

MCHB/DHSPS August, 2006 Webcast

Infant Mental Health

August 29, 2006

JOHANNIE ESCARNE: Good afternoon, my name is Johannie Escarne. On behalf of the division, I would like to welcome you to this webcast titled Infant Mental Health. Before I introduce our speakers today I would like to make some technical comments. Slides will appear in the central window and should advance automatically. The changes are synchronized with the speaker's presentations. Do not need to do anything to advance the slide. You may need to change the timing to match the audio by using the slide delay control at the top of the messaging window. Type a question in the white message window on the right side of the interface, select question for speaker, and hit send. Plus include your state or organization in your message so we know where you are participating from. If we don't have the opportunity to respond during the broadcast, we will email you afterwards. We encourage you to submit questions at any time during the webcast. On the left of the interface is the window.

You can adjust the volume by clicking on the loud speaker icon. Those of you who selected accessibility features when you registered will see the text captioning underneath the video window. At the end of the broadcast, the interface will close automatically and you will have an opportunity to fill out an online evaluation. Please take a couple minutes to do so. Your responses will help us plan future broadcasts in this series and improve our technical support. I would like to again say welcome to this web cast. And our first presenter is Yasmin Welch. Our next presenter is Dr. Mimi Graham. The director of the

center for prevention of early center policy at Florida State University. We will defer the question and answer session to follow each presentation. We encourage you to submit questions at any time during the presentation. Please identify which presenter the question is for so that we can direct the question appropriately. Without further delay, we would again like to welcome our presenters and the audience and begin the presentation. Yasmin.

YASMIN WELCH: Yes.

JOHANNIE ESCARNE: You can go ahead.

YASMIN WELCH: Hello. Thank you. Hi, I'm Yasmin Welch, and I could speak on infant mental health for about 30 hours, not just 30 minutes. So I've tried to put together a presentation that describes a few things that are significant, impact of maternal depression on parenting and infant development, what is infant mental health?

Next slide, please. My credentials and if people need to reach me an email address.

Next slide, please. What is infant mental health? Infant mental health refers to the quality of social and emotional development of children in the first two years of life. Because young children social experience and opportunities to explore the world depend on the love and care they receive, their relationship between the baby and the caregiver are central to infant mental health. So what we're looking at is how the mom primarily, or the

caregiver, usually the mom, interacts with the baby, and how they actually are together with each other in sort of a dance that they do back and forth. We'll talk some more about that. Why does infant mental health matter? Research indicates that delinquency, school failure, violence and intervening at an early stage is a preventative approach. If we can access the kids and work with them while their brain is developing, then we are having an impact on them that's going to last them the rest of their lives.

What are the goals of infant mental health? To enhance social competence and emotional well-being in very young children and their families. I think one of the things that is significant is that if we look at some of the social factors that affect our well-being of our families these days, and we consider that by working with very young children we can have a long-term impact on them, it's huge what the goals is. To enhance the care for the young children and their families and form and influence early childhood policy and I'm hoping we are going to hear more of that from our Florida group who will talk after I do. Some aspects of infant mental health, emotional development includes the experience of feelings about self and others with the range of positive and negative emotions, as well as the ability to control and regulate feelings. And healthy social emotional development is essential for successful school and life. I think looking at regulating feelings is one of the most significant things that we do in infant mental health. Because if a child is starting to learn how to regulate themselves appropriately, as they're learning to identify and to actually express their feelings, then they're going to be able to have some self-regulation later on in life which is going to significantly help them emotionally and socially and cognitively as well, because cognitive is the latest to social and emotional.

Caregivers and babies in relationships, a nurturing loving relationship enhances development. We know that in adults, it enhances our mental health. But this also provides what we call a secure base from which children can explore the world. And one thing we know that children do, of course, is with their learning to explore the world, they are also learning about themselves. And if they feel that they have a secure base, somebody who is nurturing and comforting to them, they can come back to the secure base as they go out into the world and say hey, I found something that is maybe a little scary, but I know I can go to mom and she can protect me, and then I try something else that is not so scary and I'm going to be learning about myself and the world as I do this. The more babies explore and try new things, the more success they experience. Kind and nurturing relationships treat children how to treat others. Valued and children loved and cherished are adults who care about others, which is really the goal that we all have for society. How can caregivers nurture social, emotional development? This is one of the things we specifically look at in terms of infant mental health in working with young moms and babies.

Identify and get treatment for emotional problems. For example, depressed mothers have a negative effect on their babies. And I'll talk more about how it affects a mom's parenting and her response to the baby. Understand and respond to baby cues. I think what is remarkable to me, as I was starting to learn infant mental health and watch babies, babies are just enormously interactive with their environment and the people they are around, from the time that they are born even in the womb to some extent. They are starting to

respond to people and respond to their environment around them. Babies born at birth can smell and know the sound of their mom because they have heard her voice in the womb, and they know her scent. They are very responsive to the mom. And if it's responding to the baby's cues, they'll have a relationship that develops that is hugely significant and important. Develop routines to promote predictability and security. Of course, predictability and security are significant to us as adults. Imagine how important they are to a young, young child.

