RESEARCH TO PRACTICE

Lessons Learned from Interventions to Address Infant Mental Health in Early Head Start

THE EARLY PROMOTION AND INTERVENTION RESEARCH CONSORTIUM

Early Head Start continues the legacy of Head Start in providing comprehensive services to low-income children, families, and communities. The commitment to supporting children's social-emotional well-being is central to the mission of Early Head Start (EHS). However, programs often struggle to understand and address the emotional and mental health needs of very young children and their families and lack the knowledge, skills and infrastructure within the community to assess and serve children. In response to questions from program staff and members of the technical assistance network and at the urging of the Early Head Start Technical Work Group, in October 2000 the Administration for Children and Families held a national meeting, the Infant Mental Health Forum. The primary goals of the Forum were to address the role of Early Head Start and the Migrant Head Start programs along with their community child care partners in promoting infant mental health in all children, preventing problems in at-risk populations, and accessing treatment for those with identified needs. The Forum allowed for the sharing of information from leaders in the field of infant mental health and the sharing of promising practices from Early Head Start programs. See http://www.acf.hhs.gov/programs/opre/ehs/mental_health/index.html for more information on the forum and for a report summarizing the discussions (ACF, 2000). As a result of that meeting, the Early Head Start Infant Mental Health Initiative was begun. The initiative included the Pathways To Prevention Training provided by the Early Head Start National Resource Center (Boss, 2004; Zero to Three, 2004) and a research component consisting of the Early Promotion and Intervention Research Consortium (E-PIRC).

The Early Promotion and Intervention Research Consortium (E-PIRC)

E-PIRC is a research consortium of five grantees designed to develop and test approaches to support the mental health of infants and toddlers and their families within the Early Head Start program (for more info, http://www.acf.hhs.gov/programs/opre/ehs/epirc/index.html). Each grantee partnered with one or more Early Head Start programs to implement their intervention. This research brief highlights some of the lessons learned from this consortium. We provide some specific information, learned from the research projects, related to depression and trauma and then, based on both our own experiences as well as the broader literature on infant mental health, we provide some discussion of how both Early Head Start and Head Start programs can work to address the mental health needs of families and provide support to staff.

Project	Intervention Level	Intervention Modality
Tulane University	Family	Group psychoeducation or therapy for young adolescent mothers
University of Maryland	Program Staff	Enriched staff preparation to infuse infant/toddler mental health into regular program activities
University of Miami	Family	Single-session assessment combined with parent-child psychotherapy
University of North Carolina	Family	Interpersonal psychotherapy delivered to depressed, Latina mothers in the home by nurse-EHS home visitor teams
University of Oregon	Program Staff	On-site mentor-consultant to direct service staff

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EARLY HEAD START

Recognizing Depressive Symptoms in Latina Mothers

"Mis sentimientos me roban las palabras. Nunca le hablo. Lo único que tengo para decirle a la niña son palabras de tristeza. Es mejor no hablarle para nada. Soy una mala mamá."

"My feelings rob me of my words. I never talk to her. I have nothing but words of sadness to say to her. It's better not to talk at all to her. I am a bad mother".

An Early Head Start Latina mother described her silence in this powerful quote, a silence brought on by profound depressive symptoms.

Many families in Early Head Start struggle with depression. In fact, the Early Head Start Research and Evaluation Project found that at the time of enrollment, over half of mothers reported elevated symptoms of depression that placed them over the clinical cutoff for depression (ACF, 2006; Chazan-Cohen et al, 2007). One of the E-PIRC projects, the University of North Carolina project was successful in reducing maternal depression in a population with high needs which often gets overlooked, new Latina immigrants. The mothers in the North Carolina project faced challenges associated with the immigration experience; most spoke little or no English; and all were encountering severe stressors in the form of previous trauma and episodes of depression, poverty, substandard housing, dangerous neighborhoods, isolation, the pressures of separation from their extended families and immersion in a new culture. Many of these mothers had risk factors associated with the development of severe depressive symptoms – a "pile up" of stressful life events, lack of social support, previous depressive episodes, loss of a sense of control and self-esteem, and demanding life roles. While an early childhood intervention staff person might easily recognized the risk factors in a Latina mother, the recognition of depressive symptoms may be complicated by other factors. For example, we experienced the following:

