KIT
"Keeping In Touch"
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Resource Article

This month's KIT article entitled Maternal Depression: A review of relevant treatment approaches for mothers and infants, appeared in the Infant Mental Health Journal in 2006. It was authored by Nylen, Moran, Franklin and O'Hara from the University of Iowa and is available at:

http://www.granitescientific.com/granitescientific%20home%20page_files/IMHMatDepression-Review06.pdf.

Maternal depression is a serious disorder that impacts not only the well-being of the mother but also the mother-infant relationship and the infant's development. Infants of depressed mothers have been shown to be less securely attached to their caregivers and often have cognitive, emotional, and behavioral deficits that persist well into childhood.

Research suggests that reduction of depressive symptoms in the mother alone may not be sufficient intervention. Instead, treatments targeting the mother-infant relationship may have greater potential in providing protection against the effects of postpartum depression on the infant.

The review of studies suggests that mother-infant psychotherapies and home-based interventions are generally efficacious in their goal of ameliorating detrimental consequences for children of depressed mothers. Especially interesting are the positive outcomes for infants through the use of infant massage therapy. Future efficacious treatment approaches will probably include the mother, the infant and their relationship.

Nylen, K. J., Moran, T. E., Franklin, C. L., & O'Hara, M. W. (2006). Maternal depression: A review of relevant treatment approaches for mothers of infants. *Infant Mental Health Journal 27(4),* 327-243.

On the WWW

The Centre of Excellence for Children's Well-Being (www.cecw-cepb.ca) is a Canadian agency that disseminates information, develops policy and fosters research for child welfare throughout Canada. While not focused on early intervention programs, their website has excellent brief resources under the heading **Information Sheets** that can be integrated into our early intervention work.

One example, *Assessing Emotional Neglect in Infants* (2008, #59E) was recently co-authored by a Zero to Three Fellow, Evelyn Wotherspoon and her colleague, Pamela Gough. The direct link to this resource is:

http://www.cecw-cepb.ca/files/file/en/EmotionalNeglectInfants59E.pdf

While the brief is directed at helping welfare case workers, the authors provide concrete information about the effect and signs of emotional neglect in infants that is relevant for all home visitors. Particularly thought provoking is the notion that emotional neglect is related to the co-occurrence of risk factors in the child's family and environment. She also suggests questions to think about regarding parenting capacity. Knowing the questions to ask is the first step in identifying and addressing factors that may impact families with whom we work. This information sheet is only one of many available at this website.

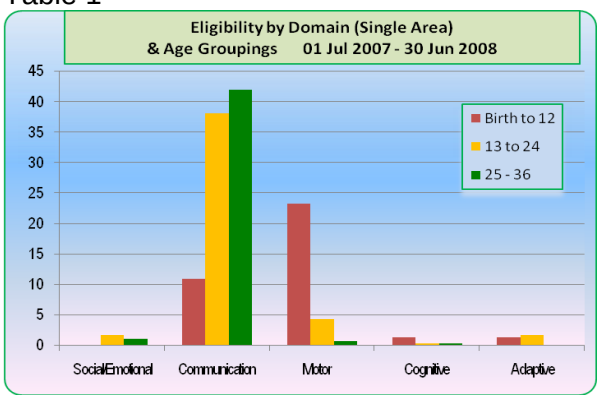
What Do the Data Say?

How does age (birth -12 months; 13-24 months; 25-36 months) correlate with delays in each of the developmental domains for children eligible for Army early intervention services?

Last month we examined the percentage of children with qualifying delays in different developmental domains. This month we will further analyze these data by looking at different age groupings. To answer this month's question, SNPMIS data for the past DoD reporting year (1 July 2007 – 30 June 2008) were examined. The data included in this analysis comprise only children eligible under developmental delay and not those eligible due to an established biological condition.

