Educational & Developmental Intervention Services (EDIS) Personnel Development

KIT

Keeping In Touch

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Resource Article

The relationship between maternal mental health and maternal and child health is synergetic. These disciplines, however, are not always treated as such. Rather they tend to be viewed as two different, loosely related entities. But this may be changing, for the better. In their article, *Grand challenges: Integrating maternal mental health into maternal and child health programmes*, Rahman, Surkan, Cayetano, Rwagatare, and Dickson (2013) explore the idea of expanding maternal and child health (MCH) programs to include maternal mental health (MMH). They discuss myths that contribute to the separateness of these two important disciplines and then they examine three different intervention programs (in three different countries) designed to integrate MMH and MCH.

The authors begin their discussion by listing some of the common misconceptions surrounding MMH:

- **Myth 1**: Maternal Depression is Rare – perinatal depression (i.e., depression during pregnancy and in the year after birth) is present cross culturally and among all socioeconomic strata. Depression is the second leading cause of disease burden in women worldwide, following infections and parasitic diseases (Box 1).
- **Myth 2**: Maternal Depression is Not Relevant to Maternal and Child Health (MCH) Programs – maternal depression has been strongly correlated with infant and child outcomes, especially for those women with limited social supports and for women with premature infants and infants with low birth weight.
- **Myth 3**: Only Specialists Can Treat Maternal Depression – Psychological therapies and, to a lesser extent, medication are among the formal treatments for maternal depression. However, informal approaches to depression are being developed and showing promising results. The authors note, "Over the last decade, the evidence for the effectiveness of non-mental health specialist-led interventions (e.g., involving nurses, health visitors, and midwives) in high-income countries has been building." (p. 2).

Myth 4: It is Not Possible to Integrate Mental Health Care into MCH Programs – Viewing maternal health as separate from family and child health fails to recognize the "holistic nature of health and

Resource Article (continued)

erroneously propagates the defunct theory of the "mind-body" dualism." (p. 2). Additionally for those living in low- and middle- income countries (LMIC) resources for overall health care may be limited.

Knowing what we know about MMH and MCH it seems reasonable and even cost effective to consider how to assimilate the two in order to provide families with high quality, supportive care.

The authors examined three different programs in three different countries designed to do just that (Table 1). A program in Kingston, Jamaica integrated MMH into a Nutrition and Positive Parenting Program. Another program in rural areas southeast of Rawalpinki, Pakistan integrated MMH into a Community Health Program. And the final program, located in Khayelitsha (outside of Cape Town), South Africa integrated MMH into a Child Development Program. Each of the intervention programs had a home visiting component. The programs in Pakistan and Africa had prenatal home visits and each of the programs in had control groups. Results for all interventions were encouraging. The program in Jamaica, which integrated MMH and Nutrition and Positive Parenting Program, showed a decline in depressive symptomology as compared to the control group. The program in Pakistan, which integrated MMH into a Community Health Program resulted in mothers who were less likely to be depressed at 6 months postpartum as compared to the control group (23% vs. 53%), less likely to be depressed at 1 year postpartum as compared to the control group (27% vs. 59%), and these mothers had better social supports compared to the control group both at 6 months and 1 year postpartum. Infants in the intervention group had fewer episodes of diarrhea at 12 months and they were more likely to be fully immunized than those infants in the control group. Additionally, participants in the intervention group were more likely to have both parents dedicate more time to playing with the infant. The program in South Africa, which integrated MMH into a Child Development Program also showed a lower prevalence of depression as compared to the control group at 6 months and 12 months postpartum, but the differences were not significant. Interestingly, the mothers in this intervention group were described as more sensitive and less intrusive in their interactions with their infants and their infants were described as securely attached as compared to the control group.

There are some interesting components in each of these programs. Home visiting makes care more accessible for families. Prenatal visits establishes the connection to providers and helps to develop relationships. Linking MMH to child related topics (e.g., nutrition and child development) underscores their interconnectedness. And training non-specialists to be sensitive to and respond to mental health issues provides support that is often missing but needed. Given the results from this study, it seems that integrating MMH into MCH is not only possible, but it may be our path to better care for children and families in the future.

