Educational & Developmental Intervention Services (EDIS) Personnel Development

KIT

Keeping In Touch

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Inside this edition UNDERSTANDING INFANT MENTAL HEALTH

Resource Article

As we continue our series on *Understanding Infant Mental Health* we focus our attention on toddler language outcomes, home stimulation and attachment theory. Ideally, parents provide children a language rich environment with opportunities for cognitive development through play and interaction. Combined, these efforts cultivate curious toddlers who understand and talk about their environment. Murray and Yingling (2000) examined how attachment and home stimulation affected language competence in toddlers. This month we'll review this article, titled, "Competence in Language at 24 Months: Relations with attachment security and home stimulation."

The researchers selected 58 infants (26 girls, 32 boys) from a larger group of infants participating in a larger and longitudinal study of early antecedents of communication disorders born at a university teaching hospital in the Midwestern United States. The sample included two groups of infants: high and low risk.

The medically high risk infants included 36 infants (12 female, 24 male) who required intensive care at birth due to preterm birth or other metabolic and respiratory disorders (mean birthweight of 1900 gm, SD of 901). The low risk group consisted of 22 infants (14 female, 8 male) who were full term, had no abnormalities and required no special care (mean birthweight of 3488 gm, SD of 445). The researchers measured the degree to which mother acted as teacher/ stimulator by using the HOME Inventory Scale (Caldwell & Bradley, 1972). The HOME Inventory is a 45 binary choice scale that evaluates stimulating aspects of home environment (e.g., activities/toys that are challenging and age appropriate). The HOME Inventory Scale was completed by an observer during a home visit when the infants were 9 months of age. Attachment was measured by coding video-taped sessions of the Ainsworth strange situation (Ainsworth, Blehar, Waters & Wall, 1978) when the infants were 21 months of age (infants in the high risk group were adjusted for prematurity).

Resource Article (continued)

The behaviors were coded according to the interactive behavior ratings for two reunion episodes and the children were classified as secure, avoidant or resistant. Language was evaluated by completion of the Receptive Expressive Emergent Language Scale (REEL; Bzoch & League, 1970) when the infants were 24 months (those infants born premature were age adjusted for prematurity). A Speech-Language Pathologist completed the REEL via interview with parent as well as by information gleaned from a one hour observation of the child.

Results suggested that gender and medical risk status were significantly correlated, reflecting a higher number of males in the higher risk group. Gender and expressive language were also significantly correlated, suggesting better expressive language skills in the females than male toddlers. Attachment was significantly related to both receptive and expressive language skills; toddlers with secure attachment demonstrated higher language skills than insecure toddlers. Results for the HOME Inventory Scale positively predicted receptive but not expressive language skills. The authors point out, "These findings suggest an additive effect of attachment security and home stimulation on receptive language" (p. 137).

The researchers sought to examine the relationships of attachment security and home stimulation to language development in toddlers. In this study, receptive language development appeared strongly affected by both secure attachment and home stimulation. The authors suggest, "… that displays of expressive abilities may depend more heavily than receptive skills on motivational factors related to emotional security, such as self-confidence, and less on exposure to a stimulating environment" (p. 138).

As we continue this KIT series, *Understanding Mental Health*, it is clear that helping families bolster their attachments with their infants and toddlers is also supporting their children's language development.

Murray, A. & Yingling, J. L. (2000). Competence in language at 24 months: Relations with attachment security and home stimulation. *Journal of Genetic Psychology, 161*(2), 133-140.

Check out the past KIT series online at www.edis.army.mil

What do the data say?

What are typical social emotional milestones for very young children birth to three years of age?

Babies enter the world ready to build relationships; they communicate expressions before they are even able to talk. Yet, they are also very dependent on caregivers to recognize and support their needs in responsive, sensitive, engaging, and consistent ways. All of these early experiences and interactions help babies develop healthy social emotional skills. These skills will be important throughout the child's life. They are also key indicators of children's future success in school and ability to develop and form long lasting relationships. Yet, pinpointing these milestones is a bit harder than physical development. Social emotional development includes expression and regulation of feelings and emotions, ability to form close and secure relationships, and learning to resolve conflicts and cope with challenges in the context of family, community, and culture. While there are variations in attainment of social emotional milestones reviewing typical developmental progressions is helpful as you work with families and help them support their children's learning and positive social emotional growth and development. Take this opportunity to review social emotional milestones. Using the defined age ranges match the milestones listed below with the appropriate age expectation. You'll find three milestones for each age range.

