

# **Head Start Bulletin: Mental Health**

## ***Issue 80***

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## **Welcome to the Mental Health Bulletin**

Promoting mental health is a vital component of the work we do every day to enrich the lives of the children and families in Head Start. That is why we are devoting this issue of the Head Start Bulletin to mental health. We know that to prepare children for school, we must support their social and emotional well-being. We also know that children's caregivers at home and in Head Start benefit from resources that can support their own mental health, and in turn, help them support the children in their care.

We also recognize that risk factors affecting social and emotional well-being are present in the lives of many Head Start children and families. One common thread among the Head Start population is poverty. In a report on mental health, the Surgeon General cites "multigenerational poverty" as a factor that puts children at greater risk for mental health problems (U.S. Department of Health & Human Services 1999). Our programs, often in conjunction with community partners, can help reduce the impact of such risk factors. We understand too, that a healthy body and mind are connected. In 2005, the Administration for Children and Families (ACF) Region III Office initiated a pilot project, *I Am Moving, I Am Learning*, to prevent and reverse the negative consequences of obesity. This successful project is being disseminated to grantees nation-wide. Knowing what we know about the challenges faced by the children and families we serve, it is important that we recognize the creative approaches that Head Start takes to promote mental well-being and learning.

We acknowledge that mental health also has been a priority for former President George W. Bush, who established the President's New Freedom Commission on Mental Health. The Commission's full report (2003) recommended "a national focus on the mental health needs of young children and their families that includes screening, assessment, early intervention, treatment, training, and financing services. A coordinated, national approach to these issues will help eliminate social and emotional barriers to learning and will promote success in school and in other community settings for young children."

### ***What is in the Mental Health Bulletin?***

Given the longstanding commitment that Head Start has shown to promoting mental health, it is timely to issue this Mental Health Bulletin. Its themes are fostering the mental health of children, families, and staff; prevention of onset; reduction of risk; early intervention; effective service delivery; and perhaps most important, strengthening resilience. The Bulletin is divided into these sections:

- Approaches to Services, including current research
- Child Mental Health, including resilience and social and emotional development
- Parents and Family, including maternal depression and its impact on families
- Life-Changing Events, including refugee resettlement and homelessness
- Program Approaches, including examples of promising practices across the country
- Staff Well-being, including teacher mentoring
- Resources, both online and in print

While some articles focus exclusively on Early Head Start and others focus on preschool Head Start, it is important to remember that much of the information is applicable to both programs. Many articles are research-based. Some reflect research conducted in Head Start; some interventions described here include evaluation of their impact on Head Start children and families and their community. Many voices are represented—program managers, mental health specialists, professionals who work closely with special populations, and academicians and researchers. We also hear the voices of Head Start children and families, speaking of their struggles and their unyielding capacity to triumph over adversity. Throughout this Bulletin, you will also find examples of program models and success stories of programs and parents that demonstrate the resilience of the Head Start community and offer insight on how other programs can learn from their successes.

Because there is simply so much we can say about mental health in the context of Head Start, we are continuing this discussion online. You will see at the bottom of some articles, such as the first one, “Mental Health in Head Start,” a link to the Early Childhood Learning and Knowledge Center (ECLKC) Web site <http://www.eclkc.ohs.acf.hhs.gov/> where supplemental information can be found. We encourage you to check out this resource to learn more.

Also on the ECLKC, you will find a 2002 edition of the Bulletin dedicated to Child Mental Health. This 2009 edition of the Bulletin on Mental Health builds on the information provided in the earlier edition.

One final note... on December 12, 2007, former President George W. Bush signed into law, The Improving Head Start for School Readiness Act of 2007 (P.L. 110-134). The law upholds Head Start’s longstanding commitment to the social and emotional well-being of our children, our families, and our staff. The Office of Head Start (OHS) will be issuing regulations to reflect the new law and to inform programs of policy changes. Currently, the Head Start Program Performance Standards, first published in 1972, remain in effect. They list more than 40 standards related to promoting and supporting mental health, and they are referenced throughout this Bulletin. As OHS continues to respond to the new law, it will be important for programs to consider any implications for their mental health services.

In support of the many varied efforts to support mental health in Head Start, I am proud to present this Mental Health Bulletin. I hope that you find this Bulletin as valuable a resource as we intend it to be.