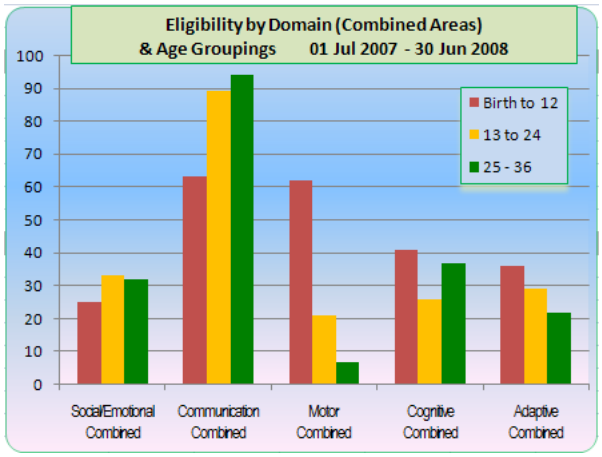
Table 1 illustrates the percentage of children with a qualifying delay (i.e., 2 standard deviations below the mean) in only one domain. The different age groups are also represented. These data reveal a relatively low percentage of children across the three age groups with a qualifying delay in the social/emotional, cognitive or adaptive domains alone as compared to communication and motor. Also shown, is that a higher percentage of children in the upper two age groupings (13 to 24 months and 25 to 36 months) had a qualifying delay in the communication domain of development while a higher percentage of children in the youngest age group (birth to 12 months) had a qualifying delay in the motor domain of development.

Table 1



Looking at qualifying delays in two or more areas, Table 2 illustrates the percentage of children with delays of 1.5 standard deviations below the mean in two or more areas within the three designated age groups. The greatest variation by age in domains of delay is seen in the communication and motor domains. In the area of communication, for the time frame examined, 63% of children birth - 12 months had significant delays while 94% of children 25 - 36 months had qualifying delays in this area. In the motor domain 62% of children birth – 12 had qualifying delays while only 7 % of the children 25 – 36 months had qualifying motor delays. Compared to these two domains, the percentages of children with qualifying delays in the other three domains showed less variability.

Table 2



Considering our population of children eligible for early intervention services, it is realistic that a greater percentage of children in the older age groups include communication delays in their eligibility mix, while the youngest age group includes a relatively high percentage of children with motor delays. While these data do not inform the quality of practice per se, they do intuitively represent the population we serve.

Local Look

Seasons Greetings and Happy New Year to all.

As this year draws to a close, we can likely anticipate changes in the new year. One of those changes is a new

EDIS logo. Through a consensus process the new logo, highlighted below, was agreed upon. In the new year, this updated logo will make it's to Army EDIS publications.

Consultation Corner

From October 2008 through January 2009 ***Early Childhood Mental Health (ECMH)*** and the training project that took place over the last three years at EDIS Stuttgart (Germany) will be featured in the KIT Consultation Corner section.

This is the second segment summarizing the EDIS-Stuttgart team project, which focused on integrating early childhood mental health practices into early intervention. Each segment focuses on a parent-practitioner interaction in an attempt to answer the following questions:

- *How is our approach with families different now?*
- *What outcomes have resulted from the change in our practices?*

The vignette this month describes an early intervention practitioner's attention to a depressed mother, the suspected impact that depression had on the mother's relationship with her toddler and the actions taken by the practitioner in identification, referral, and intervention. This involved attending and being present for someone's suffering without feeling overwhelmed.

Introduction

A father called the office about his 16-month old son who was not walking and was banging his head. When the practitioner returned the call to schedule the appointment, the mother answered and was unsure if an appointment was necessary as she thought her son was doing fine. Despite her initial reluctance, she agreed to a home visit for screening.

Both parents were present at the initial interview. The family had been in their home for only two months since arriving in a foreign country. Unpacked boxes were stacked throughout the living room. The mother and father spoke lovingly of their only child. Like most parents, they were eager to demonstrate to the practitioner what their child could do: "Alex, turn your music box on. Alex, show the lady the frog."