0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	25-36 months

A.	Becomes more interested in peers and what they are doing or what they are playing with. She will watch peers but may not initiate any interaction with them.	
B.	Recognize a familiar voice and follow it by turning head in the direction of that voice	
C.	Begins to learn about others' feelings and the concept of empathy. May cry when she sees someone get hurt. This is just beginning to see another person's perspective.	
D.	Begin to miss her caregivers when they are not around. May become upset when caregiver leaves the room.	
E.	Can be sympathetic toward peers when they are upset. Might comfort peers when they are upset.	
F.	Can focus for longer periods of time and can make eye contact for longer periods of time because she can now see things more clearly and farther away	
G.	Express emotions through cries and actions. Can let caregivers know that she needs attention, is hungry or is tired or uncomfortable.	
H.	Beginning to learn how to share and take turns with peers.	
I.	Parallel play starts and she will play next to another child doing the same activity.	
J.	Laughs and smiles while interacting with caregivers may even wave arms and legs when excited	
K.	Starts to use words like no or mine to state ownership of objects/toys. Has difficulty sharing.	
L.	Begins to actively form friendships with peers when given a chance. May have one specific friend she prefers to be around.	
M.	Understands social communication including words like "no" and "bye."	
N.	Can read facial and vocal expressions. When she hears her caregiver getting angry and speaking in a louder than normal voice she may become scared and cry.	
O.	Early relationships and experiences beginning at this age help lay the foundation for their mental health	
P.	Begins to imitate actions of others and take on imaginary roles – may pick up a broom to sweep or push a toy grocery cart to shop.	
Q.	Begins to intentionally tell her caregiver what she wants using pointing or gestures like reaching arms up to be picked up.	
R.	Enjoys hearing the same short book or song over and over. She enjoys knowing what will happen in the book/song.	

Now that you've had the opportunity to review several social emotional milestones check how you did using the key on page 7. These developmental milestones and more detailed information are available in the "Hand in Hand Growing Together Every Day Social Emotional Milestones Overview" available from Infant mental Health Promotion (IMHP) at http://www.imhpromotion.ca/Portals/0/IMHP%20PDFs/Help%20Me%20Grow/Hand%20in%

Consultation Corner

From August 2015 through February 2016 we are excited to have Neal Horen, Kristin Tenney-Blackwell, Amy Hunter, and Rob Corso as our consultation corner experts addressing infant mental health.

Understanding Infant Mental Health

Talking about Adult Mental Health with Families

Why think about the parents' mental health in Early Intervention?

Mental Health problems are common.
The National Institute of Mental Health (NIMH) estimates approximately 18.5% of the adult population in the United States have experienced a mental illness in the past year.[1] The majority of adults experiencing mental health problems are parents.[2] The most common mental health problems are anxiety (characterized by feelings of fear and worry often associated with symptoms such as: feeling tired, restless, irritable, difficulty concentrating, and difficulty sleeping) and depression (characterized by persistent sadness and/or loss of interest in previously pleasurable activities).

Parents of children with disabilities are at a higher risk of developing mental health problems.
Parents of children with disabilities are at higher risk of developing mental health problems largely due to the increased stress of caring for a child with a disability.[3] Parenting is hard work. Parenting a child with a disability or a delay can pose increased challenges and create additional stress which can contribute to parental mental health problems. Stigma related to children with disabilities causes added stress on parents contributing to feelings of isolation and reduced social opportunities with friends or family.

