<u>Highlights and Notes from a Reflective Seminar for Supervisors in the Child Welfare System</u>

Double Jeopardy—Depressed Mothers and Their Very Young Children: A Remarkable Prospect for Change

Held at the Humphrey Forum*

June 17, 2011

<u>Context</u>

The fate of the mother suffering from depression and the future of her baby are intrinsically intertwined. The prevalence of this phenomenon of "double jeopardy" underlines the importance of this topic: more than half of the babies born to a family in poverty have mothers who are in the grips of a severe depression.

Three distinct observations add to our need for concentrated attention on this topic. First, research findings from early brain development and infant mental health alerts us to the long-term consequences of neglect in the early years. Secondly, there is a marked prevalence of infants and toddlers in Child Welfare caseloads alerting us to consequences of neglect and abuse. And thirdly, the root cause of success or diminished expectations of a child's educational future is linked to the quality of this early relationship. When almost 50% of Minnesota children are not Ready for K, we can understand why there is a convergence of interest in maternal depression and the condition of the infant. The literature references reflect this interest: depression alters parenting. The emotionally unavailable mother, withdrawn from empathetic responses, is intrinsically linked to her infant's behaviors of apathy, disorganization, and other behavior disorders.

A guiding assumption in the "double jeopardy" concept is that the focus of attention is on the <u>relationship</u> between the mother and the baby.

In this relationship, it has been demonstrated that the mother's capacity to respond to the intentions of the infant's behavior predicts the overall quality of infant attachment. (See "Fostering secure attachment in infants in maltreatment families through preventive interventions," by Dante Cicchetti, Fred A. Rogosch, and Sheree L. Toth, in <u>Development and Psychopathology</u>, Vol. 18, 2006, pp. 623-649.)

<u>The Following is a Brief Summary of the Exchanges</u>

<u>Comments from Terrie Rose, Ph.D., L.P.</u>

Terrie Rose is the founder and Executive Director of Baby's Space, a child and family care model created in the heart of Little Earth, a neighborhood chiefly settled with Native American families. She has received national and international honors for her model, Baby's Space. This initiative is based on the principles derived from early childhood development and research findings from studies and practice that focus on "attachment" as a core concept.

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Baby's Space is a model of a neighborhood-based resource that offers high-quality child care and family support. This full-spectrum set of responses has had its test of effectiveness: in 2010, 100% of Baby's Space kindergarteners, most of whom started at Baby's Space as infants or toddlers, met or exceeded the Minneapolis Public Schools' post-kindergarten assessment.

The following is a "Question and Answer" exchange between Esther Wattenberg and Terrie Rose:

1. Are there training principles for child care providers and center care staff on how to initiate nurturing interactions with babies and toddlers who have developed insecure and disorganized attachment styles, in response to emotionally unavailable, depressed mothers,?

It must be clear to staff there is a problem. Unfortunately in most childcare settings, staff would not recognize a child's passivity or her mother's lack of engagement as warning signs of difficulties that the Center can help resolve. The baby's mother may quickly be categorized as unlikable or difficult and held responsible for any problems exhibited by the child.

A child who does not learn that her feelings and needs are important does not learn that she should respect other people's feelings and needs. This inconspicuous infant could become an aggressive, unfeeling, and unruly preschooler. We know based on research that if the causes and consequences of this disengaged pattern of development remain unacknowledged until she reaches her toddler or preschool years, problems are more entrenched and difficult to fix.

Directors and staff need training that allows them to recognize their role in creating healthy outcomes for child and parent. When a child of a mother suffering from depression makes few demands and shows no preference for who cares for her, staff need to know what to do to create stability, consistency and predictability that enhances the child's social and emotional development. The training goal is for staff to recognize that a child's passive or indifferent behaviors are significant and deserve attention – that a baby will not simply "out grow" difficulties.

2. The literature refers to a wide range of "therapeutic skills" that are used in response to infants with disorganized attachment styles. Can you identify one or two of these therapeutic skills?

Even in situations in which a mother possesses a strong willingness to provide a secure foundation for her child and to respond to her baby's cues and signals in a consistent and accurate way, other factors may influence the consistency of those responses and compromise the security of the attachment relationship. Clinically, the most worrisome attachment relationships are those in which the parent both provides basic care and yet maltreats the child. Under these conditions, the baby, with limited cognitive and psychological capacities encounters a relationship with her most intimate caregiver in which the person who fed and held her also hurt and neglected her.

In the research lab, it has been observed that such a child will display a wide variety of unusual reactions to the parent's departure and re-appearance. For example, a child may hold his arms up to a parent to be held while turning his head away with a worried or frightened look. A child

may freeze, not moving or looking around the room. Another child may react to this stressful situation by fondling the wall, going prone on the floor, becoming frenetic, or some other distressing and atypical response for a child of 12 or 18 months of age. Correspondingly in the childcare center, the child relies on behaviors like clinging, whining and becoming uncooperative as strategies to manage his distress and to compensate for his lack of confidence in the availability of his mother or other adults.