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## **Mental Health in Head Start**

by Amy Hunter and Jim O'Brien

A home visitor is sitting on the floor with a 9-month-old baby who is crawling toward his mother. The baby smiles and babbles. The home visitor encourages the mother to speak back to him, "Look how he's telling you, 'I'm coming. I see the rattle in your hand.' See how he talks faster and louder as he gets closer. He's so excited." The mother holds out the rattle to the baby and says, "Here is your favorite rattle. You are such a fast crawler!" The home visitor affirms, "Yes, that's just what he wanted. He wants to be close to you."

In this scene, the home visitor is helping the mother tune into the baby's cues—what he wants and how he feels. She encourages the mother to talk with her baby and express love and pride. These everyday interactions help build secure attachments between young children and adults and lay the foundation for early learning.

A teacher sits on the floor with the children and as he reads a story to them, he smiles and makes eye contact with each child. Along the way, he asks the group how they think the character feels, drawing their attention to facial expressions. He asks them how they would feel in a similar situation and if it has ever happened to them. After the story, the teacher encourages the children to draw a picture of a time when they felt happy or sad, angry or surprised.

This is an example of how interactions between staff and children promote children's mental health. The teacher is friendly, sensitive, and engaging. He encourages the children to talk about their feelings. He provides a learning activity that further helps them articulate their inner emotional life. He offers a safe and supportive environment in which the children can learn about themselves and others. Taken together, these are some of the ingredients that help promote mental health in early childhood.

### ***What is Mental Health?***

According to the U.S. Surgeon General (U.S. Department of Health and Human Services 1999), mental health:

- is a state of successful performance of mental function;
- results in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; and
- is indispensable to personal well-being, family and interpersonal relationships, and contributions to community and society.

### ***Promoting Mental Health in Early Childhood***

The following description of early childhood mental health (Figure 1) reflects the connection between young children and parents and caregivers who nurture, stimulate, and care for them. Serving the mental health needs of young children includes working to promote health and well-being in parents and other caregivers. Promoting and protecting children's mental health is part of a comprehensive approach to supporting healthy child development.

FIGURE 1:

Mental health in early childhood (birth to five) has been described this way by the Infant and Toddler Services Summit Mental Health Subcommittee (2004) in Massachusetts (adapted from ZERO TO THREE):

Early childhood mental health is the developing capacity of children birth through age five to: experience, regulate, and express emotion; form close, secure, interpersonal relationships; and explore the environment and learn—all in the cultural context of family and community.

Early childhood mental health is synonymous with general health and well-being and healthy social, emotional, and behavioral development.

It is affected by a child's biological predisposition, the child's environment, including access to adequate food, clothing, and safe shelter, and the continuity of nurturing relationships.

END OF FIGURE 1

Promoting mental health is much broader than treating mental illness. As described in the Report of the Surgeon General (1999), an individual's mental health, like physical health, may vary throughout the life span and may even vary within a given day. Over the course of a lifetime, personal characteristics, such as temperament, medical history, personality, cognitive skills, interpersonal skills, and life circumstances, including relationships with family and friends, losses and traumatic events, may affect one's mental health.

### ***School Readiness***

Children's mental health affects their capacity to explore their environment and learn. It is critical to school readiness. Research on early brain development, child development, and clinical practice has confirmed what the founders and providers of Head Start have known for years: promoting mental health of young children is key to healthy development and later school success (Knitzer 2000).

Furthermore, mental health is closely tied to physical health. The Head Start mission of supporting the "whole child" includes the recognition of the mind-body connection. I Am Moving, I Am Learning, a national initiative supported by OHS, reinforces that physical activity and nutritious eating foster healthy early childhood development and learning.

The Head Start Child Outcomes Framework includes positive outcomes in the Social & Emotional Domain that encompass self-concept, self-control, cooperation, social relationships, and knowledge of families and communities. Growth in these areas is integral to a child's readiness for school. A child who can perform tasks independently and with confidence, and who is cooperative and friendly, is better prepared to learn in Head Start and later, in elementary school.

### ***Head Start Program Performance Standards***

Promoting mental health for children, families, and staff has been an integral part of the Head Start program since its inception in 1965. Mental health in Head Start includes a broad spectrum of services to children and families—from promotion and prevention to

In the Head Start Program Performance Standards (1998), more than 40 Standards address the mental health of children, families, and staff. The Standards are woven into various service components, but many are concentrated under Child Mental Health 45 C.F.R. Part 1304.24. They support a comprehensive approach to promoting children's social and emotional development. For instance, programs are required to:

- build trust, foster independence, and encourage children's self-control;
- support and respect the home language, culture, and family composition of each child in ways that support the child's well-being; and
- encourage the development of self-awareness and autonomy and provide daily opportunities for each child to interact with others and to express him or herself.

