KIT
"Keeping In Touch"
November 2008

A Publication of the Army Educational & Developmental Intervention Services CSPD

Resource Article

This month's article entitled *Supporting Healthy Relationships Between Young Children and Their Parents: Lessons from Attachment Theory and Research* is by Karen Appleyard and Lisa Berlin (editor of the book *Enhancing Early Attachments*). The article is located at the Center for Child and Family Policy Duke University. See link below:

www.pubpol.duke.edu/centers/child/publications/policybriefs/files/eca/Attachment-final.pdf

The authors highlight the importance of early child-parent relationships, which lay the foundation for children's later social, emotional and school functioning. They emphasize that attachment is about the ***quality*** of the relationship rather than determining if a child is attached or not. According to the authors, attachment usually takes pace the first year of life.

Sensitive, responsive parenting promotes secure attachment. Insensitive, rejecting or inconsistent parenting is linked to insecure attachment. Quality of attachment is important, as it is one of the strongest predictors of later development.

The authors provide four guidelines for supporting healthy relationships.

1) *Help parents to understand their responsibilities to comfort their child and to facilitate their child's exploration of the world.*
2) *Help parents understand typical development.*
3) *Help parents reflect on their own parenting strengths and challenges.*
4) *Use the parent-child relationship as an "engine of change."*

The authors also review five curricula and programs related to attachment currently available for use in a variety of settings including childcare, clinic, and home. Aspects of these programs may also be of value to early intervention. For example, from *The Circle of Security* program, a sample list of informed strategies for building a secure attachment is included at the end of the article. The growing body of research supports the promise that these strategies have for promoting healthy development in young children.

Also included are listings of resources, one for practitioners and one for parents. In addition, books are articles on attachment are provided.

Appleyard, K. & Berlin, L. (Spring 2007). Supporting healthy relationships between young children and their parents: Lessons from attachment theory and research. *Center For Child and Family Policy Duke University*, Duke University Durham, North Carolina.

On the WWW

As part of the Alberta Health Services, the Calgary Health Region Collaborative Mental Health Care provides infant mental health consultation to community professionals. At

their website are copies of past newsletters entitled Collaborative Corner and useful pamphlets.
Two pamphlets relate to this months KIT topic: *Red Flags in Early Childhood Mental Health,* which provides a listing of vital at risk behaviors. The direct link to this resource is:

http://www.calgaryhealthregion.ca/mh/pdfs/collaborative/HealthInformationBrochures/red_flags.pdf

A second resource entitled, *Observing the Parent/Child Interaction* includes a checklist of topical cues to organize parent-child interaction observations. Early interventionists will likely find this resource helpful for assessment as well as ongoing intervention with children and families. It can also be useful in childcare settings. It is available at:

http://www.calgaryhealthregion.ca/mh/pdfs/collaborative/HealthInformationBrochures/observingparentchildinteraction.pdf

Additional resources from the Calgary Health Region Collaborative Mental Health Care can be found at:

http://www.calgaryhealthregion.ca/mh/collaborative.htm

What Do the Data Say?

What percentage of children eligible for EDIS early intervention is eligible with qualifying delays in different developmental domains?

Last month we looked at qualifying delays in the social emotional domain. This month we will look at all domains and the percentage of children with qualifying delays in one domain as well as the percentage of children with delays in more than one domain of development. To answer this month's question SNPMIS data for the past DoD reporting year (1 July 2007 – 30 June 2008) were reviewed. The data included in this analysis include only children eligible under developmental delay (N=243) and not those eligible due to an established biological condition.
Table 1 below illustrates the percentage of children with a qualifying delay (i.e., 2 standard deviations below the mean) in only one domain of development. Not surprisingly, the highest percentage of children with a qualifying delay in only one area was in the communication domain (27%). This was followed by physical at 6%, social emotional at 3%, and cognitive and adaptive both at 1%.

Table 1

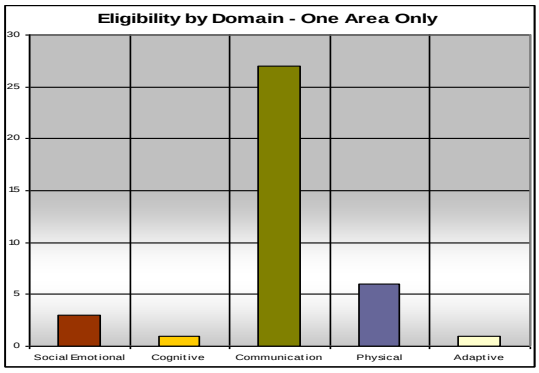
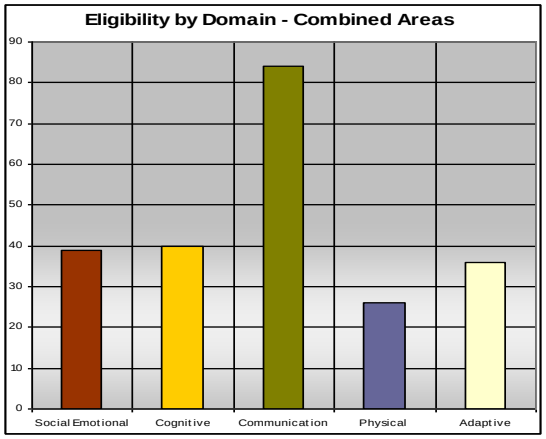


Table Two illustrates the percentage of children with qualifying delays (i.e., 1.5 standard deviations below the mean) in two or more areas. Again, the highest percentage of children has qualifying delays in communication (84%), followed by cognitive (40%), social emotional (39%), adaptive (36%) and physical (26%).