Now, women and depression. Females are twice as more likely to suffer from depression but only in the child bearing years, and five biologically times they are prone to depression. I was telling my husband I was going to learn about the five times, my husband said the first 20%, the second 20%, the third 20% -- it actually does cover a lot of the time that a woman is a woman, starting in puberty and through perimenopause. There are a fast number of years women are prone to depression. Postpartum blues, let's look at specifically depression after delivery, which is significant. 50 to 70% of adult women within 10 to 14 days of having their baby experience some sort of blues. They are transient, they don't last very well, they will go away, they may go away, there is some stress during that time. Perhaps they're not sleeping very well because the baby is waking up, so there are other factors that do come into play. But they do have a sense of feeling of blues, up to 70%, really a high number. 10% of adult women, 14%, I think is also significantly high of teen moms have what we diagnose as postpartum depression within six weeks of delivering the baby. And this can be very serious and very disabling, not only to the mom, but to the baby in the way the mom relates to the baby.

And then, of course, there is postpartum psychosis, there's been a lot in the media regarding this with various types of episodes of moms harming their children, and that's one to two of every 1,000 live births and that is an extremely serious condition. They -- therapeutic steps. What to do about a mom or you have some concerns about it. Talk to and observe the mom regarding the signs of depression. Ask open-ended questions about how she's doing, how is she eating, how is she sleeping, how does she feel about things or activities that she used to get pleasure in? Use a standardized screening or assessment tool. There are several out there. Beck depression inventory, Edinburgh specifically also to woman during the perinatal period, they have tools that women can answer to give a scale and a specific number that can be applied to looking at. Are they depressed, how depressed are they, what further treatment needs to happen? Refer them for treatment or develop a treatment plan if you are a clinician for the mother and the child. I think that is what is most significant, both the mom and the baby are going to need some intervention.

Neonatal effects, decreased motor tone, not track as well, this is impaired attachment, we'll talk more about that, cognitive disturbances, and overall maternal depression is predictive of what we call a negative infant temperament. Needless to say, by the could in -- connotation, is not good. Ways that it impacts parenting. The intersection between the mom and the baby is impaired significantly because the mom is depressed and unable to interact in bright and cheerful and responsive way to the baby's cues. That also then affects the attachment. We'll talk more attachment. When the attachment is affected, it has

serious long-term effects on the well-being. Social, emotional, cognitive development of this child. Of course when the mom is depressed, her perception of the mom's behavior is also affected significantly, and most often ways a mom may see a child as behaving very negatively and be unresponsive to positive behaviors, also because she is depressed so her impression of the child's behavior may be more negative because she is depressed. And then social factors, having a depressed husband, poverty, stressful life.

Let's talk about attachment because I brought it up in the last slide. Attachment is the deep and lasting connection between a baby and caregiver in the very first two years of life. Something that children and caregivers create together in an ongoing, turn-taking relationship. Baby and parent influence each other over time. It's remarkable how I will watch just observing moms and babies together and watch how sometimes there is what I really see as a dance that they do back and forth where a mom will move into a baby and try and interact with the baby and coo or talk, and the baby will smile back and respond and this type of an ongoing relationship, turn-taking is what helps build that attachment. Attachment is a biologically based human need. Babies reach out to caregivers for safety and security and parents protect and nurture their babies. It's one reason why babies look the way they do. They are cute and cuddly. Babies -- puppies are cute and kittens are cute, are like that, because parents then want to take care of them. Instinct to seek closeness for one person who will comfort, protect, organize feelings, help them to regulate and get together with their feelings. This is the back and forth turn-taking the baby will establish with one person in their life.

Caregiving is to watch out for the baby, comfort and protect, and help the baby organize their feelings. And exploration is the baby's instinct to follow the curiosity and their desire to learn because they know there is somebody who is secure for them, who is caregiving, there to protect and nurture them so they can explore the world which may be a little scary place for them. A secure attachment is a relationship that creates confidence in that baby. That is specific protective caregiver is available if needed, and will support the baby's exploration of his surroundings in order to learn. What that really means is that baby recognizes that this person is their go-to person. This person is somebody who they know will always protect them and be there for them. And so it lets the baby feel safe in going out and exploring the world around them so that they can grow cognitively as well as socially and emotionally. The importance of a secure attachment is that patterns of attachment between infants and parents are some of the strongest predictors of social, emotional, and cognitive development, and there are infant attachment classifications. That actually remain stable over time and they are predictive of later infant and parent behavior. Part of what we learn in our infant mental health training is how to assess the patterns of attachment between infants and parents and to be able to actually classify these attachments so we can make intervention plans, treatment plans, and learn how to intervene with the baby and mom in order for them to have the best relationship if there is something such as depression with the mom that may have affected that relationship.

The other part of a secure attachment is children who begin their lives with a central foundation for a secure attachment have better self-esteem, better able to handle stress, their relationships with their parents and authority figures are much better. They have

better behavior and improved academic success in school, and better relationships with our own children. If we are looking at some of the things that are really significant when a child is a young infant, and as they grow it continues to develop into better relationships, better academic success in school, you understand how important it is for a secure attachment between the mom and baby.

One of the impacts of maternal depression on parenting the child, mothers are less attuned to the child. Then they are not as likely to be there and as supportive while the child is exploring the world and they won't have a secure base, won't give as much positive affirmation. Increased hostility toward the child and disengaged with the child. And when these types of elements are present and the child is also less likely to feel secure and safe and be able to grow socially and emotionally. Moms who are depressed also have less positive play with their baby, and less pleasant social interaction. All of these types of things are significant in how they affect the baby negatively. The next slide is a visual of a program called a circle of security which you can look at online. You can log onto circle of security and see the program, it's described, developed by four people who created it really to make a system, a program, protocols available for moms to manage their relationship with their babies more effectively. And what it describes that you are seeing here on this slide are the hands of what could be the mom, which are secure basin, a safe haven.

