

**Integrating Bright Futures into Public
Health at the State and Local Levels**



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prevention and health promotion for infants,
children, adolescents, and their families™

BRIGHT FUTURES

Promoting Child Development and Mental Health - (Part 1)

January 26, 2011

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Introduction to Media Site

**Ann Stueck, Infant and Child Nurse Consultant
Bureau of Community Health Promotion (BCHP)
Family Health Section (FHS)**

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Before We Get Started

http://dhs.wisconsin.gov/dph_bfch/MCH/BrightFutures.htm

Remember to complete the evaluation when we are finished.

It can be found on the above website,
along with the slides from today's presentation.

If more than one person is at your site, please send
one email informing us of how many.

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Evaluation for the Early Childhood System Participants

[http://www.dhs.wisconsin.gov/DPH_BFCH/MCH/
EarlyChildhoodSystems.htm](http://www.dhs.wisconsin.gov/DPH_BFCH/MCH/EarlyChildhoodSystems.htm)

Please complete both evaluations by February 9th!

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ASK A QUESTION !!

**by using feature at top of speaker screen
anytime during the presentations**

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PRESENTERS

**Murray L. Katcher, Chief Medical Officer, BCHP
Wisconsin Department of Health Services (DHS)**

**Therese Ahlers MS, MPA, Executive Director
WI Alliance for Infant Mental Health**

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PRESENTERS

**Roseanne Clark, PhD, Associate Professor
Department of Psychiatry
UW School of Medicine and Public Health**

**Pence Revington, Child Development & Home Visitation Specialist
Family Living Programs - UW Cooperative Extension**

**Linda Tuchman-Ginsberg, PhD
Waisman Center, University Center for Excellence
in Developmental Disabilities, University of Wisconsin-Madison**

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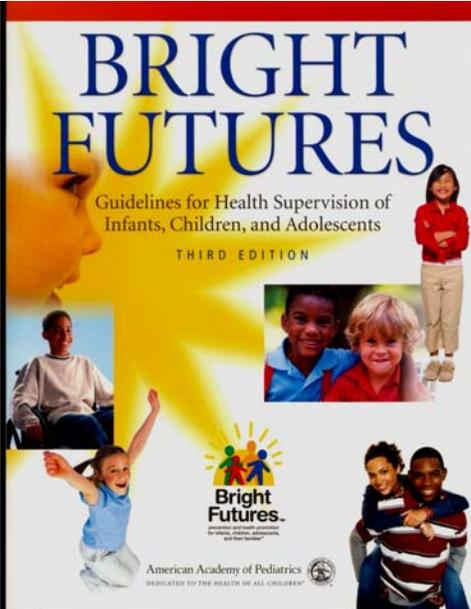
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**Murray L. Katcher, MD, PhD
Chief Medical Officer, BCHP
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What Is Bright Futures?



Bright Futures

Bright Futures is a national health care promotion and disease prevention initiative that uses a developmentally-based approach to address children's health needs in the context of family and community.



Bright Futures.

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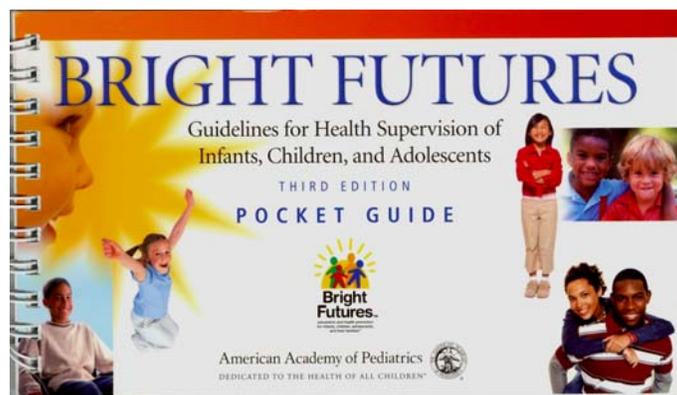
Bright Futures Guidelines—3rd Edition

Features of special interest to Public Health professionals:

- Revised Periodicity Schedule
- Integrated adaptations throughout for children and youth with special health care needs
- Visit section defines newer, more family- and community-driven, enhanced content for the well care of infants, children, and adolescents in primary care practice
- The 10 Themes have special application to Public Health



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EARLY CHILDHOOD | 12 MONTH VISIT

Observation of Parent-Child Interaction: How does parent interact with toddler? Does child check back with parent visually? Does toddler bring an object to show parent? How does parent react to praise of self or child by health care professional? How do siblings interact with toddler? Does parent seem positive about child?

Surveillance of Development: Plays interactive games, imitates activities, hands parent a book when wants a story, waves "bye-bye," has strong attachment with parent and shows distress on separation; demonstrates protodeclarative pointing; imitates vocalizations/sounds; speaks 1-2 words; jaddles with normal inflections; follows simple directions; identifies people upon request; bangs 2 cubes held in hands; stands alone.

Anticipatory Guidance
FAMILY SUPPORT
Equipment to the child's developmental changes and behavior, family work balance, parental agreement/ disagreement about child care.

- Discipline with time-outs and positive distractions; praise for good behaviors.
- When your child is troublesome, what do you do?

Key: Guidance for parent, questions

Physical Exam. Complete, including: Measure and plot length, weight, head circumference. Plot weight-for-length. Examine for red reflexes. Perform cover/uncover test. Observe for caries, plaque, demineralization, staining. Observe gait. Determine whether testes fully descended.

Screening (See p 59.)
Universal: Anemia, Lead (high prevalence/Medicaid)
Selective: Oral Health, Blood Pressure, Vision, Hearing, Lead (low prevalence/Medicaid), Tuberculosis.