The Program Performance Standards recognize that parents are their children's most important teachers, and therefore involve parents in classroom and service decisions. Programs are required to:

- implement a curriculum for infants, toddlers, and preschoolers in collaboration with parents that supports each child's individual pattern of development and learning;
- solicit information and concerns from parents about their children's mental health and establish a system of ongoing communication about children with identified mental health needs; and
- involve parents in planning and implementing any mental health interventions for their children.

Parents and staff are best equipped to help address a child's mental health needs when their own mental health needs are met. Consequently, the Program Performance Standards require programs to:

- provide mental health education for program staff, parents, and families that include individual opportunities for parents to discuss mental health issues related to their child and family;
- facilitate opportunities for parents to participate in counseling programs or receive information on issues that put families at risk, including substance abuse, child abuse, and domestic violence; and
- support pregnant women with mental health interventions and follow-up, including substance abuse prevention and treatment services and postpartum recovery (including depression).

Children's and families' mental health needs are best addressed when they are identified early on. The Program Performance Standards require programs to:

- ensure that each child receives an appropriate and timely screening to identify behavioral, social, and emotional concerns and to obtain or arrange for further diagnostic testing or treatment if necessary;

- implement ongoing procedures to identify any new or recurring medical, dental, or developmental concerns (including changes in emotional and behavioral patterns); and
- design and implement program practices responsive to the identified behavioral and mental health concerns of an individual child or group of children.

Other Program Performance Standards are related to program planning and management. For example, staff or consultants who deliver mental health services must be licensed or certified mental health professionals with expertise in serving young children and their families. Other program requirements are to:

- ensure that services of a mental health professional are sufficient to provide timely and effective identification and intervention in family and staff concerns;
- utilize other community health resources as needed; and
- make mental health and wellness information available to staff with concerns that may affect their job performance.

Head Start's commitment to ensure that programs provide mental health services is also reflected in the FY 2009 Office of Head Start Monitoring Protocol. The Mental Health Services section of the protocol that determines whether grantees meet the requirements is divided into three subsections: Section 1—Human Resources; Section 2—Implementation of Mental Health Services; and Section 3—Ongoing Monitoring.

## ***Conclusion***

For more than 40 years, Head Start has embraced and promoted mental health and wellness. The Head Start Program Performance Standards underline the importance of assessing, supporting, and facilitating the treatment of mental health needs of children, families, and staff. The Child Outcomes Framework provides social and emotional goals that relate to learning and school readiness. New regulations based on the Improving Head Start for School Readiness Act of 2007 will continue to emphasize the importance of promoting mental health and providing services. In recognizing the everyday opportunities to promote mental health, Head Start staff can make a difference in the lives of children, families, and staff facing some of life's toughest challenges. When programs do all of this consistently—and consistently well—they can help ensure children's future success in school, community, and life.

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Visit the Early Childhood Learning and Knowledge Center Web site at <http://eclkc.ohs.acf.hhs.gov/> in order to view a Pyramid of Mental Health Strategies, which depicts Head Start's work to support and increase protective factors and decrease risk factors. The pyramid spans the range of support from the promotion of mental health services for all children, families, and staff to intervention with the most vulnerable children and families.

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# **A Collaborative Approach to Mental Health**

by Amy Hunter

## ***Introduction***

Head Start has emphasized the importance of a comprehensive team approach to services for young children and families since its inception in 1965. In the following story, Amy Hunter, a licensed clinical social worker, shares her experience of learning first-hand the benefits of using a team approach to mental health in Head Start. We hear how her views evolved from thinking she needed to have all the answers herself, to valuing the expertise and knowledge of each team member. Ultimately, she learned the benefit of using a team approach as well as strategies for developing a team approach in order to meet the mental health needs of children and families in Head Start.

## ***The Challenge***

During one of my first weeks as a Behavior Specialist (mental health professional) in a medium-sized Head Start program, a 4-year-old child, I'll call Jess, shouted a string of profanities at me. As he was yelling, he hurled his shoes and socks in my direction. After the words and the socks and the shoes, came spit. Luckily, he missed my face by a bit. Jess was on top of an outdoor play structure, and I was at the bottom, trying to coax him down. It had been five minutes, but felt like an hour.

## ***The Expectations***

Although there were other children and teachers on the playground at the time, I felt compelled to be in control of the situation myself. I thought that because I was a specialist, I should be able to change this child's behavior immediately by myself. And yet, I felt incredibly inadequate.

