessment process ?

The scale has been designed to avoid using items that show dramatic changes with development, as development is so intense within the firststwo years oflife.However,withdrawalis

not assessed without a context, and therefore depends on the stimulation and on the environment. In fact, even if the 8 items of the scale are fairly stable with development, they in fact show some developmental changes.

This means that assessment is made within an age frame, so that the reaction of the child is compared to what is expected at this particular age. Face expression has a limited range in children aged 2 to 4 months,for example, whereas eye contact is already quite good at that age, if the examinator stays within the adequate distance.

Picture by Obel Esquivel from Unsplash

Which is the cut off score to be used?

4/5 is the cut off score found in several studies (Paris, Tampere, Brazil, Israel). This means that 4 is « normal » and that 5 is « withdrawn ». This cut off score of 4/5 is to be used for research, whereas a higher cut off, 5/6 is to be used for clinical purposes/ 5 meaning « non withdrawn » and 6 meaning « withdrawn ».

What is the signification of scores over the cut off ?

Recently high scores on the ADBB (indicative of withdrawn behaviour) have been show to be associated with less optimal interactive behaviours by both the mother and her infant in a Finnish study on 127 two-month-old infants (Puura, 2004) using Fiori's GRS scales, and in an Israeli study on 97 7 to 38 months old infants (Dollberg, 2004).

The original paper (Guedeney & Fermanian, 2001) shows the ADBB scale to have good psychometric properties on a sample of sixty infants in France, aged between 2-24 months. Good inter-rater reliability was found between raters using it during live (as opposed to viewing the videotape) assessments and an expert's rating. Inter- rater reliability, as well as acceptable test-re-test reliability (rs = 0.91, one month interval), have also been demonstrated in a Brazilian study (Lopes, 2004).

A total ADBB cut-off score of 4/5 was found to be optimal in detecting those infants considered to have unusually low social behaviour. This optimum cut-off score has recently been replicated in both a Finnish study (Puura, 2004) and a Brazilian study (Lopes, 2004).

Thus a score of 1 on only five of the eight items is sufficient to indicate possible sub-optimal social behaviour.

In a Parisian sample, infant look more fretful than Brazilian infants of the same age, who also look more mature.

The finding of the same cut off score in 3 different cultures please for some transcultural validity, but in each country, the scale has to be re-validated and the cut off score re-established.

Is there any influence of culture ?

So far, withdrawal behavior in infants aged 2-24 months of age seems to be independent of culture. Babies in the normal range of social behavior, well fed, clean, awake and without fever or any other usual cause of withdrawal, do not seem more withdrawn in a particular cultural setting than in another. Assessments have been made using the scale in Armenia, Australia, Brazil, Finland, France, Italy, Spain, Portugal, Netherlands, Israel, Ivory Coast, without yielding any clues asto cultural differences. The differences are found between high and low risk samples, and not between cultures.

However, infants do not look the same at the same age in different countries. Infants of same age but from different cultures were assessed one after the other, the dispersion of ratings between blind raters would probably be greater than if different infants of the same age but of the same culture were assessed by the same judges.

What is the range of age to use the scale ?

Initially, the scale was validated on a sample of 2 to 24 months old infants. This was done to avoid any discussion about prenatal influences on the withdrawal behavior of very young infants(Cioni& al, 1997). The scale can be used from day one till the beginnings of language, where it looses much of its interest.

However, it is clearly easier to say that an infant aged a few days to 2 months is not withdrawn than to say the infant is withdrawn. Validation of the scale in this age range is still to be done.

Picture by Алеся Фартушняк from Pixabay

Is the scale to be used with prematures ?

Correction for age is to be applied with premature, when assessment is made with the scale, so that the correct behavior is expected from the infant at that age.

Factor analysis

The original paper (Guedeney & Fermanian, 2001) shows the ADBB scale to have good psychometric properties on a sample of sixty infants in France, aged between 2-24 months. Factor analysis, using the criterion of factor loadings of 0.5 or more, identified two factors accounting for 63.6% of the variance - an interpersonal factor (five items: eye contact, level of activity, self-stimulating gestures, relationship, attractivity) and a non- interpersonal factor (3 items: facial expression, vocalization, response to stimulation), with one complex item (response to stimulation) loading greater than 0.5 on both factors (but with the authors deciding to put it under the non-interpersonal factor).