I had been meeting with a group of profoundly depressed EHS Latina mothers for several months exploring their depressive symptoms and tailoring the intervention content to their needs. An EHS staff person was serving as my interpreter. Toward the end of a very difficult group, most of the women were crying hard. There was a loud knock on the door, and the EHS staff person answered it. The bus driver had arrived (early) to take the mothers home. I turned to see who it was and then turned back to look at the group of mothers. Every mother was smiling broadly without a visible tear! I was startled by the group of beaming faces. The EHS staff person talked briefly with the driver, then shut the door. The mothers resumed crying immediately. When we completed the group, I asked them about my observation. They chuckled and shook their heads – "Linda, it is not safe to be depressed here."

The need to hide depressive symptoms and suffer in isolation is the greatest challenge to the recognition of depressive symptoms in the Latina mother, especially if the mother is in an early stage of acculturation. Child-focused enrichment programs serve an essential bridge for newly-immigrated mothers by offering support, socialization, guidance and linkages to essential services. By recognizing depressive symptoms, EHS and other child-focused programs can support the mother and through the trusting relationship, help her accept mental health intervention if needed. Timely intervention can help the Latina mother regain the energy to talk, play and provide an envelope of affection and protection in which the infant or toddler can explore, grow, achieve balanced acculturation and achieve optimal mental health. The most critical step toward recognizing depressive symptoms in Latina mothers is the establishment of a trusting relationship in which the mother can relax her guard and show her "true face." Programs can support such relationships by hiring fully-bilingual staff who are skilled in relationship-based work, and by offering home-based options that reach mothers who may be unable to drive a car or use the bus system, or exercising a culturally-influenced belief that children should be reared at home. If such a mother struggles with depressive symptoms and is also isolating herself, she may be missed in a center-based option-only program.

In the ALAS ["Wings"] project serving EHS Latina mothers in North Carolina, Latina mothers were found to be "triple-traumatized." These traumas were experienced before, during and after immigration to the U.S. by these mainly mono-lingual Spanish-speaking women. These multiple traumas were directly linked to mothers' depressive symptoms with potential deleterious effects on children, including developmental delays, lack of language, and poor regulatory skills.

"My feelings rob me of my words. I never talk to her. I have nothing but words of sadness to say to her. It's better not to talk at all to her. I am a bad mother".

Depression: Signs to Look for in Mothers

In our work with depressed Latina mothers, we have noted other warning signs that may indicate that a mother is struggling with depressive symptoms:

- **Sadness, tearfulness with a visible struggle to enjoy their infant or toddler:** Motherhood was of central importance to our Latina mothers, and depressive symptoms robbed them of the joy and pleasure of being a mother. A striking difference that we noted between our mothers who had depressive symptoms and those who did not was the inability to put the sad feelings aside in the presence of the infant or toddler.
- **Distracted thinking with continual thoughts of wrongdoing or loss:** Mothers may focus on "dark" thoughts that are so persistent, that their ability to organize their work and carry it out may be impaired. Mothers may demonstrate this symptom by being disorganized, having lapses in attention, being forgetful or seeming unable to hear and understand what is being said to them. Mothers may report the symptom as their "stupidity".
- **Fear of leaving home or socializing with other mothers:** A signal sign of depressive symptoms in our work with newly-immigrated mothers was the reluctance to meet other mothers or venture out of their home to planned socializations. A mother who continually refused to become involved with other mothers was often in need of a closer evaluation for depressive symptoms.
- **Sleep problems:** Many of our Latina mothers had trouble with their sleeping, with sleeping too much and (Spanish) "being a captive of their bed" during daylight hours. When we questioned them more closely, their daytime sleepiness was often combined with nighttime wakening or early morning awakening not related to the need to feed or care for their child. Trouble getting up and going was often accompanied by a sense of sluggishness or slowness that is a more typical depressive symptom.
- **Weight gain:** Classical depression literature uses weight loss as a sign of depression with a growing recognition that women may gain weight when depressed. In our work, mothers typically gained weight as an outgrowth of a shift to USA food consisting of processed, high-carbohydrate diets, confinement to small living spaces, transition from rural lifestyles where walking was the primary mode of transportation and a pattern of eating to reduce stress and depressive feelings.
- **Headaches, stomach disturbances and menstrual difficulties:** While there is a belief that Latinas primarily express depressive symptoms through illness, pain and functional problems with their bodies, the mothers in our project did not experience elevated rates of headaches, stomach disturbances, and menstrual difficulties.
- **Family conflicts and parenting stress:** Many of our Latina mothers did not acknowledge their depressive symptoms initially, but did reveal severe relational stressors such as overt fighting or silent conflict with their spouses and turmoil with their parents and extended family. As we addressed their marital or family problems, mothers revealed their depressive symptoms, often seeing them as the reason why their relational problems were such a struggle to resolve. Fathers expressed helplessness in the face of their spouse's symptoms and welcomed support and in some instances, mental health intervention.