Rahman, A., Surkan, P. J., Cayetano, C. E., Rwagatare, P. & Dickson, K. E. (2013). Grand challenges: Integrating maternal mental health into maternal and child health programmes. *PLoS Medicine, 10* (5), 1-7.

What do the data say?

What is military culture?

In a 2011 SAMHSA News article Sandy Cogan wrote an article "What Military Patients Want Civilian Providers to Know." Although the article spoke about service members seeking mental health care from non military civilian providers, the underlying message aligns with our early intervention work supporting military families. The fundamental message was that providers need an understanding of military culture to effectively support military service members and their families.

In early intervention an essential first step is being family -centered and culturally responsive when meeting and beginning the early intervention journey with a family. By learning more about the cultural of the military, providers new to working with military families can be better equipped to understand and appreciate families' unique circumstances within the culture of the military. The military is a diverse population with a distinct set of value systems, rules, norms, and ways of communicating with a unique language/alphabet and hierarchy/rank structure.

Just for fun, see if you know the meaning of the following military acronyms. Check your answers at the DoD Dictionary of Military Terms online at http://www.dtic.mil/doctrine/dod_dictionary/

1. POV	2. TDY	3. MOS	4. OIC
5. MRE	6. DoD	7. PCS	8. AOR

Military culture is a way of being. In fact, the military services share the mantra "mission first; people always." This, in addition to service specific (i.e., Army, Navy, Air Force, Marines, Coast Guard) mission, value, and belief statements, helps guide behaviors of the military community and culture.

Consider the following bullets from a Military Culture 101 briefing (Goodale, Abb, & Moyer, 2012).

- The military is unlike any other career and the demands of military life create a unique set of pressures on service members and their families.
- For most people, their job is what they do; in the military it more deeply defines who they are.
- For families, military life offers a sense of community with clearly defined rules and expectations.
- Members of the military and their families share a unique bond, professional ethic, ethos, and value system.
- The military offers a sense of community and camaraderie unlike any other profession.
- But it also fosters a warrior ethos that rewards physical and emotional prowess and frowns upon weakness and timidity.
- It is said that the military defends the constitution it does not emulate it. There are strict rules limiting freedom of speech and association.
- To maintain "good order and discipline" commanders at all levels are given widespread authority over the personal affairs of their subordinates and held personally responsible to resolve any issues that could potentially affect performance of duty.
- Military members are subject to performing their duty at any time. They are told what to wear, where to live, and there are rules about who among fellow service members you can and cannot socialize.
- Military families endure many of these same restrictions and their actions reflect directly upon their service member. This burden increases with the pressures of maintaining the family household during extended military deployments.

As you read this list take some time to think about the following questions:

- How might these practices inform and influence family life?
- How can knowing about these practices help me as an interventionist working with military families?
- What experiences have I had or heard about that align with these practices?

See the full Military Culture 101 brief online at: http://www.citizensoldiersupport.org/lib/resources/ORNC%20Military%20Culture%20101%20Workshop%2014%20Sep%2012.pdf

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

This month we build upon our understanding of infant mental health and red flags, and move forward to consider relationship-based strategies for working with families of infants and toddlers.

In relationship-based work with families, it is helpful to remember that the transition to parenthood can be a time of many emotions – worry, happiness, anxiety, excitement, stress, uncertainty, etc. Following birth, major developmental milestones are often anticipated and there is careful watch for when these skills will be developed. Any developmental concerns that arise may create tensions within parent-child interactions, as well as impact excitement and appreciation of their child's emerging skills.

Parent-child interactions are also impacted by the fit of the child's temperament with the parent's temperament, individual strengths and qualities, as well as other traits influenced by genetics. A child's unique reactions and responses to particular parenting behaviors and styles also affect the parent-child relationship (Deater-Deckard & O'Connor, 2000). An online Infant Toddler Temperament Tool developed for the Center for Early Childhood Mental Health Consultation can be found at http://ecmhc.org/temperament/.