The baby runs off because they need to explore and the mom supports the exploration, or the dad for that matter. The mom also watches over, delights in the baby, helps the baby,

enjoys the baby. And once the baby has explored a little bit he comes back and the mom is welcoming to the baby. And the child knows that the mom is there, and that I can reconnect and I have a safe place to go to. So what the parent does, really, is protect, comfort, delight in the baby and help organize the feelings, and I love what it says for the parent. Always be stronger, bigger, wiser and kind. Whenever possible, follow the child's need and whenever necessary, take charge. This really is a good description of what it's like for a child to be able to go explore the world and then come back to the secure base like children do. Most of you who are watching this webcast I'm assuming have worked or work with young children and parents, and if you observed for a little while and you noticed that a child very often will go off and try and explore the world, but always will either look back or run back to touch the mom to check in with the mom. And that's a secure attachment. What can happen if the child does not have the early relationship? The baby may be sad, lethargic, they can be observed. Some babies may develop eating or sleeping problems. Some will self-stimulate where they rock back and forth and seek hugs from anyone.

Infant mental health training was with Dr. Charlie Zeanuth. And he shared with us videotape of some of the children he will worked with in Romania in the orphanages there, and it's something that impacted me to see how the babies who did not have obviously healthy early relationships growing up in an orphanage with multiple caregivers, were using different things to self-stimulate. It's sad to see that. So being aware of some of the symptoms is significant when we work with babies they may not get the attachment they need. Some babies get angry and aggressive. Behaviors that indicate emotional or mental

health problems with babies. Most infant and toddlers are full of different emotion. They won't show interest in sights, sounds or touch, or be as responsive. Difficult to sooth or console. Most moms in learning to be with their baby and growing to love their baby actually know what to do. So when I work with a mom and baby and see it's hard for her to console the baby, then it's a red flag for me to consider something is going on here that shouldn't be happening. Babies who are unable to comfort or calm themselves down, where they just kind of start to escalate in their emotion and their crying and kind of spiral out of control and are not able to regulate themselves are babies that don't turn to familiar adults for comfort. It's also a huge red flag. Sometimes I hear families who tell me oh, he's such a happy baby. He goes to anybody and he's happy with anybody, and I'm thinking in the back of my mind that may not be so good. Sometimes babies like to stay with one specific person and they are not happy going to a lot of other people.

Preschool children, a little older than infants cannot play well with others. An absence or lack of language, and that's very noticeable. Preschoolers are starting to talk a lot and they want to talk a lot. Frequently they'll fight with others. They may be extremely active. Their sudden behavior changes. Destructive to self or others. In my practice, and I'm a clinician, I work directly with moms and babies, some of what I see, a very young child, 2-year-old, 18-month-old, may be diagnosed by a pediatrician as attention deficit disorder showing up as their extremely active behavior. Upon my evaluation with them, it's determined it may be that they have a very depressed mom who actually needs the intervention. So, looking at some of these differences in the symptoms that show up with

mom and baby can help give a specific diagnosis and you need an infant mental health trained person to be able to identify those things.

How infant mental health interventions can help. A specially trained intervention can screen mom and babies and provide recommendations. It amazes me sometimes people are so willing to address the problem specifically with the child. Oh the baby is too active, this baby cries too much, this is a really fussy baby. Without looking at how significant the mom is to that relationship and how we need to pull that mom into that and look at some intervention for the mom and baby together because the baby is not alone. If this baby is relating to the world based on its relationship with its caregiver. Infant mental health intervention can be with the mom or the baby alone or together, as I said. Evidence indicates these interventions are effective in enhancing development and later problems. As I indicated earlier, in terms of violence or substance abuse or diagnosis later in life can be prevented if there's intervention at an early age. Research has also shown that infant mental health intervention can prevent other disturbances of early childhood to ultimately be quite successful and cost effective in the long-term. The cost effective piece of that is what is significant to me and in terms of policy making also, that if we can do something at this stage when they're so young, and intervene with them without it being very costly, we can keep them out of the jail system and being incarcerated, which is extremely costly later in life. They won't be as prone to do drugs or prone to violence, etcetera. So I think looking at some of the elements of infant mental health and working with moms and babies is significant to me in that in the long run it proves done much cheaper than other implementations in people's lives. The last slide is about credentialing and training. Most

specialists, consultants, have a masters in psychology or social work or others, and there is lots of training available around the country. I put some websites in there as a reference. Of course I put Charlie's book, it's the text we all use, so if there are any questions we'll defer them to towards the end of the webcast. You may also email me. My email is on the set of slides, and the information is available if you have any questions after this webcast. Thank you.

JOHANNIE ESCARNE: Thank you, Yasmin. Now we will hear from Dr. Mimi Graham.

MIMI GRAHAM: Hello. Welcome from Florida.

JOHANNIE ESCARNE: JOHANNIE ESCARNE: Hi, Mimi. Go ahead.

MIMI GRAHAM: Hi. Can you see me?

JOHANNIE ESCARNE: Yes, we can.