Immunizations
CDC: www.cdc.gov/vaccines
AAP: www.aapredbook.org

- Make time for self and partner; time with family; keep ties with friends.
- Maintain or expand ties to your community; consider parent-toddler playgroups, parent education, or support group.
- Who do you talk to about parenting issues?

EARLY CHILDHOOD | 12 MONTH VISIT

ESTABLISHING ROUTINES
Family time, bedtime, teeth brushing, nap times

- Establish family traditions: "What do you all do together?" Tell me about your family's routine.
- Continue 1 nap a day; nightly bedtime routine with quiet time, reading, singing, a favorite toy.
- Establish teeth brushing routine.

FEEDING AND APPETITE CHANGES
Self-feeding, introducing foods, textures, drinking

- Encourage self-feeding; avoid small, hard foods.
- Feed 3 meals and 2-3 nutritious snacks a day; be sure caregivers do the same.
- Provide nutritious food and healthy snacks.
- Trust child to decide how much to eat (toddlers tend to "graze").

ESTABLISHING A DENTAL HOME
First dental checkup, dental hygiene

- Visit the dentist by 12 months or after first tooth.
- Brush teeth twice a day with plain water, soft toothbrush.
- If still using bottle, offer only water.

SAFETY
Home safety, car safety seats, showering, guns

- "Childproof" home (medications, cleaning supplies, heaters, dangling cords, stairs, small or sharp objects).
- Use a rear-facing car safety seat until at least 1 year old AND at least 20 pounds.
- It is best to use a rear-facing car safety seat until highest weight or height allowed by manufacturer; make necessary changes when switching to forward facing; never place rear-facing car safety seat in front seat of vehicle with passenger air bag; back seat is safest.
- Stay within an arm's reach ("touch supervision") when near water, empty buckets, pools, bathtubs immediately after use.
- Remove guns from home; if gun necessary, store unloaded and locked, with ammunition locked separately.



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How do the 3rd edition Guidelines differ from previous editions?

- **Structure**
 - Part I—Themes**
 - Includes 10 chapters highlighting key health promotion themes
 - Emphasizes “significant challenges”—e.g., mental health and healthy weight
 - Part II—Visits**
 - Provides detailed health supervision guidance and anticipatory guidance for 31 age-specific visits
 - Lists 5 priorities for each visit
 - Includes sample questions and discussion topics for parent and child
- **Health Supervision Priorities**
 - Designed to focus visit on most important issues for age of child
 - Anticipatory guidance presented in several ways
 - Include health risks, developmental issues, positive reinforcement



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Wisconsin's Bright Futures Webcasts

http://dhs.wisconsin.gov/dph_bfch/MCH/BrightFutures.htm

Applying the 10 Bright Futures Themes to Public Health

- Promoting Oral Health
- Promoting Safety and Injury (and Violence) Prevention
- Promoting Healthy Weight
- Promoting Healthy Nutrition
- Promoting Physical Activity



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Applying the 10 Bright Futures Themes to Public Health

- Promoting Family Support
- Promoting Child Development
- Promoting Mental Health
- Promoting Healthy Sexual Development and Sexuality
- Promoting Community Relations and Resources



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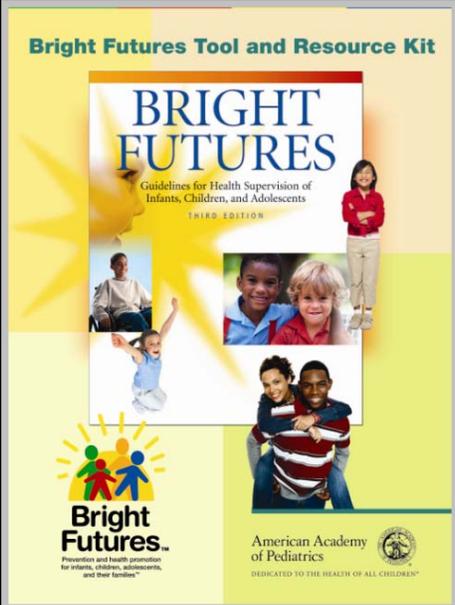
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Bright Futures Tool and Resource Kit



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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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Child Development and Infant Mental Health

Reference: Institute of Medicine Study (2000)

Jack Shonkoff and Deborah A. Phillips, eds

*From Neurons to Neighborhoods:
The Science of Early Childhood Development*

http://books.nap.edu/catalog.php?record_id=9824

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INFANT MENTAL HEALTH

**Therese Ahlers MS, MPA,
Executive Director**

WI Alliance for Infant Mental Health



**What is Infant Mental Health
and
What it is Not**

How is Infant Mental Health Developed?

Why Care About Infant Mental Health?

Infant and Early Childhood Mental Health

The developing capacity of the child from birth to five to:

- Experience, regulate and express emotions;
- Form close and secure interpersonal relationships; and
- Explore the environment and learn all in the context of family, community and cultural expectations for young children

Adapted from a working definition developed by Zero to Three: National Center for Infants, Toddlers and Families—Infant Mental Health Task Force

What Infant Mental Health is **NOT**:

It all started
in my
childhood



Synonymous with healthy social and emotional development

Curiosity

Persistence

Trust

Self confidence

Motivation



Healthy Social and Emotional Development: What is it?

- A sense of confidence and competence
- Ability to develop good relationships with peers and adults/make friends/get along with others
- Ability to persist at tasks
- Ability to follow directions
- Ability to identify, understand, and communicate own feelings/emotions
- Ability to constructively manage strong emotions

**“THERE IS NO SUCH THING
AS A BABY
THERE IS A BABY AND SOMEONE”
D.W. Winnicott**



How developed?