As an early interventionist, you can make a difference in the lives of families where there are concerns about the infant or toddler's development, and also about early relationships and the adjustment to parenthood. The strategies used in your work will relate directly to understanding yourself, the unique young child, and his or her family. In fact, Jeree Pawl, Ph.D., who has written extensively on infant mental health issues, commented that "Several overarching ideas or beliefs form the central understanding of what we, as practitioners of various kinds, need to be aware of, thinking about, and trying to achieve when we work with infants, toddlers and their families" (2000). Pawl argues that these overarching ideas all work together and intersect to create the "crucial interpersonal center" of the work we do, irrespective of our discipline, and include the following:

1. **Trust in parents**: In the face of a parent's anger or distress or the parent being upset, we need to hold genuine trust in the parent and believe the parent has some investment in the well-being of his or her child.
2. **Mutual clarity**: In our work with families, it is important to reach an understanding of what we will be doing together and work toward a mutual understanding with this particular family about the purpose of our being there with them. In essence, our work requires that we establish shared goals and objectives.
3. **Hearing and representing all voices**: We hear and represent all possible perspectives and voices. We observe and represent the infant's voice and are dedicated to representing any and all voices that might be unheard within the circumstances of a particular family.
4. **Hypotheses, not truth**: Our professional knowledge is best considered hypothesis; the families we work with have all the information we need.

Consultation Corner (continued)

5. **Maintaining an appropriate role**: Maintain flexible boundaries, establish a sense of mutual responsibility and working "with" a person rather than "doing" something to that person.
6. **Knowledge, beliefs, biases and meanings**: Recognize your own beliefs and knowledge in order to be respectful of difference or sameness; this leaves us able to be curious and to understand.
7. **Inclusive interaction**: Be aware of your own feelings, reactions, and urges while working with a family in an effort to maintain an understanding of interactions as they unfold.

In your work with infants, toddlers and families, you can continue to demonstrate knowledge around how young children learn through relationships and use strategies to engage and support parents and other primary caregivers in positive interactions with their infants and toddlers. Careful observation and connecting to the parents' experience in the moment, can lead to parents feeling understood and less alone. Below are strategies that you, as an early interventionist, can use during your interactions with families to support mental health.

Notice and Listen: Listening is a powerful way of showing parents and other primary caregivers that you care and can reinforce to the parents their role and importance to their child. Helping parents and other primary caregivers recognize the meaning in their child's behavior and helping them to reflect on what their child is doing, thinking, feeling, and needing are critical to guiding an infant and toddler through cognitive, social and emotional development while contributing to early brain development.

- Observe with the family and notice what the infant or toddler is doing. By doing this with the family ongoing, you may see parents learning how to notice their infant and toddler's development on their own, too, and share this information and their experience with you during visits. *"What are you noticing?"*
- Consider videotaping portions of a family visit and then watch the videos and learn alongside the family. *"Cassie seems to really like this ball when we roll it back and forth. See her smile and the way she leans forward."*
- Notice moments of inquiry or doubt from a parent. *"She's doing something that makes you feel she is frustrated. What are you noticing?"*

In the article, *Cultivating Good Relationships with Families Can Make Hard Times Easier*, describes active listening as, "…giving our undivided attention when someone seeks us out for conversation. Rather than using only our hearing, active listening requires the use of our intellect, feelings, and physical responses to attain information about an interaction." Four steps to active listening include:

- **Stop** – stop what you are doing and pay attention.
- **Look** – face parents and make eye contact (if fitting depending on culture) and look for nonverbal cues (facial expressions and body language) that may tell you something about their thoughts and feelings
- **Listen** – listen to what parents are saying and pay special attention to their words used and tone of voice. Keep in mind they may be communicating several messages (some unspoken).
- **Respond** – throughout the conversation use cues such as eye contact, nods, and smiles to confirm your attentiveness. After parents finish speaking, reflect on what has been shared in order to check and reinforce your understanding of the situation.

Consultation Corner (continued)

Talk With Parents About Their Child: Listen to parents and invite them to tell you about their infant or toddler.