MIMI GRAHAM: Okay, great. And are the slides up? There. Can you see them?

JOHANNIE ESCARNE: I won't but the audience will be able to see them.

MIMI GRAHAM: Okay. Good. Greetings from Florida. We are hoping this hurricane doesn't manifest here, although some of our programs are closed in the state today. So, I

enjoyed listening to Yasmin and I, too, have been asked to talk about what is infant mental health. If you could show the next slide, I think a lot of folks have this misconception of some baby laying on some Freudian couch, it means the first five years of life. Some people have been debating what to call it over 25 years. We decided to go ahead, if it's good enough for the world, it was good enough for Florida. Generally infant mental health covers the first five years of life. The next slide is what really is infant mental health? And there is, as many different definitions as there are people who were involved in it. There's a delay here with the slides. So the definition we use is from 0 to 3, and that ask, from the prenatal period to 5 years of life, how children grow and develop and how they develop relationships.

Next slide. In Florida, we have developed a three-level kind of chart that has really helped us to show that there is a role for everybody. You can do the next slide, please. It's not just typical mental health that is reserved for mental health therapists, but rather there's a role for everyone. And so I would like to explain these three levels. Level one is really a prevention level. And it's for all people who come into contact with children. Level two are for those children, more of an intervention. It's for those children who are at risk for some kind of mental health problem, and then level three, those children who have a diagnosable mental health problem. So level one here is strengthening the caregiver/child relationship. Level one services are a range of services in the prevention mode. And there are many of these.

The first one is responding to the baby's cues. We can have the next two slides, please.

So this is the list of what we consider the prevention level one services. The next slide, so I'm going to give you examples of each of these. So one of the most important infant mental health services is prevention, responding to the baby's cues, and how many times have you been on a home visit or you have been with folks who don't recognize that the baby is tired, it's 10:00 at Wal-Mart the baby is crying because they haven't had dinner and they are sleepy, and so recognizing what the baby's cues, and responding appropriately are one of the key features of infant mental health. The next slide is about incorporating brain development and attachment theory -- you are going backwards, please, go to the next two slides, so you should be on the one that says attachment.

So incorporating attachment theory into whatever services that we have. So, for example, in our juvenile delinquency program here in Florida, and probably other places, it's the policy that incarcerated girls, to the next slide, that they take the baby away at birth. Now, these girls are generally incarcerated because they hit their mother or they have stolen a pack of cigarettes or some kind of juvenile delinquency and they happen to be pregnant. So that should be an opportunity for the pregnancy period is generally an opportunity that women fall in love with their babies, and it's a time of attachment. And so what we'd like to see are that these theories of attachment are incorporated into whatever kind of work that you have going on. The next slide, this one, is knowing how to effectively manage behavior that supports emotional development. This little girl was, she was being required to brush her teeth and so she was having as a typical toddler, has a tantrum and so the mother is down on all fours trying to make her brush her teeth. That's not effective way to

support her emotional development. She doesn't feel confident, she feels ashamed, she feels angry, and so knowing that toddlers tantrum and they like to have it their way and helping to manage and control their behavior in a way that makes them feel competent and confident, not ashamed.

The next slide is about responsive caregiving. And another preventive mental health approach is helping caregivers to be responsive to the needs of children. So when children cry, we are not crying just to, you know, annoy their parents. They cry because they have a need. Their diaper is wet, too hot, hungry, they have some kind of problem that they are trying to communicate. And what we know is that when kids get responsive care, they are more likely to be attached, they are, have a higher level of intelligence and they do better. And yet so many caregiving situations, the caregivers are nonresponsive. How many child care centers have you walked in and children are left in their cribs crying, or their needs are not attended to. So an approach is responsive caregiving. So we also know that responsive caregiving is a buffer for stress. Dr. Gomers work out of the University of Minnesota on Cortisol has shown responsive caregiving can buffer some of the negative effects of stress.

Next slide, please. So another key infant mental health service is family support. And we see this in home visitors, healthy families, healthy start, early head start, and programs that support the families. And we do this by helping families understand what is a typical toddler behavior, that -- that biting and tantrums are, the kids are not just being mean, but these are developmental milestones for toddlers. The next slide shows the parallel

process of how when we as supervisors support our home visitors, then the home visitors feel all nurtured, and then they support the parents, and the parents can nurture their children. There is this parallel process of emotional support. And family support.

Next slide. And so when, when car -- caregivers feel supported, they are more able to be emotionally available for their children. The next slide, understanding the is sequence of development. What we know is that when parents understand that children go through these stages of development, that all children go through the same sequence. It may take longer for some children, but they all go through the same sequence of development.

Then they can understand what, that their child last week went to grandma or to anybody.

This week they are into stranger anxiety. When they understand those developmental milestones then they are better able to appropriately respond to their children. The next slide is about knowing how to comfort children during those developmental, those difficult stages. So, for example, we know that children go through a stranger anxiety phase, from about eight months to sometimes 18 months. So you would want to make sure that you don't move the child to a new caregiver, a new child care center during that difficult developmental time. So when parents understand these situations, they can prevent emotional trauma for the baby and for the adult.