Relationships with parents and other caregivers

- Fostered through nurturing, responsive and supportive relationships
- The child learns that she has an impact on her environment

The first three years of a child's
life are critically important to
brain development

**Plasticity: the capacity of the
brain to be affected
by experiences**

**700 new neural connections form
every second
in the first three years of life**

Domains of development interrelated

Cognitive

Language

Social

Emotional

Physical

**Closely intertwined and dependent on early
experiences and relationships**

Why Care About Infant Mental Health?

- **Babies can't wait**
 - Early years offer a critical window of opportunity –born wired to feel and learn
- **Science supports**
 - Babies more vulnerable than older children to emotional and social deprivation
- **Social and emotional development is firmly tied to all other areas of development**
 - Cognitive, language, memory, physical

Neurons to Neighborhoods: The Science of Early Childhood Development

Why Care About Infant Mental Health?

- **Economic benefits of healthy social and emotional development**
 - Public investment in early years show a huge payoff
- **Social and emotional development linked to success in school and beyond**
 - Poor social and emotional development predict early school failure
- **Protective factor against child abuse and neglect**
 - Center for the Study of Social Policy

- If a child doesn't know how to read, we *teach*.
- If a child doesn't know how to swim, we *teach*.
- If a child doesn't know how to multiply, we *teach*.
- If a child doesn't know how to drive, we *teach*.
- If a child doesn't know how to behave, we ...?

Why can't we finish the last sentence as automatically as we do the others?

- *Tom Herner (NASDE President) Counterpoint 1998, p.2)*

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PARENT- CHILD RELATIONSHIPS

**Roseanne Clark, PhD,
Associate Professor**

**Department of Psychiatry
UW School of Medicine and Public Health**

The Importance of Early Parent-Child Relationships:

Secure Attachment Relationships and the Promotion of Emotion, Behavior and Attention Regulation

The Influence of Parent's Mental Health on the Child's Development: *Maternal Depression*

Intervention approaches for supporting Healthy Parent-Child Relationships: *Special Play*

Roseanne Clark, Ph.D.
Associate Professor of Psychiatry
Director, Parent-Infant and Early Childhood Program and
Co-Director of the UW Infant, Early Childhood and Family
Mental Health Certificate Program



Basic Tenets For a Relational Approach in Infant Mental Health

- The infant's relationships form the cornerstone of their development
- The relationship of an infant and caregiver is the unifying environmental context
- The caregiver is the central organizing agent for the child
- Practitioners value and respect the context of the infant-caregiver relationship
- Relationships are valued as central to all assessment & intervention
- The interaction reflects the life experiences and capacities of both the infant and the parent

-Adapted from AZ Dept. of Health Services (1998)



**There is no
such thing
as a
baby**

Winnicott (1965)

The Importance of Parenting for Infant and Early Childhood Development

Why do early
relationships matter
in social and emotional
Development?



Biological Evidence for the Importance of Early Relationships

- There is growing biological evidence that infants need sensitive, responsive care in order for the parts of their brain that regulate the experience and expression of emotions to develop
- The brain operates on a “use it or lose it” principle as it develops: only those pathways that are frequently activated are retained
- When the caregiver effectively manages the infant’s emotional states, the baby develops the neurological, endocrine and emotional foundations that allow them to gradually learn to regulate their emotions on their own

History of Being Parented



- “Ghosts” & “Angels” in the nursery
(Fraiberg et al., 1980; Lieberman, 2007)
- Representations of history of being parented
 - Adult Attachment Interview (George et al, 1996):
 - Secure, pre-occupied, dismissive



Attachment Patterns

Secure attachment

Parent: *Is sensitive, responsive, and available*

Child: *Feels valued and worthwhile; has a secure base; feels effective; feels able to explore and master, knowing that parent is available and supports autonomous strivings.*

Attachment Patterns

Insecure and avoidant attachment

Parent: *Is insensitive to child's cues, avoids contact, and rejects*

Child: *Feels no one is there for him; cannot rely on adults to get needs met; feels he will be rejected if needs for attachment and closeness are shown and, therefore, asks for little to maintain some connection; and learns not to recognize his own need for closeness and connectedness.*

Attachment Patterns

Insecure attachment characterized by ambivalence and resistance

Parent: Shows inconsistent patterns of care; is unpredictable; may be excessively close or intrusive and then push away; and seen frequently with depressed caregiver

Child: Feels he should keep adult engaged because he never knows when he will get attention back; anxious; dependent; and clingy

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Assessing Strengths and Areas of Concern in Early Parent-Child Relationships

Parental positive affective involvement, sensitivity, & responsiveness

Parental negative affect and behavior

Parental insensitivity, inconsistency and anxiety

Assessing strengths and areas of concern

Infant Positive Affect, Communicative and Social Skills

Infant Quality of Play, Interest and and Attentional Skills

Infant Dysregulation and Irritability

Assessing Strengths and areas of concern

Dyadic Mutuality and Reciprocity

Dyadic tension

Goals of Emotional Development	How Early Relationships Can Support Healthy Development
Homeostasis and Regulation	Awareness of child's sensory thresholds and needs. Provision of predictable, responsive care.
Attachment	Capture child's alert states for pleasurable and joyful face-to-face interactions.
Two-way Communicating	Exchange animated facial expressions, sounds and gestures. Help child open and close circles of communication.
Problem-Solving and Self-Discovery	Utilize floor-time for joint attention and scaffolding to encourage problem-solving. Help child clarify intentions with language.

(Greenspan, 1999)

Early caregiver sensitivity, responsiveness and consistency are crucial for healthy infant/child emotion, behavior and attention regulation

The Importance of the Development of Self-Regulation

Children with inadequate self-control can be impulsive or hyperactive, heightening concerns for safety. At the opposite extreme, children with excessive self-control tend to be anxious or have fixed behaviors. Of course, behavior varies so that a child may exhibit a great variety of behaviors at any given time in response to the same external cues.