Maternal Depression: Signs to Look for in Infants and Toddlers

Infants and toddlers had behavioral changes that also could be observed as a way of alerting programs to depressive symptoms in the mother. These were:

- **Rapid or excessive weight gain:** In our project, Latina mothers who were struggling with depressive symptoms conserved their energy by using feeding or food to calm the infant or occupy the toddler. At the same time, some mothers valued heavy babies because they were "healthy." Thus, assessment of this sign had to be done carefully with attention to the cultural values of the mother. Many of our mothers were breastfeeding, and thus, time spent feeding was a more useful question to ask rather than the amount of daily intake by the infant. Other factors such as living in small spaces and passive play (e.g., watching videos) that were shared by the mother probably contributed to weight gain in the toddlers.
- **Behavior problems:** Children's severe tantrums, biting and antisocial acts that are difficult to control have been associated with depressive symptoms in mothers, and the Latina mothers and toddlers were no exception. However, we discovered that while mothers in the project were upset by the behavior, they also had great difficulty establishing behavioral limits and helping the toddlers gain self-regulatory skills.
- **Language delays:** Bilingual children often lag behind monolingual children in language acquisition, and thus, must be evaluated carefully in the Latino family who is speaking Spanish at home. However, we observed a lack of early babbling and vocalization in the infants in the project, indicative of the strikingly low verbal exchange and prompting by their symptomatic mothers.
- **Neglect or physical abuse:** We observed no instances of either neglect or abuse in our project which we believe was a strength in these mothers who, no matter how little energy they had, made certain that the infants and toddlers were cared for and protected. While reflecting a strength, the lack of visible signs of neglect or abuse in the child may also prevent recognition of depressive symptoms in the mother.

Trauma in the Lives of Young Children

In recent years, the early childhood field has come to recognize the implications of trauma for young children. While the effects of trauma have been long understood for adults, it is clear that highly traumatic events have significant effects for young children too, whether the trauma is a single event or an on-going stressful situation. Parent and child trauma was a central factor addressed by the E-PIRC projects. Trauma included severe maternal depression, exposure to partner and community violence, as well as stresses related to parenting a young child or to lack of resources due to poverty.

Trauma is common in the lives of EHS families. The University of Miami project found that almost three-fourths (71%) of the EHS children had experienced at least one trauma such as :

- child had a serious illness or injury (38%)
- a prolonged separation from their primary caregiver and/or eviction and/or homelessness (23%)
- the death of a close relative (21%)
- the serious injury or illness of a close relative (11%)
- involvement in a serious accident or witnessing one (9%)

About one-third of children also were exposed to violence at home (39%) or in the community (30%). Some children (15%) witnessed a close relative being attacked or beaten.

Trauma Symptoms in Infants or Toddlers: The study found that 44% of the children were reported by parents to be experiencing trauma symptoms. Children show trauma through words, play, and behavior. While some behaviors can be common in early childhood and can reflect temperamental traits or other family difficulties, researchers have found that symptoms of trauma begin suddenly or are severe.