The next slide is about appropriate developmental expectations. And child abuse is often the results of inappropriate he expectations. In Miami, we had a mom who had her 2-year-old go down two flights of steps and take out the trash. Or an 18-month-old potty trained, they are not ready to control their bladder. So helping parents to understand what is a

reasonable expectation is a way to prevent mental health problems. The next slide is about being able to recognize problems and know when to intervene. What we encourage is that we look at what the behavior is. So if the kid is biting, for example, when I was principal at the school, we had a kid who bit 27 times one day. We tried to figure out well, it turned out both of his parents were in jail and lived with an elderly grandmother and she worked the night shift. And this kid was angry. The only way -- he was preverbal, he could not say I'm mad, all he could do was to bite. We started giving him lots of love and attention in the morning. Within two weeks he quit biting. How many kids are kicked out of their child care program because we just look at the presenting behavior, not the underlying trauma or emotional needs the child is not having met.

The next slide is about the size of problems in a baby. And so some babies who haven't been picked up out of the crib, they resist holding because they have never been picked up. Their whole world has been in the crib. So they find it offensive to actually be picked up. Or you have the other kids that are clinging and other kids who just cry and cry and cry and who are insoluble. The failure to thrive kids. We had twins in Miami who were not taken out of their crib in the first year of life and they actually had what they called inorganic failure to thrive. The brain circumference decreases because they are not held and love so their body actually stops growing. Other signs of problems in a baby are kids who will just randomly go up to any caregiver. They are just so starved for attention that they are indiscriminate. Most babies only go to people they know. So the babies that are not getting the kind of emotional support they need will go to anybody.

The next slide is signs of problems in the caregiver. Have you seen these types of mom who have little interest in the baby, don't look at the baby, the babies have a flat head from being in the car seat because they are never taken out, they go from the car to the house to the child care in the same car seat. Or the parents who rarely speaks to the baby or who speaks angrily to the baby, or just doesn't seem to enjoy -- there's not a reciprocal. There's no joy in holding and smiling with the baby. Those are some of the problems you'll see in the caregivers. So who provides -- all of these are examples of preventive infant mental health or the level one. And if you'll show the next slide, who provides these level one mental health services? These are a lot of your front line caregivers. These are parents, these are child care providers, health care providers, anybody who comes into contact with a child is in a position to either enhance their social emotional well-being, or to detract from it. So we would hope that everybody who comes into contact with young child would be supporting these preventive types of mental health services.

The next slide starts the level two. Now these are the children who have some kind of risk for a mental health problem. So perhaps it's that their family had a mental health problem, their parents have a history of depression or violence, they are in child welfare, they have a developmental delay. For some reason these children are at risk for a mental health problem. The next slide shows children in the high risk nursery like the newborn intensive care. We know that some children spend the first year of life, or extended time in the hospital. Used to, you weren't allowed to even hold the babies. Now at least, you know, parents can go in and hold babies. There could be all kinds of attachment problems from the babies having prolonged periods of time being separated from their, their caregivers.

The next slide shows children with risk or disabilities. We know that these kids that, that development is interrelated, so sometimes if they have a cognitive problem or a motor problem that can cause a problem in another area, including emotional problems.

The next slide is infant mental health for pregnant and parenting teens and their babies. What we know is teen mothers are often going through their own adolescent development, and are not always attuned to their child's emotional development. So really you have the teenager and the toddler acting out in similar ways. So helping these teen moms to realize their baby is not throwing things on the floor to annoy them, they are interested in cause and effect. They are little scientists, trying to see what happens if I drop my bottle off the high chair, or what happens if I do this. And so we do a lot of work with teen mom, helping them to understand many of these teen moms have never been parented themselves. They don't know, nobody read -- read stories to them or tucked them in at night, or kissed their boo-boos, or helped them when they were feeling afraid. And so teaching them to parent as they would have liked to have been parented.

So the next slide is well, who provides these kind of intervention, the level two mental health services. These are social workers, therapists, child development specialists, mostly degreed or master degree folks in early childhood programs, nurses, OT, PT, speech therapists, folks working with these at risk children. The next slide goes into the level three. We talked about level one prevention, level two and level three being treatment. So these are children with a diagnosed mental health condition. And we know through the good work of the 0-3 colleagues, they have developed a classification system

especially for children 0-3. We know kids under 2 cannot tell us they are mad because they saw their dad do something last night, or haven't been getting their needs met. They can't tell us verbally why they have problems. So it -- so these folks are especially trained to recognize the other cues. They are sleeping, eating, their responsiveness to see if they have a problem. And what we know is that children even before their first birthday can suffer from depression. We know babies learn by imitating their moms. If their moms have the flat affect, and the babies try to smile, but they have a flat response, the baby can mirror her depression. Babies can suffer from post traumatic stress syndrome. They can internal eyes and have diagnosable mental health conditions.

The next slide defines attachment disorder when there are difficulties so profound and pervasive there is a high chronic risk of chronic distress. And we know the good work as Yasmin was talking about of Charlie Zeanuth working in the orphanages. You don't have to go to Romania to find children with detachment disorders. Some children have been in 20 different foster care homes by the time it's their first birthday. These kids have all kinds of attachment problems because of the way the systems work. So the next slide says what are the types of people that work in the treatment area? And generally these are licensed mental health specialists. These are people with clinical competency, they know how to diagnose and treat children under 5. What I'd like to talk about now, what are the five characteristics of an infant mental health approach?