- Observe with the family and listen to what the parent is noticing. Discuss what the infant or toddler is doing and anticipate what might be coming next.
- Talk and wonder with parents about their concerns. *"What do you think might be causing your child's (concern)?" "Let's think about this together. What have you noticed about (child's behavior)?" "I know you have been concerned about Sonji and (the behavior or area of development). We have both been seeing (the behavior) happening during visits. Could we talk more about this?"*
- *"This has been hard. I'd really like to hear more about Haley's fussiness. What has it been like for you to take care of Haley with all of this fussiness?"*

Offer Developmental Information, Feedback, and Encouragement: Help parents recognize what they know about their infant or toddler, as well as think about the different strategies they are using to support their young child's growth and development.

- Observe a parent's strengths and capacities, actions and statements – offer positive remarks. *"You have created a special bedtime routine just for Celia. You are an attentive father by the way you make sure she has a consistent routine and gets the rest she needs."*
- Encourage continued enjoyment of the baby.
- *"He really settles down when you wrap him so snugly and hold him close to your chest. Is this something you do regularly?"*
- *"Would it be helpful to hear more information about (area of development)?"*

Emotional Responsiveness: Relationship-based work seeks to provide a validating, partnering relationship between you, as the early interventionist, and the parent that in turn promotes the relationship between the parent and the child.

- Pay attention to the emotional experience of each infant, toddler and parent. Ask yourself, "What is it like to be this young child?" "What is it like to be Josiah's father?" "What is it like to be Charlie's mother?"
- Wonder about early parent-child relationship experiences – *"What have the first few months with Jordan at home been like for you?" "Who has been here to help you?"*
- Empathize with parents to help them feel understood, valued and cared for. "Empathizing means imagining how the other person might be feeling and what the person's emotions, thoughts or circumstances might be – all without trying to fix the problem" (Gillespie, 2006). *"It's so hard to care for a baby that cries often. Other parents have shared with me they just wish they knew the why it was happening so they could change something and figure out a way to make it better."*

Support Reflection: Parents are not always aware or conscious of the ways they are helping their child or why what they did is important. By commenting on what parents do and offering time to reflect are ways of supporting parental competence and confidence.

- *"Dustin settled right down when you starting singing to him in such a soft and calm voice. You really helped him to relax and be able to refocus on the blocks you were stacking together. Why do you think that worked so well?"*
- *"I wonder what could be causing this change in her behavior?"*

Consultation Corner (continued)

Infant mental health is an important aspect of a young child's ability to learn, grow, and explore the world and it is closely linked to the relationships that young children have with their parents and other primary caregivers. The strategies you choose and your approach with a family can provide a roadmap that helps parents and other primary caregivers navigate and manage situations with their infant or toddler that feel of greatest concern. As an early interventionist, you can continue to help parents develop confidence in caring for their infants and toddlers and supporting their growth and development, including social and emotional development, or mental health. Additional resources highlighting relationship-based strategies can be found at:

- The Technical Assistance Center on Social Emotional Intervention (TACSEI): http://challengingbehavior.fmhi.usf.edu/
- Parents Interacting with Infants and Toddlers (found on the CSEFEL website): http://csefel.vanderbilt.edu/resources/training_piwi.html
- The FAN Approach: http://www.erikson.edu/fussybaby/national-network/
- Promoting First Relationships: http://pfrprogram.org/
- The National Center on Health (Using Motivational Interviewing Techniques to More Effectively Partner with Parents): http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/health/mental-health/ec-mental-health-consultation/mit.html.

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On the WWW

This month we highlight the Sesame Street web resource for military families. The associated resources focus on military families and are designed to help children and families through deployments, separations, transitions, homecomings, as well as injuries and death related to combat.

The available resources include books, videos, information guides, blogs, apps, and more. The following link takes you to the Sesame Street for Military Families homepage: **http://www.sesamestreetformilitaryfamilies.org/**

Within each of the linked topics there are several helpful tools. For example, the "Relocation" link includes information about 'breaking the news about move,' 'preparing for the move,' 'moving,' 'steeling in,' and additional resources and links related to relocation.

As early intervention providers working with military families that experience relocations, homecomings, deployments, injuries, and grief you may find these resources helpful to increase your understanding and to share with families.

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**