Unfortunately, children with these patterns of insecure attachment do not reap the same benefits from their relationships with their caregivers as do children with secure attachments. The child behaves erratically because he has come to believe that there is no real connection between what he wants/needs and how he should go about getting it.
As preschoolers, these children without holistic intervention, appear less cooperative in learning situations and don't make friends easily. In school, these children behave as if others are going to reject them or abandon them, making it easy for other children to do just that.

The good news is that as suggested by a growing body of research, a child's earliest experiences, relationships, and environment are dynamic forces in directing her growth and development (NCR, 2000). Through day-to-day interactions like talking, feeding, playing, and even the changing of a diaper, the baby constructs an internal knowledge of herself, her relationships, and the world in which she lives. Built upon the premise that childcare and early education offers a strategic and early intervention point, Baby's Space provides holistic approach to providing innovative, yet practical, applications for early childhood mental health services. This approach— raising awareness of the importance of social and emotional development and using the skills of early childhood teachers to respond to the emotional needs of children—prevents the emergence and decreases the impact of mental health problems in early childhood.

Providing holistic services in childcare centers, using the Baby's Space model, allows for interventions that focus on the significance of early relationships in the formation of the child's sense of self and in affecting the child's abilities to manage emotions, develop close interpersonal relationships, and learn by actively exploring the environment. Teachers offer a sensitive, responsive, and consistent experience to baby and parents. This, in turn, can provide a redirection in the child's and family's developmental course.

Equally important is that a parent who does not start out with the necessary internal resources may later have the opportunity to develop adaptive responses to stressful circumstances, enhance interpersonal skills, and increase knowledge about parenting that, in turn, may help him or her become a more sensitive and responsive caregiver. Building the parent's responsiveness and sensitivity at the same time that the staff works to improve the child's abilities to manage emotion, engage in relationships and learn . . . all of this helps get the dyadic mother-child relationship back on track towards security and responsiveness.

3. From your experiences, do you have an optimum way of engaging the depressed parent? For example: brief exchanges when they come to pick up their baby? Small group exchanges in an informal setting?

Traditional therapeutic services rely on 50-minute sessions in which the patients come to the practitioners. Given that it is estimated that 75- 85% of maternal depression goes untreated, this intervention technique is clearly ineffective. Based on data gathered by the Minnesota Department of Human Services, parents preferred to receive services in the most familiar of settings - neighborhood-based childcare centers. Baby's Space provides opportunity for support in a variety of formats including informal, group, knowledge-based individual visits, and referral to medical partners. The key is to provide a menu of options of support so that the mother can choose the best fit for her, increasing the likelihood of treatment success.

Summary Comments from an Exchange with the Audience Following Terrie Rose's Presentation

Q: Should every community have a therapeutic child care center?

TR: Yes, multiple services at the location of a quality child car center is cost effective. Bring the lens of the baby to decision-makers (a judge can court order the child to attend Baby's Space). Quality child care is a substantial anchor in a neighborhood. For example, recently, after a violent incident in the neighborhood, mothers gathered at Baby's Space to grieve.

Comments from Dr. Benita Dieperink, M.D.

Dr. Dieperink, along with Dr. Helen Kim, initiated the Women's Mental Health Program in the Hennepin County Medical Center. A huge window of opportunity for early intervention should be provided during obstetric care. "We are an independent culture." There is considerable attention during pregnancy and immediately after child birth. Then suddenly, mothers are on their own. Allowing clients to have a continuing relationship with the therapist is important, e.g., providing mothers with a phone number, in order to keep in touch. "The phone can be a lifeline."

The origin and circumstances that lead to maternal depression are well known to those who treat post-partum depression. (Among those seen in the OB clinic, about 30% suffer post-partum depression in Hennepin County.) For some patients, the cause may be severe sleep deprivation and for others, it could be a traumatic recall of rape and violence. Cultural factors also contribute to the complex phenomenon of maternal depression.

An observation from a cultural anthropologist may be of interest. Almost every culture assigns a high value to the "mothering instinct." When this does not come into play at the birth of a baby, depression sets in. The mother wonders why this "natural talent" is unavailable to her. Dr. Dieperink asserts that "there is a widespread interest, internationally, in post-partum depression."

The psychiatric condition of the loss of self-competency can be devastating: restoring a sense of confidence is the task of psychiatric help. The capacity of a parent to recover in a brief time interval is questionable. Exploring and resolving maternal behavior rooted in ambivalence, trauma, and acute and chronic stress is not immediate.

For teen parents, the depression may be linked to a psychiatric condition that existed before pregnancy. Their situation is not a lack of family support (most families step in). but rather treatment for their emotional difficulties, which existed prior to her pregnancy.

Catherine Wright, M.S. Early Childhood Mental Health Program Coordinator, Minnesota Department of Human Services

Minnesota has several initiatives that are promoting developmental screening of infants and children 0-5.

Infant mental health is synonymous with healthy social and emotional development. Parent-informed screenings that identify early childhood mental health issues are highly recommended. The Ages and Stages Questionnaire: Social Emotional (ASQ-SE) is widely used among child welfare staff, the Follow Along Program, and Head Start.