Our slides are a little delayed here, if we can get to the next slide. In Florida we did not have any infant mental health therapists five years ago. So one of our priorities was to

bring training to Florida. Over the past five years we have trained over 100 licensed mental health therapists to have expertise to work with children under 5. So these are the five characteristics of a mental health approach. And if we could talk briefly about these, so the, go to the next slide, the first of these characteristics is a relationship-based framework. That's probably the most defining characteristic of an infant mental health approach, it's not, the intervention is not just focused on the baby or the adult, it's focused on the relationship of what happens between the child and its caregiver. There's no such thing just as a baby, every baby exists within the context of a relationship of a caregiver. And so the -- so this work is based on the relationship and on the attachment and the way the parent and the caregiver interact. What we know as we go to the next slide is that children thrive when they're in a loving relationship. And even children who are not in a good situation, the research has shown if they have one person in their life that they have a good relationship with, it can mitigate all those other negative influences.

Next slide. So what we know about development is that this whole cycle of mental health begins very early in life. A baby has a need, and the baby's wet or hungry or wants to be held and the baby cries. And if somebody comes and meets the baby's need, then they build trust. And they learn predictability, and learn if I cry I get my needs met. Lots of babies don't have their needs met. When I was in Miami, it was during the crack cocaine days. We went to a home, the mom had the baby in a shoe box under the bed and she was out finding her next crack deal. So this baby cried and nobody came and the baby cried harder and still nobody came. So the baby gave up. And so that baby does not learn about trust. That baby learns that there is not a predictable world. And so this mental

health approach is about the relationship and establishing trust and trusting relationship early in life.

The next slide is the second characteristics of an in -- it's multi-disciplinary nature frplt -- it's the judges, the school care, health care professionals, everybody has a role in the infant mental health. Because we all can either help in the prevention, the intervention, or the treatment, depends on your specialization. And the third is that it's developmental. What we know, all children develop in the same sequence. Never heard of a kid running before they walked. They have the same sequence of development. Some may do it earlier than others, but all go in the same sequence. What we know, the sequence of emotional and social development is also in a predictable sequence of development. What we know if you'll go to the next slide, young children learn best in the context of relationships. They learn best when they feel loved and cared for. When they feel competent. When they are playing. This is the way children learn, not by rote learning, ABCs, without the context of relationship. So we are concerned about the whole school readiness when it is outside the context of relationships and the social and emotional development is just as important as the ABC kind of readiness for school.

The fourth characteristic of infant mental health approach is the next slide, is that it is multi-generational. It's about the parent and the child. And often we are working with the parents' unresolved emotional or mental health issues, so that we don't transmit them from one generation to another. And we know that many things, like depression, there can be a genetic component but there is also the environmental component, and kids who

have both the genetic and the environmental problem are at much higher risk than others. The next is about attunement. When we are hoping for is that parents fall in love with their baby, that they are attuned to the child's needs, when the child is happy, when the child is afraid. If they can see the cues and respond appropriately, depending what the baby is communicating. The fifth and final characteristic is a focus on prevention. And we know that, for example, quality child care can be the same component of quality care are those that are qualities of infant mental health, having a primary caregiver, at this -- continuity, small group size so there are not too many kids to take care of, so the caregiver knows the baby's cues and knows Sally likes the pacifier, and Johnny sucks his thumb. They know the cues. Focus on prevention in the hospital. Nurses know the babies need to be held and encourage the parents to come in and hold the babies. Physicians that screen for depression or looking for those signs that there is any kind of problem. And judges who realize that children do best with the same caregiver. And so they don't put them in multiple placements, and so they have attachment concerns.

The next slide is about ways that we can infuse infant mental health into health care. Some of Gunner's work on Cortesol, they have been able to swab the kids inside the mouth and look at the stress when the children that come in for the immunizations. What she's found, children who sit on the mom or dad's lap, they may cry but don't cry as long because they feel the support of their parents. So little things that health care providers can do to reduce the stress. We also, there is great work going on at Erickson Institute in Chicago of using the routine medical visits, like the sonogram time as a way to help mom fall in love with their baby. Half of pregnancies are unintended. So if we can use those

opportunities as they come in to see the so in a gram and say look at the baby, look how they are growing, what do you think is developing this week, and help them to fall in love with their baby during the pregnancy time, during these routine medical visits.

The next slide is about, is timely, it's about the American Red Cross, and we have had more than our share of hurricanes here in Florida, and what we saw after the hurricanes was that there was a lot of focus on getting folks the basic needs, their food and shelter. What there was not was any kind of reassurance to the children. We have children who are, you know, when it starts raining they go into this terror alert that oh, my goodness, the hurricane is coming again. And so what can we do to help the American Red Cross to prevent and to reassure children and to help after hurricanes, to help reassure children that they are going to be okay. One of the things we have done, the next slide, is on our web site, is to put some resources that you can download and use with families to help reassure the children about the storm. And then the final slides are just in summary that 100 years from now it won't matter what your bank account was, or what kind of house you lived in, or what kind of car you drove. But the world may be different because you were important in the life of a child. And what we know is like the starfish story, you know, you throw in one, there's -- it mattered to that one. It mattered to this child what we did, and what we also know is that our policies lag way behind our practice. And so wouldn't it be a better world if we could infuse these different mental health strategies into our programs?

I'll finish with the last slide, which is one of my favorites, we hope that the day will come when the progress of nations will be judged not but their military or economic strength, nor by the splendor of the capitol cities, but the well-being of their people. From UNICEF. My email is at the end if you have any questions. I would be happy to respond. Thank you so much.