Mastering activities in daily life shows that the child is moving toward achieving self control.

Chief among these are learning how to calm herself (which is needed to establish a regular sleep pattern), feed herself, toilet train, and take the major step of attending school.

Health care professionals should actively prepare parents and their toddlers for achieving these milestones through discussing these topics and, when concerns persist after counseling, make referrals for appropriate consultation.

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Early Relationships and Emotion Regulation



- Infancy is a period of relative dependence on adult regulation
- Episodes of emotion dysregulation are typically managed by caregivers - promoting a sense of well-being and minimizing experience of stress and danger

Cole, Michel & Teti, 1994

Early Relationships & Emotion Regulation

- Facilitates periods of sustained attention so infant/child is available for interaction and learning, including exchanges of positive emotion
- Provides basis for secure attachment response



Cole et al., 1994; Ruff & Rothbart, 1996;
Winnicott, 1955

Early Relationships and Emotion Regulation



- Experience of positive emotion helps infants to organize their experience
- Infant-caregiver relationships provides the context for the socialization of emotion regulation - particularly in the context of face-to-face interactions

Cole, Michel & Teti, 1994

Early Relationships and Emotion Regulation



- Infants as young as 7 months old reference the emotional expressions of caregivers before determining their emotional state and behavior.
- Longitudinal studies have demonstrated a relationship between early maternal contingent responsiveness and emotional synchrony and subsequent development of social and cognitive skills related to emotion regulation.

[Pathways to Competence: Encouraging Healthy Social and Emotional Development in Young Children](#)
Landy, 2009

Emotion Regulation Cycle



-Adapted from J. Dean (1999)

Encouraging Emotion Regulation

- “The emphasis in describing different attachment classifications, at least partly, in terms of how a parent and child manage emotions and in linking this to different behavioral and neurobiological reactions has lead to some researchers to describing attachment theory as primarily a theory of emotion regulation.”
(Cassidy, 1994; Hofer, 2006; Laible & Thompson, 1998; Schore, 2001, 2003).
- During infancy, emotion regulation depends on caregiver support and caring responsiveness
 - During caring and attuned interactions, the parent’s emotional containment is absorbed by the infant, which enables the infant to gradually be able to regulate and organize his own states
 - “When a mother is less engaged and sensitive to her infant in the first year, the child will show more signs of anxiety during her third year.”
(Crockenberg, 2006).
 - “Securely attached children who have been responded to consistently are able to accept and understand positive and negative affects, whereas insecurely attached children frequently exhibit limited or heightened negative affect and have difficulty in modulating emotions.”
(Calkins & Hill, 2007; Cassidy, 1994; Laible & Thompson, 1998; Sroufe, 2000)
 - “If parents are dismissive of their children’s emotions, criticize them for having them, or become overwhelmed themselves, the lack of containment results in children being unable to manage their emotions.”
(Berlin & Cassidy, 2003; Denham et al., 2007; Eisenberg et. al., 2001).
 - “Certain characteristics of mothers have been found to relate to emotion dysregulation in children including past experience of trauma, that was related to parenting that is very dysregulated.”
(Kaitz & Maytal, 2005; Koren-Karie, Oppenheim, & Getzler-Yosef, 2004).

Landy, 2009

Early Relationships and Attention Regulation

- Caregivers’ modulation of arousal for the infant helps him focus and sustain attention to interactions with both objects and people
- When an infant is over-stimulated or over-reactive to stimuli, she may withdraw and lose opportunities for interaction and learning
- If mothers are unable due to depression, to modulate environmental stimuli for their infants, the infant becomes a reaction to impingements from the environment or anxious.

(Winnicott, 1965; Ruff & Rothbart, 1996)

Behavior Regulation

Beyond nurturance, love and a sense of security and well-being, children need consistency, clear limits and behavioral guidance to be able to learn to regulate their behavior.

General features of effective behavioral guidance include several essential components, all of which are necessary for successful discipline:

- A positive, supportive, loving relationship between the parents and child (children want to please their parents)
- Clear expectations communicated to the child in a developmentally appropriate manner
- Positive reinforcement strategies to increase desired behaviors (eg, having fun with the child and other family members sets the stage to reward and reinforce good behaviors with time together in enjoyable activities)
- Removal of reinforcements or use of logical consequences to reduce or eliminate undesired behaviors
- Parents can increase the likelihood of achieving their behavioral goals for their child by establishing predictable daily routines and providing consistent responses to their child's behavior. Especially during early childhood,
- Consequences should be administered within close temporal proximity to the target behavior and, if possible, related to the behavior

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Parents can use the following techniques to help foster positive behavior in their child:

- Praise the child frequently for good behavior. Specific acknowledgement (rather than global praise) helps teach the child appropriate behaviors (eg, "Wow, you did a good job putting that toy away!" rather than "Great!"). Time spent together in an enjoyable activity is a valuable reward for desired behavior.
- Communicate expectations in positive terms. By noting when the child is doing something good, parents will help the child understand what they like and expect. Words such as, "I like it when you play quietly with your brother," or "I like that you climb into your car seat when I ask you to," are nonjudgmental statements and communicate to the child that these are behaviors the parents like.
- Model and role-play the desired behaviors.
- Prepare the child for change in the daily routine by discussing upcoming activities and expected behaviors.
- State behavioral expectations and limits for the child clearly and in a developmentally appropriate manner. These expectations should be few, realistic, and consistently enforced.

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Behavior Regulation

Key Messages for Parents:

Discipline means teaching, not punishing.

All children need guidance, and most children need occasional discipline.

Discipline is effective when it is consistent; it is ineffective when it is not consistent.

Parents' discipline should be geared to the child's developmental level.