The authors of the scale recommend that further studies investigate this factor structure. This has been done in a Brazilian study on 90 infants aged between 0 and 2 years (Assumpcao, Kuczynski, Da Silva Rego, & Castanho de Almeida Rocca, 2002). This study found four factors accounting for 63.5% of the variance. While the authors specified the factor loading criterion of 0.5, examination of the data reveals that all non-included items had loadings of less than 0.3, which is the usual criterion used in factor analysis (Child, 1990). Factor 1 consisted of facial expression and level of activity; factor 2 of eye contact and response to stimulation; factor 3 of self-stimulating gestures and the relationship to the observer; and factor 4 of vocalisations. There were no items loading on more than one factor recent confirmatory factor analysis was made with a FrenchCleft palate syndrome infants assessed with ADBB and m-ADBB at 4 months and 12 months. Scores with the MADBB closelymatched the oneswith the Fullscale. The FA showed the same 3 dimensions solution than in Brazil, with temperamental items being thought to be facial expression, activity, vocalization; the relational ones being eye contact, relationship and attractivity, the third on being loaded with item 6, reaction to stimulation and self-stimulation. This solution makes sense as the 4 and the 6 items are clearly both temperamental and relational. In this sample the FA with m ADBB confirms the clear two dimensions solution. Further Brazilian study will show what is the structure of the scale in ASD children.

What is the difference between social withdrawal behavior and temperament ?

While measurement of the infant's temperament may have some overlap with his social behaviour, it is important to realise that

these two constructs are separate. Temperament refers to the infant's degree and style of responsiveness to varying internal and external stimuli (e.g., noise, heat, as well as social stimuli), whereas social behaviour in infancy refers to degree and style of responsiveness just to social stimuli. Thus while an infant may, within temperament measures, be considered « shy » or « slow» to warm up to others, he will still be responsive to the adult. A socially withdrawn infant however will lack many of the features of responsiveness to others.

Why is withdrawal behaviour assessed with a stranger observer, the nurse or the pediatrician, and not with the mother or caretaker ?

One advantage of assessing an infant's social behaviour with a comparative stranger, rather than with his parent, is that it does not put the parent under any perceived pressure. Within a clinical setting, such as a hospital or early childhood clinic, to ask a parent to « playwith their infant » and for the clinician to assess the resultant infant social behaviour would undoubtedly make parents feel anxious, and possibly unwilling to visit such centres if they felt their competence was being assessed.

A scale that therefore neither requires special apparatus, nor a special sequence of prescribed interactions, and which does not require the parent's active interaction with the infant, could be considered by clinicians interested in assessing the infant's social behaviour as being more desirable.

What is the standard error of measurement with the scale? How to yield good assessments?

The validity of the assessment depends on the quality of attention from the observer is demanding, and one cannot expect to assess at more than 4 infants during one session. It is important that the observations are done on a healthy, fed, cleanly diapered child. It is very important not to take into account any information that is given during the examination or what one may know of the infant or the family situation. What is observed here ? And now is what is important ?
Otherwise, one tend to bend the assessment towards what one knows about the family or the situation: the withdrawal of an infant is not properly assessed, because one does not want to add to the mother's burden, for example.

Clinical use ofthe scale showsthat withdrawal froma relationship by the infant is not an accident due to events during the day or the night before, butthatitis already a reaction in the child facedwith a situation that challenges his/her ability to adapt.
The ADBB scale is used to identify withdrawal early enough to look for a cause and intervene, since ongoing withdrawal is in it self hampering the infant's development.

Translations of the scale

Several translations of the scale have been made. Check with the website to see if there is one already made in the language you are interested in. Translations into English, Armenian, Spanish, Catalan, Italian, German, Hebrew, Dutch, Portuguese (Brazil) and Portuguese (Portugal) are already available and can be loaded on the website.

How to train with the scale ?

To train with the scale, one has to get in touch with one of the regional training supervisors, whose address and e-mail can be found on the website, or through Antoine Guedeney (antoine. guedeney@aphp.fr) and with Martine Vermillard, with Pr Jaqueline Wendland Phd or Dr Sylvie Viaud Savelon MD PhD.

In Europe training can be also obtained with Dr Kaija Puura, MD, PhD (Tampere University, Finland); with Alexandra Deprez Phd in Luxemburg and Belgium in Israel with Daphna Dollberg; In Australia, with Stephen Matthey, PhD, Sydney, or with Clara Bookless, Ph D, Adelaide, and in Brazil with Dra Simone Lopes, MD, Belo Horizonte.