JOHANNIE ESCARNE: Thank you Mimi for that wonderful presentation. We have now entered our question and answer portion of this webcast. There are several questions. Since we have about 20 minutes, in case your question is not answered, I did want to remind the audience that I will be relaying the questions to the speakers if we do not have time to answer all the questions. The first question is for Ms. Yasmin Welch. The first question is, if the mom refuses to be referred for treatment for depression, how do you develop a plan? Is there a guide to developing a plan? Yasmin.

YASMIN WELCH: Yes. Here I am.

JOHANNIE ESCARNE: Okay.

YASMIN WELCH: That's a hard question to answer because hopefully in working with the mom and baby you are going to be able to sometimes what I call use the baby as the incentive for the mom to get into treatment if she is diagnosed as depressed. So what, what I do in working in those situations is to work with the mom and showing her look how your baby responds to you, and how he doesn't respond to you at certain times perhaps,

when she has more of a flat affect, and not as cheerful and interactive with the baby. So the mom would want to improve herself for the sake of her baby. So it's not easy to provide treatment for people who are not willing to go in for extreme. But using whatever kind of gimmicks or types of influences that you have, and other systems, I think Dr. Graham spoke very well of prevention approach using the front line workers. Case managers, people who are connected to the mom and perhaps can help influence her in a way that they can illustrate, too, it's for the baby's sake she's going to get treatment.

JOHANNIE ESCARNE: Thank you. The next question is also for you. How do multiple caregivers affect secure attachment. How can child care providers and parents work together to strengthen attachment?

YASMIN WELCH: One of the most significant things about attachment is that babies connect with one primary person that they feel safe with and connected to. So even if a child is in daycare during the day, hopefully they're at home with the primary caregiver in the evenings, and even that limited opportunity can be really quality time. There are some things that we teach our moms that bathing, for example, can be a time of bonding. Feeding is a huge opportunity for bonding. So, some of those types of routines and regular types of things we do with the baby can be huge for developing that bond, even if the child is in daycare during the day.

JOHANNIE ESCARNE: Thank you for that response. The next question, I believe, can be directed to either of our speakers. The question is, are there any studies or information on

the role of father's mental health that can play in infant's mental health? I don't know which one wants to go first.

MIMI GRAHAM: It doesn't matter. I'll just say there is limited, but there is research showing, looking at father's depression and it also has a negative effect on the children. There is longitudinal research about depression, those kids whose moms did not get treatment in school age, and there is the look at the father. So I think you could probably just Google, you know, fathers and depression, for example, and find some of that research.

JOHANNIE ESCARNE: Yasmin, do you have anything to add?

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YASMIN WELCH: I'll agree with what Dr. Graham had to say.

JOHANNIE ESCARNE: Thank you. This question is directed for Yasmin. When you state intervening early, could you give a parameter on how early? Under 1, under 3?

YASMIN WELCH: I recommend intervening in the prenatal period if that is at all possible, to try and support the mom while she is pregnant so that she takes care of herself through her pregnancy. Because if she has a healthy pregnancy, then she's likely to also be more connected to the baby and then, therefore, be, have, the baby will have a secure attachment. So as far as I'm concerned, early intervention is prenatally while the mom is still pregnant.

JOHANNIE ESCARNE: Thank you. Another question for you. You list unable to comfort or sooth self as a sign of an emotional problem for a baby. Is this -- what age are you suggesting a baby should be able to do this?

YASMIN WELCH: I think the biggest consideration is that babies start to regulate themselves and they learn some self-regulation as they, from two months on. There is some actual interaction with other people. And their regulation is also dependent on how their routines are established and how well, as Dr. Graham pointed out, there is predictability in their life. So I think the consideration is that if there are these other things established for a baby, the routines with predictability in their environment and they learn to regulate their environment. They will be able to sooth themselves from a very, very young age, beginning at two months.

JOHANNIE ESCARNE: Thank you. Another question for you. You talked about the most susceptible periods in a woman's life for depression. Postpartum depression, more of a chance later in life, or if the risk is the same as a woman who does not have postpartum depression?

YASMIN WELCH: I'm going to answer that question in two different parts. Definitely if a woman experiences postpartum depression, she is more at risk for depression later on in her life. But it's also the other way around, the second part of the question. If a woman is already at risk for depression, even prior to postpartum, before she has a delivery. For

example, if there is a young girl who is diagnosed with depression in puberty, she is more like -- likely at risk for postpartum depression. But yes, definitely, there is more of a chance of depression involved at any of those stages.

JOHANNIE ESCARNE: Thank you. The next question is for Dr. Graham. Providing responsive care in a child care center takes time and effort. Child care centers are often dealing with limited resources. How might these centers improve their level of responsive care?

MIMI GRAHAM: Well, some centers use foster grandparents or parents to come in and to supplement their ratios. But having adequate staff is one of the most important things. I mean you can't hold but, you know, the ratio in a good center is one to four babies. It's hard to hold four babies and be responsive. But I think that if we have kont new -- continuity of care, it's easier to be responsive, than the centers that move them every several months to a new caregiver. So keeping the same staff over time, supplementing ratios, having the kids interesting with what we are doing. When the kids are playing and happy, then they need less intervention.