Discipline is most effective when the parent can understand the child's point of view.

Discipline should help a child learn from his mistakes. The child should understand why he is being disciplined.

Disciplinary methods should not cause a child to feel afraid of his parents.

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Challenges to the Development of Mental Health

Signs of possible problems in emotional well-being in infants include the following:

- Poor eye contact
- Lack of brightening on seeing parent
- Lack of smiling with parent or other engaging adult
- Lack of vocalizations
- Not quieting with parent's voice
- Not turning to sound of parent's voice
- Extremely low activity level or tone

Signs of possible problems in emotional well-being in infants cont.:

- Lack of mouthing to explore objects
- Excessive irritability with difficulty in calming
- Sad or somber facial expression (evident by 3 months of age)
- Wariness (evident by 4 months of age; precursor to fear, which is evident by 9 months of age)
- Dysregulation in sleep
- Physical dysregulation (eg, vomiting or diarrhea)
- Poor weight gain

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Signs of possible problems in emotional well-being in young children:

Regulatory difficulties in sleeping, feeding or behavior

Irritable, serious or depressed mood

Aggressive, disruptive or hyperactive behavior

Avoidant or withdrawn behavior

Excessive fears or anxieties

Hypersensitivity to touch or sound

Disorders of communication or relatedness

Developmental delays

Relationships at-Risk



Effects of depression on
maternal functioning and
mother-infant and family
relationships

Depression and its effects on Maternal Functioning

- Impaired ability to be involved in child's physical care and play
- Irritability and self-preoccupation- inability to meet child's normal needs for attention
- Lack of affection towards child and resulting feelings of guilt and inadequacy
- Anxiety about doing psychological or physical harm towards child
- Feeling confused about how they could feel this way with a new baby

Weissman et al., 1979

Mother-Infant Interaction Quality

- In the still face paradigm, infants of depressed mothers showed less interest, more anger and sadness and a greater tendency to fuss than infants of non-depressed infants. These findings suggest that infants of depressed mothers have difficulty regulating emotions and repairing interactions after a disruption.
- Depressed mothers perceived interactions with their infants more negatively, and showed more anger in interactions with their infants than non-depressed mothers.

Weinberg & Tronick, 1998

Mother-Infant/Child Attachment

- Severity of maternal depression symptoms related to quality of mother-infant attachment
- Disorganized-disoriented attachments 3-4 times more likely in children whose mothers were depressed compared to children whose mothers were not depressed
- Interventions focused on increasing maternal sensitivity are effective in enhancing maternal sensitivity and infant attachment, regardless of risk characteristics

Lyons-Ruth, et al., 1986 ; Bakermans-Kranenburg, et al, 2003; Teti, et al, 1995

Bi-Directional Effects in Depressed Mother-Infant Interactions



Mother's depressed mood may induce a depressed state in the infant

Field 1997

Bi-Directional Effects in Depressed Mother-Infant Interactions



- Infant's subsequent distress and unresponsiveness are likely to maintain and perhaps increase the severity of the mother's depression
- Lack of infant responsiveness may validate the mother's depressive self-schemata and her experience of herself in relationships

Consequences of maternal
depression for infant/child
development and problems in
regulation

Infants of Postpartum Depressed Mothers: Behavioral Observations

- More negative affect both with mother AND other non-depressed adults
 - More sober, sad and/or flat affect
 - More protest behaviors
- Regulation difficulties
- More gaze aversion; less eye contact
- Fewer vocalizations; delayed language development
- Lower activity level
- Limited exploration of the environment

Clark et al., 1994; Field, 1995

Physiologic and Behavioral Correlates of Infants of Depressed Mothers

- Less orienting behavior
- More depressed behavior
- More stressed behaviors
- More indeterminate sleep
- Right frontal EEG activation
- Lower Vagal tone
- Higher norepinephrine levels
- Higher cortisol levels



Profile of
dysregulation

Field, 1997

Effects of ↑↑ HPA System Activity on The Developing Brain

- Ongoing elevated cortisol interferes with memory, learning, attention and behavioral regulation
- ↑↑ Elevated cortisol levels ⇒ contributes to the hyper-responsive infant by lowering the threshold for experience of negative emotions (fear and anger) and for activation of stress systems

Gunnar, 1998

Mechanisms by which Maternal Depression May Effect Infant/Child Development

- Exposure to symptoms
- Alterations in parenting
- Changes in family structure or functioning
- Genetic Factors
- Interaction of genetic and environmental factors
- Depression is incidental but correlated factors are influential
- Interaction of depression and correlated factors

Cox et al., 1987

Risk and Protective Factors Moderating Infant/Child Outcome

- Mothers' personality and history of relationships
- Father's involvement with the child
- Infant/Child Temperament
- Infant/Child Gender
 - *Mothers show more anger toward their sons and sons shows less positive affect and have greater difficulty regulating their emotions*

(Weinberg, 1996)