Before the practitioner and the parents could sit to complete initial paperwork, the mother had to clear the dining room table of papers. The mother seemed embarrassed about the condition of the apartment and looked rather tired. She explained that she had multiple sclerosis and was having trouble unpacking. They completed paperwork and again the mother mentioned she had little energy to unpack boxes.

Parent: I just feel like I have no energy. (*The practitioner paused and wondered if it was too soon to explore the topic and was hoping the mother might continue spontaneously to contribute more information to explain her tiredness).*

Practitioner: *(The practitioner was at a **port of entry** and **choice point** and decided to explore the topic)* Do you feel this way often?

Parent: I do. *(Suddenly the mother started crying and the practitioner was starting to feel panicked. She was searching her mental toolbox for the words to say.)*

Practitioner: *(Very calmly spoken to be supportive but without dismissing the parent's distress she said...)* There is probably a good reason why you feel this way.

Parent: I think I suffer from depression. I think that I have always suffered from this problem *(Mother continues to cry deeply).*

Practitioner: *(takes a deep breath)* You don't have to continue to feel this way. There are resources that you can contact if you are interested. *(When the parent expressed interest, the practitioner explained community resources from which she could choose.)*

Reflecting Back

As this brief snapshot of the home visit illustrates, the parent volunteered important information about herself. The information could have easily been discounted or minimized as normal for anyone establishing a new household while coping with a chronic medical condition. But a simple inquiry quickly suggested otherwise.

In asking the practitioner what was done differently in this home visit, she said she was more attuned to the importance of seemingly benign parent comments e.g., about tiredness. At the **choice point,** the practitioner expanded her assessment process in light of her awareness of maternal depression and its potential impact on a child and the parent-child relationship. She slowed down, asked a question and paused. She waited for a parent's response.

The brief invitation to elaborate on her comments resulted in a sudden reaction, a brief discussion about the parent's on-going depression, and the opportunity to suggest resources. The practitioner's description makes the process of identification and referral seem simple. Before training on this topic, practitioners naturally felt uncomfortable exploring this topic fearing it might be an unwelcome intrusion into private matters.

Highlighting Positive Interactions

Though the referral was not an immediate solution, it had significant implications for the role of home visiting interventions that followed. After eligibility was determined, the practitioner observed how the mother's lack of confidence and hesitancy impacted the relationship between the parent and the young child. It was suspected that this was contributing to the child's slower development and put the child at risk for social-emotional problems.

Interventions were always infused with encouraging observations of positive interactions between the mother and her son. For example, while on the playground, the practitioner highlighted the meaning of the child's behaviors and the implications for the mother: "He turned to look for you for reassurance—he's checking in with you." Or, "You're good to watch that he does not bump his head on the play equipment—nice job protecting him!" The practitioner believed that her awareness of the mother's depression shaped her interactions with the parent.

Combined Services

At another visit, the mother sat with her son at his high chair and shared her beliefs about their feeding routine. She was given positive feedback along with acknowledgement of her expressed concerns. At some point in feeding, the mother stopped and asked her husband to take over stating he is the one who usually feeds their son. This retreat from responsibility was registered by the practitioners and was an opportunity to provide support and instill confidence. She mentioned how well she had read her son's cues during their interactions without providing gratuitous praise. Over time through counseling and home visits, the parent's confidence as a nurturing caregiver increased; she reported pride in her developing parenting abilities and her son's development rapidly progressed.

Continuing Education for KIT Readers

In line with the topical focus on Early Childhood Mental Health, KIT readers are invited to receive continuing education contact hours for reading the four monthly KIT publications (October 2008 – January 2009) and then completing a multiple choice exam about the content covered in these KITs.

If you are interested, complete the exam online at www.edis.army.mil and upon successful completion, you will receive a certificate of non-discipline specific continuing education contact hours.

Please send your KIT ideas via email to:
EDISCSPD@amedd.army.mil