JOHANNIE ESCARNE: Thank you. The next question I believe is directed to either of our presenters. Does Texas have an infant mental -- does Texas have any infant mental health professionals. If so, where are they located?

MIMI GRAHAM: I do know there is a Texas infant mental health association.

YASMIN WELCH: I was getting ready to say the same thing. I know there is a Texas infant mental health association. I'm not sure of the training in Texas but you can probably find that on line.

JOHANNIE ESCARNE: Thank you. I believe this question could also be directed to either of our presenters. If a baby's brain is your -- circumference shrinks with the lack of the failure to thrive, would it go back?

MIMI GRAHAM: The failure to thrive, in six months they were back on target, developmentally, and so that's the wonderful thing about the plasticity of the brain, it can decrease and increase. So that's the amazing thing about early intervention, it's always better to do it early but it's never too late. Those were the twins who came into the center. Oof an thank you.

JOHANNIE ESCARNE: Thank you. The next question is directed to, I guess it could be directed to either of our presenters. How do anti-depressants affect the development of the fetus? Do either of you have a response?

MIMI GRAHAM: I don't know if you want to go ahead, or -- I heard the psychiatrist from Andrea Yates speak recently and there's quite a lot of debate about women, the effect of anti-depressants on the fetus. I think the jury is still out. Her advice was you need to see what the repercussions are for the mother. If the mother is like and -- like Andrea Yates,

unable to exist without her anti-depressants or her medication, then you need to look at the risk to the baby and to the mother. And you know, certainly lots of mothers are on anti-depressants and their babies seem to be okay. I think the research is pretty -- it is not, the jury is still out on that question.

YASMIN WELCH: I wanted to refer the person who wrote that question to Emory University women's health center. Dr. Stowe is a psychiatrist there, has done some excellent work and research at looking at the effects on pharmaceuticals on fetuses. So perhaps go online and check with Emory University. There is some research out and some not yet published. But he's done some excellent work in this arena. And again, to confirm what Dr. Graham said, it's to weigh the risk factors and in most situations the problems with the mom are going to not only hurt the mom, but as I indicated, hurt the baby, once the baby is born. So it's more beneficial to have the mom on the anti-depressants, to manage they're depression, if that is what needs to happen so that she can maintain a stable emotional status to be a mom and interact and relate to her baby. Thank you.

JOHANNIE ESCARNE: Thank you. Another question that could be directed to either of you. What do you tell a mother who has a baby that does not respond to her loving cues? They don't want to be held or comforted.

MIMI GRAHAM: They need an infant mental health therapist to work with them. Because that's one -- that's a classic sign that there is something going on with the baby. It could be

a neurological problem. It could be a sensor integration problem. But I would contact their infant mental health therapist and get a full evaluation.

JOHANNIE ESCARNE: Yasmin, do you have anything to add?

YASMIN WELCH: I agree with Dr. Graham, and this is actually where some of the specialty training that we have in doing some assessments with moms and babies can come in.

JOHANNIE ESCARNE: Thank you for your responses. This question again could be directed to either of you. Is there relationship between mothers who use marijuana and depression and all subsequent problems?

YASMIN WELCH: I'm going to start by answering that and suggesting that in my experience, sometimes moms who are depressed and using marijuana are what I call self-medicating. They have not been properly treated for their depression or diagnosed. So yes, there are subsequent problems associated with that as I suggested because the relationship between a depressed mom and her baby can be so impaired.

JOHANNIE ESCARNE: Dr. Graham, do you have anything to add?

MIMI GRAHAM: I agree with Yasmin. Whether it's alcohol or marijuana or any kind of depressive drug, it just adds to the depression, and all that affects the mother's ability to interact appropriately with her baby.

MIMI GRAHAM: Thank you. The next question is directed to Dr. Graham. Please discuss how Florida funded and provided training for child care providers on infant mental health.

YASMIN WELCH: Well, actually what I was talking about was that we didn't have any licensed mental health, infant mental health therapist, and that's what we had training for. So I'll answer that part of it. I was a 0-3 fellow and my fellowship we had to have a project. And my project was bringing training to Florida. So three years, knocked on doors to different groups saying would you help us fund this, how can we do it? A doctor from LSU was agreeing to come to Florida and help us train folks. We got people from Chicago to come, and our Medicaid money in Florida matched those monies. So we pieced it together and then local groups, like the Palm Beach children's services council funded training there. So that trained a level three therapist that could work with programs. For child care folks, we call it a level one training. It's a two-day training where we talk about what are developmental milestones, and what are the problems when they should refer to a therapist. And we have provided that through, through infant/toddler quality dollars, through Medicaid dollars, through other dollars, any kind of dollars there are available that we go into communities and ask if they would like the training and provide it. So if you want to email me specific, I'm happy to help you in your state to try to figure out who might fund it there.

JOHANNIE ESCARNE: Thank you for your response. There are many more questions, but unfortunately we are running short on time. So I would like to remind the audience that I will get the questions to the appropriate presenters and they will try to respond to your questions. On behalf of the division of healthy start and perinatal service, I would like to thank the presenters and audience for participating in the webcast. And also thank the center for the advancement of education, school of public health, for making this technology work. Today's webcast will be archived and available in a few days on the web site, www.mchcom.com. We encourage you to let your colleagues know about this web site. Thank you, and we look forward to your participation in future webcasts.