Risk and Protective Factors Moderating Infant/Child Outcome

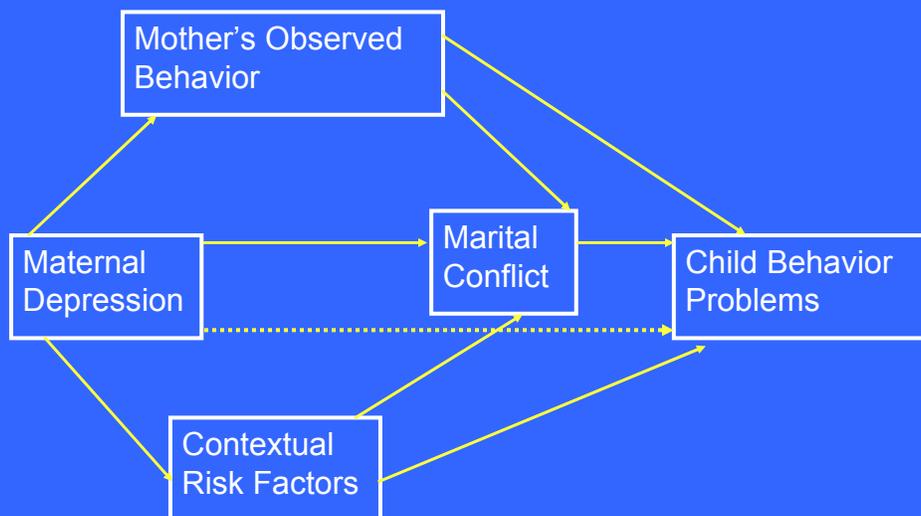
- Length of Parental Leave
 - **Mothers who returned to work earlier expressed more negative affect and behavior in interacting with their infants.**
 - **Mothers who reported more depressive symptoms or perceived their infants as having a more difficult temperament and had shorter leaves, compared with mothers who had longer leaves were observed to express less positive affect, sensitivity, and responsiveness with their infants.**

Clark, Hyde, Essex, & Klein, 1997

Maternal Depression and Child Development

- Maternal depression related to less optimal mental and motor development in infants at one year of age
Lyons-Ruth, et al., 1986
- Women with chronic depressive symptoms were the least sensitive when observed playing with their children from infancy through 36 months
- Children of mothers who reported feeling depressed performed more poorly on measures of cognitive-linguistic functioning, cooperation and behavior problems at 36 months
- **Maternal sensitivity moderated outcomes**
NICHD Early Child Care Research Network, 1999

Theoretical model of the relationship between maternal depression and child behavioral outcome



The Importance of Play

Play is a critical part of development, and toys are a critical part of play.

Health care professionals often are asked to recommend appropriate toys by parents.

Toys should be educational and should promote creativity.

Parents and health care professionals should avoid toys that make loud or shrill noises, toys with small parts, loose strings, cords, rope, or sharp edges, and toys that contain potentially toxic materials.

Toys that promote violence, social distinctions, gender stereotypes, or racial bias also should be avoided.

Video games are not recommended for young children, but, if used, they should be screened for inappropriate content.

Health care professionals should advise parents on distinguishing between safe and unsafe toys, choosing toys that help promote symbolic play, emotional expression and learning, and using books and magazines to read and play together.

Play provides a window into many aspects of the child's developmental progress and into how she is attempting to understand and master the events, transitions, and stresses of everyday life.

Parents and other caregivers should recognize the importance of play for the development of their young children.

Play requires that children feel secure and that the play environment be sufficiently protected from intrusion and disruption.

Parent-child play, in which the child takes the lead and the parent is attentive and responsive, elaborating but not controlling the events of play, is an excellent technique for enhancing the parent-child relationship and language development.

Adapted from Bright Futures, AAP

Special Play



Special Play

Before you start:

- Are you ready?
Rested, smiling, interested
Set aside 10-15 minutes, non-distracted 1:1 time
- Is your child ready?
Rested, good mood, alert, comfortable
–Is the Special Play area ready?
Clean, safe, ready for the child to explore

Starting Special Play

- Tell you child “It’s time for Special Play”
- Help your child select two to four toys and take them to the Special Play area.
- Sit near your child and let your child begin to play.

During Special Play:

- Stay near your child
Follow if they move
- Let your child decide what to do
Follow their lead
When invited join their play
- Stay positive
Give lots of “yes’s”
Bright, positive facial expressions and
tone of voice
Provide encouragement

During Special Play

- Let your child know you are interested
 - Look at him, touch smile and laugh
 - Watch and wonder at what they do!
 - Imitate
 - Acknowledge your child’s feelings and desires
- Talk with your child
 - Describe what he or she is doing...Be a “Sportscaster”
 - Answer when they ask questions

During Special Play Avoid

- Teaching
- Asking Questions
- Correcting
- Directing

Ending Special Play

- Say “It’s time to stop Special Play. I had fun playing with you!”
- If you want, say “Let’s pick up the toys now”.
- Remind your child when you will have Special Play again.

Rewards of Special Play

- Reduction of anxiety
- Reduction of aggressive and acting out behavior
- Increase in compliance in the child
- Increase in a sense of competence in the parent
- Increase in mutually enjoyable times for parent and child together
- Development of trust and a sense of well-being in the relationship for both the child and the parent

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CHILD DEVELOPMENT AND SCREENING

Pence Revington

Child Development and Home Visitation Specialist
Family Living Programs
University of WI Cooperative Extension

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Child Development and Screening

“Bright Futures is a national health care promotion and disease prevention initiative that uses a developmentally-based approach to address children’s health needs in the context of family and community.”

- Promoting Development
- Benefits of developmental screening
- Selecting a screening tool
- Ages and Stages Questionnaires in Wisconsin
- So what?
- Resources

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Language



Intellectual



Social-emotional



Motor



Bright Futures Promotes Child Development in all Domains

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Benefits of a Screening Process

- Detects a child's strengths and needs
- Educates parents
- Builds partnerships with parents
- Opens conversations about concerns
- Identifies children at risk of developmental delays
- Provides a first step in planning for intervention
- Improves health and developmental outcomes through early intervention.

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Selecting a Screening Tool

- Is it valid?
- Is it reliable?
- Is it a normed tool?
- Is it culturally sensitive?
- Is it comprehensive?
- Is it attractive to children and parents?
- Is it affordable?
- What training is recommended?



Ages and Stages Questionnaires in WI

- Rated positively
- Recommended by AAP
- Over 800 home visitors trained in this tool since 2003
- Well-supported by authors
- Well-supported by SPHERE
- Selected by Project LAUNCH
- Supported by Wisconsin Early Childhood Collaborating Partners



So What?