Training with the scale supposes that you agree with the requirements, which are to allow for A. Guedeney to have access to the use you intend to do with the scale and to the data which are produced through this use. These data may be useful to further developments and validations of the scale.

Training is accomplished through videos, which are available through the supervisors (see list over or on the web site). Training is best accomplished as a team of two, or in a small group, which helps discussing and permits a clinical team or a research team to reach agreement on the tapes. The level of required interrater reliability depends on the goal of the training (research or clinical use).

Generally, everyone has to look several times to a first set of 5 situations (Paris I), and try to score each of these situations using the scale. As for any close look on infant videos, it is recommended to look at each situation several times, on a normal pace and also using fast forward and backward; this helps see the contingency between stimulation and response. When one feels safe enough about one's scores, then send them to the supervisor. See the reference scores and try to make sense of the differences. Then look at the tape again, and ask for the second set of 5 situations (Paris II) when you feel you agree with the reference scores.

This last set will enable you to check your agreement with the reference scores and within your group or partner. Go back to the supervisor as long as you need it. People who train together at a quick space, i.e. within two weeks have much better chances to reach agreement.

What is a correct agreement ?

Agreement is assessed firstly with the five situations correctly classified into the categories of « Normal », with a total ADBB score between 0 and 4, « Some concern », total ADBB score between 5 and 10, « Significant concern » with ADBB total score over 10.

After training with the first set of two tapes, and when agreement is reached with reference ratings, following the preceding categories, then reliability can be assessed on the following situations (provided by supervisors, or situations locally observed) through calculation of Cohen's Kappa correlation coefficient, which indicates the chances that this agreement occurs over simple chance : if the scale is to be used in low risk populations, with few differences between infants, then the Kappa between clinicians and researchers should be high, and training is considered achieved if the Kappa reaches 0.8. If high differences are expected or high scores then kappa could be a bit lower, around 0.7 at a minimum. Ideally, a working group could end the training in making a local set of training tapes, in the situation in which the scale is to be used. This would allow for testing reliability within trainees, and would help other people to train with local tapes.

Agreement is only valid when recently acquired. One has to train again, or at least to check again his or her validity in asking for a set of tapes to check with.

• A correlation of .60 allows the ADBB scale to be used for clinical screening purposes. It can be completed by 90% of individuals after training.

• A correlation of .80 allows the ADBB to be used for clinical, intervention follow-up and research purposes.

• A correlation of .90 allows the use of ADBB results in written reports that will remain on file or in expert reports. It also allows access to facilitator training.

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ALARME DISTRESS BABY (ADBB)
A. Guedeney, 2012©

Each item is rated on a scale from 0 to 4.

• 0 = No unusual behaviour, or doubt

• 1 = Slightly unusual behaviour, but sure about it

• 2 = Clear unusual behaviour

• 3 = Very obvious unusual behaviour

• 4 = Massive unusual behaviour at all times

This scale is best rated by the observer on the basis of her/his observations, immediately following the clinical interview. Initially, spontaneous behaviour is assessed, then following stimulation (smile, voice, gesture, touch, etc.), with emphasis on the evolution along time. The rating is what seems more significant during the whole examination procedure.

In case of doubt, use the lowest rating.

(1) Facial expression - Observer assesses any reduction of facial expressiveness, through changes in facial expression, raher than intensity of expression :

0 :   1 :   2 :   3 :   4 :

(2) Eye contact - Observer assesses the reduction of eye contact : usually the child locks eyes with the oserver and maintains eye contact; observer assesses if eye contact is difficult to get and to sustain :

0 :   1 :   2 :   3 :   4 :

(3) General level of activity - Observer assesses any failure of motion of the head, torso and limb without taking into account hands and fingers activity :

0 :   1 :   2 :   3 :   4 :

(4) Self-stimulating gestures - Observer assesses the frequency with which the child is ingrossed with his/her own body activity: fingers, hand, hair, thumb sucking, repetitive rubbing etc., in a sort of mechanical, non pleasurable way that seems odd and detached from the rest of the activity and does look like sef comfort. One clear an odd gesture is enough to score for a 1 :

0 :   1 :   2 :   3 :   4 :

(5) Vocalizations - Decrease in vocalizations, whether they express pleasure (chirping, laughing, babbling, lallations, high-pitched cries of pleasure), or displeasure, anxiety, or pain (screaming, whining, and crying) :

0 :   1 :   2 :   3 :   4 :

(6) Vividness of response to stimulation - Decrease in the vividness of response to stimulation during the examination (smile, voice, touch). Note: it is not the magnitude of the response that is evaluated here, but the delay of the response; the absence of a response does not allow to rate :