Table 2



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) Early Intervention Services will be featured in the KIT Consultation Corner section.

To answer the questions posed in the October KIT (see below) the EDIS Stuttgart team has written their recollections in the form of vignettes and highlighted skills associated with reflective practices.

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

The following vignette demonstrates the changes in the staff's thinking with respect to time investment and the potential rewarding outcomes for a family.

Changes in Priorities

Through our training, we have become aware of the importance of **observation**, **choice points** and **the power of allowing parents to tell their story**. Choice Points occur during interactions with families and are moments in which parents provide information (e.g., a parent reports, *I feel sad when I see other children her age who are so far ahead in development*). The practitioner can quietly skip over this comment thinking there is more relevant information to collect; acknowledge the statement by saying (*He's making good progress*); or explore further (e.g., *It's not easy comparing him with others his age*) and then listen.

Vignette

The following interaction occurs during a screening and highlights the challenge to determine which threads of information might inform the assessment, especially being conscious of the 45-day time line.

Introduction: A practitioner makes a home visit to screen a nearly 3-year old little girl suspected of having developmental delays. As the initial demographic paperwork is being completed and before a formal screening tool is initiated, the mother mentions another child's name though there was no evidence from the paperwork that another child is part of the family. In the living room over the couch are two framed amniocenteses blow-ups of infants. The practitioner suspects that the mother is probably speaking about a child who is no longer in the home. The practitioner recognizes the **choice point**. She can ignore the information since it is not directly related to the child being screened or she can make an inquiry and see if there is relevance to the screening process.

Practitioner: You mentioned another child's name, Ray. The practitioner pauses with the hope that the parent might provide information. When information is not spontaneously provided she asks a direct question.

Practitioner: Who is Ray?

Parent: Ray is my son who died about one year ago. The practitioner could comfortably say, "I am sorry to hear that," and move on gathering more intake information as the information about Ray does directly apply to the little girl being screened. Or as this practitioner wonders, "Could the information have relevance?" The practitioner chooses to inquire knowing it will take them away from the primary task of screening and at the same time she recalls her busy schedule.

Practitioner: He died one year ago (repeating the last phrase said by the parent).

Parent: Yeah, he was three months old and he stopped breathing at home. The whole time I was with him waiting for the emergency unit, I could see his condition

getting worse. At the hospital, they said it was unlikely that he would survive without continued support of medical equipment and if he lived, he would be severely brain damaged. I had to make a decision to keep artificial medical supports or to have the supports turned off. *(The mother continues to talk about the experience and the practitioner actively listens.)*

During their discussion, the practitioner learns of a genetic condition in the family and from careful observation of the mother, the practitioner notices facial irregularities. Further inquiry is made about the genetic condition and suddenly the practitioner becomes aware that the time for their appointment is over.

Reflecting Back

The practitioner reflected on how practices were different during this home visit. First, she chose not to ignore a thread of information: the name of a child not present. In their discussion, she learned that the amniocenteses photos on the walls were of their two infants, one of whom had died. The mother described in detail her personal tragic experience of loosing a child, her responsibility to make medical decisions about her child's life, and she acknowledged being at a loss for knowing how to bring these events to closure. The family's lost child and the sadness were still very present in their daily lives and probably for his sister as well.

Did this exploration have meaning for the screening process? The practitioner learned about a genetic condition that had relevance for parents' future decisions to have another child. Support to pursue genetic counseling and where to call to schedule an appointment was certainly useful practical information for the mother. The practitioner actively listened to the mother's story verified the importance of her past loss, its continued presence in the mother's current life, and verified that current feelings about the past are legitimate. She was eventually given a web-resource to help her organize the collected memories rather than forgetting.

Although this interaction and exchange of information resulted in two additional home visits and it did not directly influence the eligibility outcome, the practitioner and parent found the provision of resource information a valuable part of the contacts.

Through contact with other families, we see that inadequate exploration of risk factors, such as the loss of a child, causes us to overlook problems for the surviving child and family members. For example, this can be true when parents perceive the surviving child to carry a special value they may be unable to set appropriate limits (e.g., teaching their child to sleep in his or her own bed). It will be hard for the practitioner and the parent to address other family priorities if grief issues or other relational problems are not addressed. In addition, there is a risk that social-emotional problems could develop.

Continuing Education for KIT Readers

In line with the topical focus on Early Childhood Mental Health, KIT readers are invited 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