No one offered assistance. At the time, there was no team approach. The teachers probably wondered whether I would be scared off easily and whether I could be trusted to help without undermining their knowledge. They were probably hoping that I had a magic solution. Staff wondered if I, the "expert," was going to be able to stop the behavior that Jess had been engaging in for months. There was a clear wish that I would simply "fix" this child.

## ***The Self-Doubt***

During this challenging time, I asked myself if I was the right person for the job. I wondered if maybe another, more competent mental health professional would be able to snap this child's behavior into shape. Yet, despite my feelings of insecurity, there was a small nagging part of me that thought, maybe it's not me, maybe there is something about this situation that I can learn from.

## ***Multiple Challenges Bring On More Expectations***

The situation with Jess, as well as other situations with children, families, and staff that I

encountered over the years, tested my skills, patience, training, and knowledge about how to best work with children and families. As my skills were challenged and my anxiety was heightened, I believed that I alone could and should do the work (the emotional support, the behavioral and therapeutic work with the child, the relationship and meetings with the families, the consultation to the staff, evaluating the problem, developing an understanding for the situation, and creating change).

But I was only one person and, no matter how much professional advice I gained from others or from reading, I alone would never be a substitute for the wealth of knowledge and experience of parents and other staff who had formed enduring and meaningful relationships with the child. No relationship I could ever build with a child could be effective without parental involvement. No one was benefiting from my trying to do it alone.

### ***A Shift in Thinking***

With support from good supervisors, mentors, and colleagues and with ongoing self-reflection, I realized that I cannot and should not work alone. I was reminded that change happens in the context of caring and supportive relationships that are built over time. Change is rarely the result of a sole expert imparting wisdom.

It took time to shift my thinking about my role and to let go of the heavy burden I had put upon myself. It was hard work convincing staff and parents that I didn't have all the answers and that in fact, no one person did.

Everyone desired a simple and quick fix. Everybody involved in a given situation wished that someone would just “fix” the problem—the staff person, child, or the parent. A teacher believed a child was the “problem” and wanted him to change. A Director wanted a certain staff person's attitude to be adjusted. A teacher wanted a child's behavior to be modified. Another teacher wanted a supervisor's perspective to be more understanding. Another teacher wanted a parent to be more involved in the child's life. A parent wanted someone to explain why the child “acted up” at school but not at home or vice versa. I desperately wanted to have all the answers to be helpful.

### ***Evolution of the Work***

Over time, my work became less and less about working directly with individual children and more and more about working to establish and maintain the relationships with the team or others who interacted with the children and families much more than I ever would. My goal became not to modify a child's challenging behavior, but rather to support the staff and parent team and work together to develop an understanding of the child's behavior. I worked to help staff build their confidence and capacity to work with children and families.

The children and families who made the most progress in terms of their social and emotional or behavioral development were those who benefited from a team that included the parent(s), teachers, family advocate, the education supervisor, the bus driver, the kitchen staff, and other care providers that functioned in a cohesive, supportive, and integrated way. Similarly, staff who felt most satisfied in their work were those who most

often participated and contributed to the team. Each member of the team had a unique perspective to help us understand and guide our strategies for a situation.

Recognizing that change happens in the context of caring relationships, I cultivated these relationships among team members. I learned to pay as much attention and energy to the adults (including myself) as I initially gave to children. Every team member needed to feel that his or her expertise and experience were valid and provided meaningful direction to the understanding of a concern or problem.

### ***The Change***

As a result of our efforts, later when I was faced with another “Jess,” I no longer felt alone. I felt confident that if I was working individually with a child, it was because we agreed as a team that it was the appropriate thing to do. The teachers became my allies, and I became their support. Together, we learned that the only people who could turn behavior around were those who had a special relationship with the child and who were nurtured by special relationships from others on their team.

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# **The Center on the Social and Emotional Foundations for Early Learning (CsEFEL)**

By Rob Corso

We have found that emotional and intellectual development cannot be separated; that these two functions come together as the child actively explores the emotional, social, and cognitive challenges at each of these stages. Stanley Greenspan, M.D. (Connors-Tadros & Yates 2003)

The Center on the Social and Emotional Foundations for Early Learning (CSEFEL) is a national resource center that promotes the social and emotional development and enhances school readiness of low-income young children ages birth to five. CSEFEL disseminates research- and evidence-based practices to the early childhood community. As of 2007, CSEFEL was in its second five-year funding cycle. CSEFEL is jointly funded by the Office of Head Start and the Child Care Bureau.

CSEFEL offers training modules in the form of trainer scripts, PowerPoint slides, participant handouts, activity descriptions, resources, and video clips. Early Head Start and Head Start programs, as well as state and regional T/TA systems, have used the CSEFEL training modules as the foundation for training personnel on effective strategies for promoting young children's social and emotional development and for preventing and addressing challenging behaviors.