0 :   1 :   2 :   3 :   4 :

(7) Relationship - A decrease in the child's ability to relate to the observer, examiner, or anyone else in the room except the child's usual caregiver. Relationship is assessed by behavior, eye contact, response to stimuli :

0 :   1 :   2 :   3 :   4 :

(8) Attractiveness - The effort of attention required to maintain contact with the child, and the sense of enjoyment or concern that contact with the child brings, and the subjective sense of duration of the examination :

0 :   1 :   2 :   3 :   4 :

Name :   N° :   Age :   Examinator :   Total :

ALARME DISTRESS BABY SCALE (M-ADBB , French version)
Matthey, Črnčec, & Guedeney (2005)

Each item is rated according to the following categories :

• 0 = Satisfying

• 1 = Potential problem

• 2 = Obvious problem

This scale is best completed by the observer based on what he or she observes during the examination or test. The clinician should seek to engage the child, through smiles, talking and touching.

1 **Facial expression** - The observer assesses facial expressivity throughout the examination.

• 0 = Satisfying : Clear positive or negative facial expressiveness, with frequent changes in expression.

• 1 = Potential problem : Limited facial expressiveness, few changes in expression.

• 2 = Obvious problem : Absence of facial expressivity ; the face appears frozen, during most of the observation.

2 **Eye contact** - The observer assesses the quality and frequency of the child's eye contact with him or her.

• 0 = Satisfying : At least one episode of moderate eye contact with several episodes of brief contact.

• 1 = Potential problem : Only two episodes of brief contact, or up to one moderately prolonged one.

• 2 = Obvious problem : A single brief contact, or vague, elusive, or absent contact.

3 **Vocalizations** - The observer assesses the frequency of spontaneous pleasure vocalizations, but also the absence of displeasure or protest vocalizations, during the observation.

• 0 = Satisfying : At least a few short vocalizations (not crying), or one or two longer vocalizations, without crying.

• 1 = Potential problem : Only very rare vocalizations, without crying, or in their absence, cries in response to stimulation, or repeated whining.

• 2 = Obvious problem : Occasional whining in response to stimulation, or no vocalizations at all.

4 **General level of activity** - The frequency of head, torso and limb movements is assessed without taking into account the frequency of finger and hand movements, both spontaneously and in response to stimuli.

• 0 = Satisfying : At least moderate spontaneous activity, with some movement of the head, trunk and limbs.

• 1 = Potential problem : Very low level of spontaneous activity, very little movement of the head and limbs, but response to stimulation.

• 2 = Obvious problem : No spontaneous activity, or very low response to stimulation.

5 **Relationship** - The child's ability to engage in and sustain the relationship with the observer is assessed. The relationship is assessed by attitude towards the other, eye contact, response to stimuli and interaction.

• 0 = Satisfying : At least a moderate relationship is evident, whether positive or negative, and sustained.

• 1 = Potential problem : The relationship seems tenuous or even questionable, or only clear when the child screams or objects.

• 2 = Obvious problem : No visible relationship, positive or negative.

TOTAL :

• **Satisfying :**

• **Potential problem :**

• **Obvious problem :**

Date :   Age :   Name :

Examinator :   Place :

ADBB /m ADBB score sheet ©Renée Pierre Dupuy, Réseau de Périnatalité Occitanie

Date: ..../......./............. Place: ....Assessment made by: Child

Name: .... Surname: ....

Date of birth: ..../......./............. Age months: |_____| Gender:

M-ADBB (threshodl =23)			ADBB (Threshold = 5)		
	My score	Group Comsersus score		Ma cotation	Cotation groupe
Facial Expression	0 1 2	0 1 2	Facial Expression	0 1 2 3 4	0 1 2 3 4
Vocalizations	0 1 2	0 1 2	Vocalizations	0 1 2 3 4	0 1 2 3 4
General Activity	0 1 2	0 1 2	General Activity	0 1 2 3 4	0 1 2 3 4
			Vivacité de réponse	0 1 2 3 4	0 1 2 3 4
Visual Contact	0 1 2	0 1 2	Visual Contact	0 1 2 3 4	0 1 2 3 4
Relationship	0 1 2	0 1 2	Relationsip	0 1 2 3 4	0 1 2 3 4
Attractivity	0 1 2	0 1 2	Attractivity	0 1 2 3 4	0 1 2 3 4
			Self stimulation	0 1 2 3 4	0 1 2 3 4
TOTAL	=	=			
M-ADBB total score =			ADBB total score =		
☐ No witdrawal behavior (<2))			☐ No witdrawal behavior (<5)		
☐ Possible withdrawal b havior (≥ 2-4)			☐ Moderate withdrawa behavic (5-7)		
☒ Clear withdrawal behavior >4			☐ Clear withdrawal behavior (8-10)		
			☐ Massive withdrawal behavior[>11]		