What are other risk factors that contribute to increased risk of parent mental health problems?
Other risk factors that contribute to an increased likelihood of a parent developing or experiencing mental health problems include:

- Poverty
- Traumatic or stressful events (sexual or physical abuse, loss of a loved one, witnessing violence, life threatening event or illness)
- History of previous mental health problems
- Family history of mental health problems
- Excessive drug or alcohol use
- Chronic stress
- Temperament, personality, one's outlook on life

Parental mental health problems such as depression and/or anxiety can negatively impact parenting and child development.
Untreated depression and anxiety can interfere with: a parent's ability to be sensitive and responsive; the parent-child relationship; and the child's positive developmental, behavioral, emotional, and cognitive progress. Parental depression has also been found to impair the parent's ability to prevent injury, making them less likely to use car seats, apply electric outlet covers, install smoke alarms, or

Consultation Corner (continued)

successfully manage chronic health conditions.[4] Families and children at the highest risk of developing mental health problems are families with a history of mental health problems, with conflict and stress in the home, and where parents and/or children are experiencing their own mental health or behavioral problems. However, with increased awareness and support for parents the consequences of parental mental health problems can be significantly reduced.

Supporting parents' resilience and supporting positive parenting

Appropriate information, support, and service can prevent mental health problems from developing[5] or help to reduce their symptoms. Appropriate intervention can also reduce the impact of mental health problems on parenting and child development.

> ***Most Early Interventionists are not mental health therapists, nor, are they expected to serve as mental health experts. However, all interventionists should be comfortable working to engage every parent—especially parents experiencing mental health problems.***

What can you do?

Talk to families about their mental health

In spite of its prevalence, parental mental health can be a difficult topic to discuss with families. You may understandably have fears about bringing up the topic. You may worry that you will say the wrong thing or that talking about parental mental health problems may make it worse. In reality, you are likely working with families experiencing parental mental health problems every day. Talking about mental health problems is the first step towards getting families the help they need and improving outcomes for infants and toddlers.

The following tips may be helpful in starting conversations with families about their own mental health and well-being.

Be prepared.

- Make sure you are familiar with signs and symptoms of common mental health problems such as depression and anxiety and their impact parenting.
- Have readily available access to a trusted supervisor and/or colleagues to talk about your feelings related to discussing parental mental health.
- Have the resources to refer families for further assessment, treatment, and crisis service if appropriate.
- Receive on-going training and/or support on the topics such as: depression, anxiety, family engagement, adversity, trauma, toxic stress, stigma, cultural competence, resilience, nurturing relationships and parenting.
- Routinely discuss parental mental health in staff meetings and/or regularly practice conversations with families by role playing or discussing the topic in supervision.

Consultation Corner (continued)

- Consider using a simple screening tool for depression and/or anxiety. Help families understand that Early Interventionists are expected to ask parents how they are feeling and to assess how well families are coping.

How to talk about it?

- Introduce the topic of parental mental health during an initial home visit or during the orientation to the EI program. When families have already been introduced to the topic of parental mental health they are less likely to be surprised if an interventionist asks them about it. Ask about the parent's mental health regularly. When a parent understands how her own mental health can adversely impact her child she is more likely to seek help.
- Convey empathy. Families are more responsive when interventionists are able to show genuine care. Avoid judgment and/or labeling. If a parent is experiencing mental health problems it is important that he receive help for his feelings and symptoms. Expressing judgments about his feelings or trying to diagnose the symptoms can turn him away from getting help.
- Remain calm, comfortable and matter of fact. Try asking a parent about her feelings in the same way you might ask her about a recent illness (For example, if a parent was sick you might ask: "How you feeling? Do you have a fever or a cough?")

Where to start? What to say?

The following tips may be useful for staff to open a conversation with a parent who may appear to be experiencing mental health problems:

- "How are you feeling today?" or "How have you been feeling lately as a parent?"
- "Can you tell me more about _____...(a remark made by the parent that might indicate depression or anxiety. For example, "…when you said you felt empty or numb inside")
- "How can I help you?"
- "I've noticed you seem down or irritable this week. It might help to talk?"
- "It is common to be surprised by new thoughts after having a baby (or after receiving information about your child's disability), have you had any new or different thoughts since having your son (or since receiving the diagnosis)?"

What next?