Common Symptoms of Trauma

Sleep	Trouble falling asleep Nightmares
Nutrition	Overeating Finicky eating
Play	Aggressive outbursts Increase in activity level Re-experience the event
Language	Talk less Preoccupation with traumatic event
Emotion	Increased clinginess or separation anxiety Withdrawn or avoid interactions New fears Less joyful Memories of the event Regressive behavior or not acting in age-appropriate manner

Suggestions for Programs

Both Early Head Start and Head Start, as child development and family focused programs, are in a unique position to help families recognize how trauma is affecting their lives and to support the development of strategies to cope with the feelings and behaviors related to traumatic events. The following suggestions, while good practice for all children, may be especially important for those who have experienced trauma. These are general principles from infant mental health literature that were used to inform staff in one on the EHS programs serving children and families affected by Hurricane Katrina. For program staff who **interact with the child**:

Be patient with children when they require extra support

Help children cope with their feelings and emotions

- Frustrations, disappointments, or even being too tired can make young children who have experienced trauma lose control. Taking them aside, patiently talking with them in a soothing way, and allowing them a few minutes alone or in a quiet spot in the room will help them regain emotional control. Some children who have experienced trauma will need physical comfort as well as verbal soothing. When a child is able to calm down, support also involves praising them for being able to get back in control, which helps reinforce the positive behavior.

Provide emotion words; give words to what the child is saying with actions

- Children may not have words for what they are experiencing. Helping them to label how they feel and use words will help them control themselves better and get the support they need.

Prepare them for change or transition, even in every day activities

- When things are so busy, it can be hard to do this, but quick and gentle reminders can help quite a bit with emotional scaffolding and a child's ability to control his or her behavior.

Provide a sense of safety and trust by predictable routines and calm interaction

- This can be hard to do when there are so many active children in the room! But a calm word or two directed at a child who has experienced trauma will help focus them and calm them down, and will make them feel very cared for.

Follow the child's lead

- Children are very good at saying what they need if we listen and observe. An out of control child may be telling us they need nurturing, a few moments alone, or help saying how they feel.

Support the family and the child's existing attachments

- A child who has experienced trauma is quite possibly showing signs and symptoms, which help people pay attention but also can be stressful for caregivers. Helping them is key, too.

Tolerate regressive behavior or a lower level of functioning

- When a child loses skills, like language, begins acting differently, or is having difficulty in some areas, such as sleeping, eating, or playing, it is an important signal that the child may have had a trauma. It is important to realize that this may only be a phase in which the child needs some extra nurturing.

For program staff who **interact with the child's caregiver,** the following principles apply:

- Parents may have been traumatized as well as the child and may need support, and perhaps a referral to a mental health specialist
- Parents also need patience and help with understanding child behaviors, which may be extreme
- Focus on supporting the parent-child relationship
- Help parents interact with children utilizing the same behaviors described for program staff

Improving a mother's ability to respond to her child's trauma is important. The University of Miami research team found that mothers' report of their own response to their child's trauma was a better predictor of child outcomes then was exposure to trauma (Doty et al, 2007; Malik, 2007).

Program Practices to Support Mental Health

The following suggestions for staff support, identification of parental mental health concerns, and mental health consultation, emerge from the experience of the E-PIRC projects as captured in discussions with program staff and they also mirror previous work in the field of infant mental health.

Staff Needs

Working with children and families who have experienced trauma or difficult life situations can impact program staff too. Caregivers who are continually immersed in working with at-risk traumatized populations may experience compassion fatigue and/or sadness for child and family. Staff who experience compassion fatigue, also known as secondary traumatization, often exhibit trauma symptoms, such as:

- Nightmares
- Sense of disconnection from loved ones
- Work addiction
- Sense of hopelessness
- Feeling anxious or on edge
- Increased sensitivity to violence
- Professional burnout

Support can enable front line staff to do the work needed to care for child and family. Programs, as a team and individually, can provide reflective practice or supervision, offer peer support, and encourage colleagues' use of self-care strategies. These supports, often discussed in the literature, were also utilized by some of the E-PIRC projects.

Nurture the Nurturer

How can we nurture caregivers who support high-risk families with young children? A beginning is to identify staff's general and individual needs, including health and training needs. Building a strong organization is important, not only to ensure that program missions for child and family outcomes are achieved, but also to provide a healthy environment for staff. Finally, implementing strategies that provide ongoing nurturing experiences for staff such as professional development, reflective practice which helps to set boundaries between work and personal life, is helpful and supportive.