“A developmental screening process helps
us keep the promise
that no child will enter kindergarten
with an undetected delay”

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Resources

- Bright Futures
http://brightfutures.aap.org/pdfs/Health_Promotion_Information_Sheets/childdevelopment.pdf
- Wisconsin Early Childhood Collaborating Partners
<http://www.collaboratingpartners.com/screening-early-identification-resources.php>
- University of Wisconsin Cooperative Extension
<http://parenting.uwex.edu/>
- Regional Centers for Children with Special Health Care Needs
<http://www.dhs.wisconsin.gov/health/children/resourcecenters/index.htm>

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RESOURCES TO SUPPORT PRACTICE

**Therese Ahlers MS, MPA, Executive Director
WI Alliance for Infant Mental Health**

**Linda Tuchman-Ginsberg, PhD
Waisman Center, University Center for Excellence
in Developmental Disabilities, UW-Madison**

**Roseanne Clark, PhD, Associate Professor
Department of Psychiatry
UW School of Medicine and Public Health**

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RESOURCES TO SUPPORT PRACTICE

**Therese Ahlers MS, MPA,
Executive Director**

Reflective Practice

WI Alliance For Infant Mental Health

Competency And Endorsement System

Reflective Practice

Supportive relationship with a supervisor or consultant exploring the feelings and experiences raised by working with young children and their families over time

Provides a safe place to explore, understand, and distill the negative or difficult emotions elicited from the work with young children and their families

Consistent space to become aware of and attend to feelings to avoid reactive responses that can lead to unintended and negative consequences

Three primary facets of reflective supervision

Reflection: supervisor and supervisee's ability to explore the feelings, thinking and observations from a number of perspectives

Collaboration non-judgmental exchanges dependent on the complete attention of the provider and supervisor

Regulation: ongoing predictable frequency of meetings to establish emotional safety in order to explore strengths and areas requiring attention and supported growth regarding the complicated work with families of young children

Rebecca Shahmoon-Shanok (2009) What is Reflective Supervision? In Sherryl Scott Heller and Linda Gilkerson (Eds.), *"A Practical Guide to Reflective Supervision"* (pp. 7 – 20). Washington DC: ZERO TO THREE.



Wisconsin Alliance
for
Infant Mental Health
133 S. Butler St., Ste. 340
Madison, WI 53703
<http://www.wiimh.org>

Our Vision

For every infant and young child in Wisconsin to have his or her social and emotional developmental needs met within the context of their family, community and culture



Our Mission

- Increase knowledge
- Promote collaboration
- Influence public policy



Infant and Early Childhood Mental Health Competency and Endorsement System

Competency: What is it?

“...a set of values, knowledge, and skills that result in a person being able to do the right thing for the right reason at the right time.

Myers, Kaufman & Goldman, 1999 &
Myers, 2007

Competency: What is it?

“...the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.”

Epstein & Hundert, 2002

Competencies are multidisciplinary

- Specific educational experiences
- Direct service experiences with infants, toddlers & families
- Specialized in-service training
- Reflective supervision/consultation for levels 2, 3, and 4

Competency and Endorsement Framework

Interdisciplinary professional development system recognizing competency:

- Infant Family Associate - Level I
- Infant Family Specialist - Level II
- Infant Mental Health Specialist – Level III
- Infant Mental Health Mentor Level IV (clinical, policy or faculty/research)

Why are competency based systems for infant and early childhood mental health essential?

- To guide training programs
- To enhance professional credibility
- To provide benchmarks for knowledge and skills
- To enhance accountability in the infant and family field

Korfmacher & Hilado, Herr Research Center

League of States

- In September, 2007 leaders from states who had purchased a license to use the **MI-AIMH Competencies** and **Endorsement** formed a “league of affiliate states” to support one another in implementing the standards and agreed to convene annually.
- The leadership from these states also agreed that their affiliates/organizations would recognize **Endorsement** by any one of the member states, further promoting reciprocity, collaboration and systems change.

League Members

Alaska Association for Infant Mental Health (Competencies only)
Arizona: Infant Toddler Children's Mental Health Coalition
Connecticut Association for Infant Mental Health
Colorado Association for Infant Mental Health (Competencies only)
Idaho Association for Infant Mental Health
Indiana Association for Infant and Early Childhood Mental Health
Kansas Association for Infant and Early Childhood Mental Health
Minnesota Association for Infant & Early Childhood Mental Health
New Mexico Association for Infant Mental Health
Oklahoma Association for Infant Mental Health
Texas Association for Infant Mental Health
Wisconsin Alliance for Infant Mental Health
Virginia Association for Infant Mental Health

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RESOURCES TO SUPPORT PRACTICE

**Linda Tuchman-Ginsberg, PhD
Waisman Center, University Center for Excellence
in Developmental Disabilities, UW-Madison**

**Roseanne Clark, PhD, Associate Professor
Department of Psychiatry
UW School of Medicine and Public Health**

Mental Health Certificate

University of Wisconsin, Infant Early Childhood and Family Mental Health Certificate Program



Roseanne Clark, Ph.D.
Linda Tuchman-Ginsberg, Ph.D.
Co-Directors

Sponsoring Partners

Continuing Studies at University of Wisconsin-Madison
Professional Development & Applied Studies



- Co-sponsored by:
- University of Wisconsin
 - Department of Psychiatry, School of Medicine and Public Health
 - Waisman Center
 - Professional Development and Applied Studies
 - Wisconsin Alliance for Infant Mental Health