Temperamental items   Relational items   Mixed items

Simplified ADBB rating grid (in french)

Item	Nom :	Age:
1	Expression du visage	
2	Contact visuel	
3	Activité corporelle	
4	Autostimulation	
5	Vocalisations	
6	Vivacité de la réaction	
7	Relation	
8	Attractivité	
	Total	
	Score de référence	

Item	Nom :	Age:
1	Expression du visage	
2	Contact visuel	
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5	Vocalisations	
6	Vivacité de la réaction	
7	Relation	
8	Attractivité	
	Total	
	Score de référence	

Item	Nom :	Age:
1	Expression du visage	
2	Contact visuel	
3	Activité corporelle	
4	Autostimulation	
5	Vocalisations	
6	Vivacité de la réaction	
7	Relation	
8	Attractivité	
	Total	
	Score de référence	

Item	Nom :	Age:
1	Expression du visage	
2	Contact visuel	
3	Activité corporelle	
4	Autostimulation	
5	Vocalisations	
6	Vivacité de la réaction	
7	Relation	
8	Attractivité	
	Total	
	Score de référence	

Item	Nom :	Age:
1	Expression du visage	
2	Contact visuel	
3	Activité corporelle	
4	Autostimulation	
5	Vocalisations	
6	Vivacité de la réaction	
7	Relation	
8	Attractivité	
	Total	
	Score de référence	

Par item:
- 0= tout à fait normal
- 1= comportement discrètement anormal en cas de doute coter 0
- 2= comportement nettement anormal
- 3= comportement très nettement anormal
- 4= Comportement massivement anormal

Degrés de retrait relationnel :
- 0-4= pas de retrait
- 5-7 = retrait léger clair
- 7-9= retrait net
- >10= retrait évident/massif

Simplified M-ADBB rating grid (in french)

Item	Nom :	Age:
1	Expression du visage	
2	Contact visuel	
3	Activité corporelle	
5	Vocalisations	
7	Relation	
	Total	

Item	Nom :	Age:
1	Expression du visage	
2	Contact visuel	
3	Activité corporelle	
5	Vocalisations	
7	Relation	
	Total	

Item	Nom :	Age:
1	Expression du visage	
2	Contact visuel	
3	Activité corporelle	
5	Vocalisations	
7	Relation	
	Total	

Item	Nom :	Age:
1	Expression du visage	
2	Contact visuel	
3	Activité corporelle	
5	Vocalisations	
7	Relation	
	Total	

Item	Nom :	Age:
1	Expression du visage	
2	Contact visuel	
3	Activité corporelle	
5	Vocalisations	
7	Relation	
	Total	

Item	Nom :	Age:
1	Expression du visage	
2	Contact visuel	
3	Activité corporelle	
5	Vocalisations	
7	Relation	
	Total	

Cotation:
- 0 = pas de problème
- 1= problème possible
- 2=problème manifeste

Score supérieur ou égal à 2 = coter à l'ADBB

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Sample consent document:

Authorization to film and record :

I, the undersigned (name of person) acting in my capacity as father/mother (delete as appropriate) of the child (insert child's name), hereby authorize (name of professional/institution/service...) to make audio or video recordings for observation and evaluation purposes.

Done at .... On .... Signature : ....

Authorization to use the data :

I, the undersigned (name of the person) acting in my capacity as father/mother (cross out the unnecessary mention, or both if necessary) of the child (put the name of the child), hereby authorize (name of the professional/institution/service...) to use the data collected for (cross out the unnecessary mention) :
- research
- of training
- scientific communication

These documents can be used :
- abroad
- in my country

Data protection and anonymization will be strictly respected in accordance with the law and the provisions of the authorization issued by the National Commission for the Protection of Personal Data. Anonymity will be respected. (see what the law of the country is and recall it).

Done at .... On .... Signature: ....

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• Antoine Guedeney is a child psychiatrist, psychoanalyst, invited member of the Société Psychanalytique de Paris (SPP), and of the Association Internationale de Psychanalyse (APA)..

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