Starting a conversation with a parent about her own mental health is an important first step; however, being prepared for the response is critical. A parent may have a number of different reactions to your inquiry including, but, not limited to: anger; frustration; relief; sadness; appreciation for your concern; worry; and/or anxiety. Be prepared for any response by having the appropriate resources readily available and by being a non-judgmental understanding support for the family.

Consultation Corner (continued)

In Summary:

Talking to parents about their mental health can greatly benefit both the family and their children. When parents feel good about themselves, have the energy and interest to engage in healthy productive activities and satisfying relationships, and know how to adapt and cope with the changes that may come their way, they are better equipped to be attentive, nurturing parents. **Talking about their own mental health is often the first step towards helping parents get the services they need – for both themselves and their children. As early interventionists, you are well positioned to begin these important conversations with the families that can result in better developmental outcomes for young children.**

[1] National Institute of Health, http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml, 10/30/15

[2] Nicholson, J., Biebel, K., Williams, V.F., & Katz-Leavy, J. (2004) Prevalence of Parenthood in Adults with Mental Illness: Implications for State and Federal Policy, Programs, and Providers. In Center for Mental Health Services. *Mental Health, United States, 2002*. Manderscheid, R.W., & Henderson, M.J., eds. DHHS Pub No. (SMA) 3938. Rockville, Maryland: Substance Abuse and Mental Health Services Administration, Chapter 10, pp. 120-137.

[3] Ha JH., Hong, J., Seltzer MM., Greenberg JS., (2008), Age and gender differences in the well-being of midlife and aging parents with children with mental health or developmental problems: report of a national study. *Journal of Health and Social Behavior*. Sep: 49(3): 301-16.

[4] Chung, E.K., McCollum, K.F., Elo, I.T., Lee, H.J., & Culhane, J.F. (2004). Maternal depressive symptoms and infant health practices among low-income women. Pediatrics, 113, e523-9.

[5] Le, H. N., Perry, D. F., Mendelson, T., Tandon, S. D., & Muñoz, R. F. (2015). Preventing perinatal depression in high risk women: Moving the Mothers and Babies Course from clinical trials to community implementation. Maternal and Child Health Journal, 19, 2102-2110.

Below are the age ranges for the developmental milestone activity on page 3 of this KIT newsletter.

0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	25-36 months
B, G, O	F, J, N	D, M, Q	A, K, R	C, I, P	E, H, L

On the WWW

Comfort, Play, and Teach (CPT) Developmental Milestones are a set of ages and stages resources that describe typical and emerging skills for children ages 0-6, 7-18, 19-24, 25-35, 36-47, and 48-60 months. Each resource includes several pages of information about development, and functional ways to comfort, play and teach very young children. The comfort, play, and teach examples are organized in an *if you… your baby will…* format to further describe the impact of adult interactive behaviors on very young children. For example, at 4 months, "If you … sing and talk to your baby as much as possible …your baby will… take comfort in the songs and sounds she knows."

At 7-9 months, "If you…describe feelings; put words to your baby's expressions…your baby will…feel you are responding to his feelings and begin to recognize some of the words used to describe feelings." The full set of resources is available from Infant Mental Health Promotion (IMHP) at:

http://www.imhpromotion.ca/Portals/0/IMHP%20PDFs/Comfort%20Play%20Teach/CPT%20Ages&StagesMilestones_Full%20Set.pdf

Visit the IMHP home page too at:
http://www.imhpromotion.ca/

Continuing Education for KIT Readers

The Comprehensive System of Personnel Development (CSPD) is offering a continuing education opportunity for KIT readers.

In line with the focus on *Understanding Infant Mental Health,* readers are invited to receive continuing education contact hours for reading the monthly KIT publications (August 2015 through January 2016) and completing a multiple-choice exam about the content covered in these KITs.

KIT readers will receive the exam in February 2016. There is no need to register for the CEUs. Rather, if you are interested complete the exam online at www.edis.army.mil

Upon successful completion of the exam, you will receive a certificate of non-discipline specific continuing education contact hours.

KIT Newsletters are available online at **www.edis.army.mil**