<http://www.dcs.wisc.edu/pda/mental-health/infant.htm>

Appreciations for Contributors

- Wisconsin Department of Health Services
 - Birth to 3 Program
 - Public Health (ECCS, Project Launch)
 - Bureau of Prevention, Treatment and Recovery: Substance Abuse Services
- Celebrate Children Foundation
- Wisconsin Department of Children and Families, Home Visiting Program
- Wisconsin Head Start Collaboration Project

Participants

- Fellows in Infant, Early Childhood and Family Mental Health

Certificate Program Pathways:

- Foundations
 - Early Intervention, Child Care and Home Visitation professionals
- Advanced Clinical Practice
 - Mental health and other licensed professionals



Faculty/Staff

- Co-Directors
 - Roseanne Clark, PhD, UW Department of Psychiatry
 - Linda Tuchman-Ginsberg, PhD, Waisman Center

- Coordinator
 - Ann Whitaker, MS
 - UW Department of Professional Development and Applied Studies

- Wisconsin Alliance for Infant Mental Health
 - Therese Ahlers, MS, MPA
 - Janna Hack, LCSW, IMH-E® (IV)
 - Lana Nenide, MS

Program Components

- Monthly Sessions for 13 months
 - 2-3 days per month
- Readings
- Assignments
 - Infant Observation and Reflection
 - Assessment and Intervention Projects and Reports
 - Individual Projects
- Reflective Mentoring Groups
- Clinical Consultation

Relationship to Endorsement

- Infant Mental Health Endorsement
 - Wisconsin Alliance for Infant Mental Health
 - Associated with the Michigan Endorsement

- UW Certificate Program
 - Helps fellows meet the knowledge base, competencies and reflective practice mentoring and consultation

Reflective Mentoring Groups

- Creates time for thoughtful examination

- Involves stepping back from the immediate experience to sort through thoughts and feelings about what you are observing and doing with children and families

- Creates a “holding environment” for difficult feelings

- Recognizes the importance of relationships and reciprocity in our work.

(Fenichel, 1992)

Reflective Mentoring Groups

- 2 hours per month
 - Mentors facilitate discussion and reflection upon lectures, readings, and Infant Observation experiences
 - Case-based discussions and integration of new learning into Fellows' current work and practice

Clinical Consultation

- For Advanced Clinical Practice Fellows
- 2 hours per month between sessions
- Case-based reflections and learning

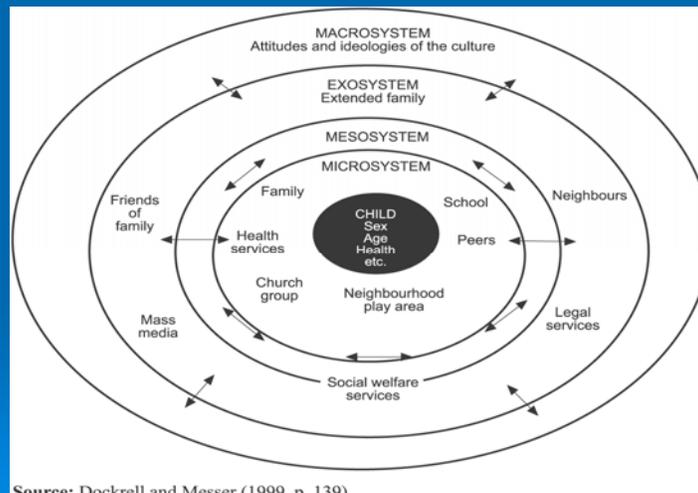
Program Schedule, Content and Faculty

- Based on competencies for the Wisconsin Infant Mental Health Endorsement (WI-AIMH)
- Faculty
 - National expertise
 - State and local expertise
 - Fellows experience and expertise

Framework



An Ecological Model for Assessment and Intervention



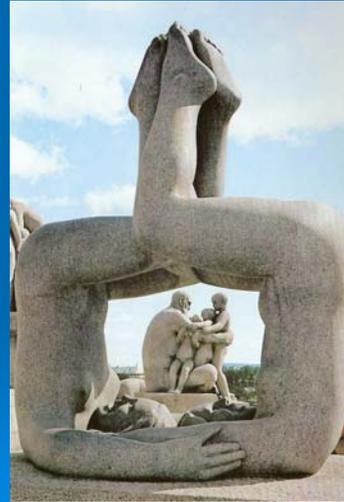
Source: Dockrell and Messer (1999, p. 139)

-Bronfenbrenner (1977, 1986)

Topics

- Promotion of Healthy Social and Emotional Development
- Supporting Early Relationships and Attachment
- Promoting Emotion and Behavior Regulation
- Infant Development and Observation
- Risk and Protective Factors: e.g. Maternal Depression; Substance Abuse; Family and Cultural Values and Support
- Screening and Assessment
- Therapeutic Interventions
- Public Awareness, Policy and Will

Early Experiences Matter: The Importance of Relationships



THANK YOU!

Roseanne Clark, Ph.D.
Department of Psychiatry
University of Wisconsin School of Medicine and Public
Health

rclark@wisc.edu

608-263-6067

Linda Tuchman-Ginsberg, PhD
Waisman Center, University Center for
Excellence in Developmental Disabilities
University of Wisconsin-Madison

tuchman@waisman.wisc.edu

608-263-6467



- **Time for Questions**



~ SAVE THE DATES ~

- **March 22, 2011 - Bright Futures:
Promoting Child Development and
Mental Health Part 2**
- **May 18, 2011 - Bright Futures:
Promoting Healthy Sexual
Development and Sexuality**

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TO DO
Complete Bright Futures Webinar Evaluation!!

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COMPLETE EVALUATIONS:

http://dhs.wisconsin.gov/dph_bfch/MCH/BrightFutures.htm

- **Early Childhood Systems Participants:**
http://www.dhs.wisconsin.gov/DPH_BFCH/MCH/EarlyChildhoodSystems.htm