Self-care strategies for program staff include:

- Avoid professional isolation
- Know your vulnerabilities
- Know when to say "no"
- Respect your boundaries
- Balance work and personal life
- Develop realistic expectations of self
- Experience and address own emotions
- Make time for own interests, exercise and relaxation

Reflective Practices and Supervision

Reflective supervision moves beyond case management; it provides an opportunity to discuss interactions with infants and toddlers as well as their families and provide feedback in a safe environment. Working reflectively, staff may become more aware of interactions that are going well, which provides a foundation for meeting new challenges or responding in different situations. (Mann, 1998; Fenichel, 1992; Norman-Murch, 1996; Parlakian & Seibel, 2001; Parlakian, 2001). Several E-PIRC projects utilized videotapes of home visits as a method in reflective practice. The comments of participating staff illustrate their appreciation of reflective practice:

"…talking about what we were seeing, it was at that point that the "Aha" came on which was the power of the videotape…we could really start to analyze the parent-child interaction, and how parent stuff impacts children. And how these things we call infant mental health are actually born out of parent-child interaction"…EHS home visitor

"I've changed how I respond to staff. I am better at helping them to answer questions and helping them solve their problems rather than offering answers and solutions"…EHS supervisor

"I guess there's a certain level of confidence I feel… And by the time the cases come up, and you talk about it [with a mentor], a lot of learning has happened that can be applied to other situations and other families. So I feel a lot more confident in that."…EHS home visitor

"Having /supervisor/ come out every week through all of this has been a Godsend. I can't tell you. For that one hour or more, sometimes it goes over and to be right in the middle of chaos, but to have that little time of peace and being able to talk about it. I have to walk around all bottled up. That has been a great help."…EHS home visitor

Through reflective practice, staff began to understand parallel process. Parallel process is the link between the functioning of parents and other caregivers (e.g., child care provider) and the mental health of young children

"The most powerful thing I learned was the very real impact that an infant/toddler caregiver can have in children's lives."…..EHS mental health consultant

Identification of Mental Health Issues

Programs should strive to have effective strategies for mental health screening. Parental depression, as the most common issue, which is often associated with other mental health problems, is a good place to begin. There are many ways to build screening into program practice. Two of the E-PIRC projects initiated screening for parental depression by incorporating a depressive symptoms screener, the Center for Epidemiologic Studies Depression Scale (CES-D), into programs' intake process. Screening can also be incorporated into the family partnership agreement process. EHS programs can build on their strong commitment to child screening and assessment. Once a mental health need is identified, the program can work to find services for parents. While not all communities have the mental health resources to help once there is an identified need, at least staff will be aware of the depression and can work to keep the family in the program. We know from past work (ACF, 2006), that depressed parents are harder to keep in the program, but they and their children can benefit from the program. It is worth the extra effort needed to keep them engaged in the program. And, once there is sufficient evidence of need in the population, programs can help to grow services and support within their community.

"(This project/ brought to light the mental health issues. Before I don't think I realized them as being a serious issue or even associating with mental problems. But since I started the training, my eyes are open now and I'm able to really recognize them." …..EHS home visitor

Mental Health Consultation

The Head Start Program Performance Standards require programs to have mental health consultation. Having the capacity within programs often makes it easier for parents and families to access services by reducing barriers and overcoming fears. The program is a trusted and safe place for families to bring concerns. Programs have flexibility in how to use their consultants. From the experience with these research projects, we have found that consultants can be most concretely helpful to program staff if they have infant/toddler training or at least are supervised by people with infant/ toddler training. Some sites may need to access supervision remotely, by web or phone, in order to get this infant/ toddler expertise. Obviously, consultants should have comfort with working with low-income families and working in program settings, rather then a typical mental health office setting, as well an openness to learning about infant/toddler infant mental health, if they do not have that expertise already. They should have the flexibility to meet the needs of working with management, direct service staff (providing staff support as well as addressing the needs of specific children), and directly with families (Zero to Three, 2004).

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Administration for Children and Families • U.S. Department of Health and Human Services

December 2008

Early Head Start evaluation reports are available online at: http://www.acf.hhs.gov/programs/opre/ehs/ehs_resrch/index.html