The importance of screening is underlined in data gathered by communities across Minnesota: 60% of the child protection population receives an elevated score on mental health screening tools.

"Referral for Disabilities: A New Responsibility for Child Protection," Practice Note #16, February 2005, from the Center for Advanced Studies in Child Welfare can be accessed at: http://www.cehd.umn.edu/SSW/cascw/attributes/PDF/practicenotes/Practice%20Notes%2016%20-%20color.pdf. Within this Practice Note is an explanation of the federal legislation reauthorizing the "Child Abuse Prevention and Treatment Act (CAPTA) 2003." The law was renamed "Keeping Children and Family Safe Act" (P.L. 108-36). Under this Act, developmental delays are to be screened and families are to be assisted in the process to receive early intervention services.

Please Note: On December 20, 2010, President Obama signed Public Law 111-320, a new reauthorization of CAPTA. Key aspects of this CAPTA reauthorization Act of 2010 are highlighted in Child Law Practice, Vol 29, No. 12, February 2011, and child welfare system advocates should be aware of and prepared to use these in practice.

Also Note: While the **referral** to screening and assessment is **mandatory**, the parent's participation in the follow-up for screening and assessment is **voluntary**. If the child is placed, under court order, the parent should be engaged in the screening process, but the parent has the right to refuse.

The Federal law, the 'Individual with Disabilities Education Act,' also known as IDEA, Part C (Early Intervention Program for Infants and Toddlers with Disabilities) is designed to require, as part of the activities and services, screening and assessment of these children. Specifically, the referral must be made to the county's identified Interagency Early Intervention Committee (IEIC) . . ."

Diagnostic assessments are a focus of attention in Child Welfare and Mental Health in Minnesota. DC:0-3R is a developmentally appropriate diagnostic process for children 0-4. There has been extensive training in the use of DC:0-3R (identifies 13 diagnoses which qualify for Part C services). More than 250 staff and clinicians across the state have received training. Terrie Rose is a trainer for DC:0-3R.

Screening has identified three groups: one-third have mental health conditions; one-third have development delays, and one-third have parents with serious family factors that affect their development.

Payment for doing diagnostic assessments are a concern: eligibility for Medicaid, insurance and programs at the county level can be explored.

Referrals to Part C

Why don't frontline workers in the Child Welfare system pursue referrals to Part C? There were many responses:

. . . Our workers don't have time; they are managing high-risk caseloads with caseplans that are required by the court system; front-line workers do not always know if the behavior is normative or troubling. The first encounter with parents reported for maltreatment may be chaotic and the baby may not be observed.

Some points of clarification were offered:

If the child is in an open case, then referral should be made to HELP ME GROW (www.MNParentsKnow.info or 1-866-693-4769 (GROW).

According to a response from a supervisor with a high caseload of African-American children, there may be reluctance to encourage parents to pursue a referral for an assessment. African-American parents are wary of how the assessment information may be used. "Later in life, a diagnosis made in a very young child's life may contribute to a negative profile as a young adult."

In sum, Part C referrals require concentrated attention for public services, community agencies, training programs, and Schools of Social Work.

Marcie Jefferys, Author of the Children's Defense Fund's Report on Maternal Depression and Early Childhood.

The double-jeopardy factor of maternal depression is of crucial importance to the state because it spans all income levels. Nevertheless, this major public health issue has prominence in families living in poverty.

There are some special policy concerns: low screening rates; reduced eligibility for medical assistance; family cap of MFIP; insecurity of child care funding for a low-income, working family.

Recommendations for an effective state policy response to maternal depression in the Report on Maternal Depression and Early Childhood have caught the interest of a considerable number of legislators. However, the next session may not see the whole report adopted, given the serious constraints on legislation requiring budget considerations.

Concluding Remarks

The "double-jeopardy" concept in addressing maternal depression has unusual importance for the Child Welfare system. The prevalence of maternal depression in Child Protection caseloads (estimated at 60%) discloses to us that these infants and toddlers are among the most at risk for poor developmental outcomes.

The treatment plan, then, must address both the mother and the child.

For the community, the challenge to assess and plan for resources is a prime responsibility. A task force of collaborative interests—public health, child welfare, Head Start, schools—should study the recommendations in the Children's Defense Fund paper, and then set the agenda and identify resources needed for early intervention in maternal depression and the impact on infants and toddlers.

[Please Note: The Learning Module on "Maternal Depression." can be accessed at: http://z.umn.edu/cwmodules.]

In order to access materials—agenda/handouts/literature reviews. etc— and to access an audio recording from this "Reflective Seminar," please go the CASCW website at: http://www.cehd.umn.edu/SSW/cascw/events/past_events/MaternalDepressionForum.asp

These notes were prepared by Esther Wattenberg, Professor, School of Social Work, Center for Advanced Studies in Child Welfare (CASCW) and Associate, Center for Urban and Regional Affairs (CURA), University of Minnesota. She can be reached at ewattenb@umn.edu.

Comments were derived from notes taken by Heidi Ombesa, MSW Candidate, Anna Shkolnik, MSW, CASCW, School of Social Work and Mary Kaye LaPointe, Administrative Assistant.
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