The modules highlight the importance of designing environments that support children's success by engaging them in meaningful activities, teaching the expectations of the environment, and implementing a predictable and engaging schedule for the child. Also they offer administrative and leadership strategies for ensuring that educators and families have the support they need to implement these strategies.

CSEFEL also offers What Work Briefs, which are summaries of effective evidence-based practices for supporting children's social and emotional development and preventing and addressing challenging behavior. The Briefs include a description of practical strategies, references to information about how to implement the practice, and a one-page handout that highlights the major points of the Brief. They are designed for in-service providers and other professionals who conduct staff development activities. The information is valuable for professionals, parents, and other caregivers. Topics include: Promoting Positive Peer Social Interactions; Understanding the Impact of Language Differences on Classroom Behavior; and What Are Children Trying to Tell Us: Assessing the Function of Their Behavior.

Over the next several years, CSEFEL will target several states to build capacity to effect and sustain change in practice and improve outcomes for children, families, and personnel. The overall goal is to foster professional development of the early care and education workforce through intensive training and technical assistance. Another priority for CSEFEL is to address staff and family mental health.

The Center has developed a comprehensive set of products and materials, which can be accessed in both English and Spanish at no cost from <http://www.vanderbilt.edu/csefel> or by calling 866-433-1966.

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# **The Role of Mental Health Consultants**

by Paul J. Donahue

Head Start staff are often the first to observe the effects of trauma and stress in families, yet many feel ill-prepared to cope with this added responsibility. An ongoing partnership between the Head Start program and a mental health consultant is useful in supporting wellness, as well as early interventions.

The consultant's primary role is to foster the behavioral, emotional, and cognitive development of all children. Prevention-oriented, this collaborative model includes classroom check-ups via observation, participation in team meetings, and wellness visits with children. The approach allows the consultant to anticipate, as well as respond to crises and dire situations and to intervene early with children at risk.

## ***Developing an Effective Collaboration***

Mental health collaboration calls for considerable and mutual enthusiasm, respect, and support. Rather than assume a rigid "expert" stance regarding child development, the mental health consultant, with Head Start staff, should develop a set of shared assumptions and goals. A team approach can demystify notions of promoting mental health, assuring teachers that the consultant is present to support their work and to help the children feel more comfortable.

An effective consultant must be flexible and team-oriented, enjoy community-based settings, feel comfortable working autonomously, and be adept at handling multiple roles and responsibilities. The consultant should be willing to share knowledge and training with teachers and parents. The consultant should appreciate that Head Start teachers often are embedded firmly in the communities they serve and maintain longstanding relationships with the families they refer.

## ***Classroom Management***

Classroom management techniques typically require more intensive and joint planning but generally begin with the teacher's request for help with difficult-to-manage children. Impulsive and somewhat aggressive, Andrew frequently would run about the classroom crashing into other children and toys, disturbing free play and story time. A behavior modification plan designed by the consulting psychologist and Ms. Winn, his teacher, and adopted by his parents was somewhat successful. However, Andrew's impulsivity and hyperactivity continued to wreak havoc, especially during circle time.

Finally, Ms. Winn chose to seat Andrew in an adult-size chair by her side. No other children were allowed to sit in this chair. Andrew readily took to his new place and began to sit throughout most circle times, though fidgety and often inattentive. Few children complained about Andrew's "special chair," seeming to recognize that this seating arrangement allowed them to enjoy the teacher's stories.

The consultant helped to design a behavior rewards system to address this classroom situation but actually played a more critical role by supporting the teacher's ideas for managing and containing her student's behavior. Together, they charted his progress, identifying changes in the frequency, intensity, and duration of the targeted behaviors.

## ***Interventions with Children***

After becoming a more familiar presence in the classroom, the consultant may work with the children as a group. This is an alternative way to reach young children whose development may be affected negatively by stressful life events as reflected in such maladaptive behaviors as withdrawal, aggression, or hyperactivity. Children actually are more likely to become unruly and disruptive when their feelings remain unspoken but continue to lurk beneath the surface. Often, they are calmed notably when given the opportunity to express themselves to adults who listen. By working with children in the small group setting, the therapist can observe and further assess social and emotional problems identified in the classroom, interpret and address problems in peer relationships, and intervene to improve adjustments to transitions, listening, and taking turns.

Ms. Marano, an experienced teacher, was preparing to leave her job and relocate out of state. Her initial attempts to engage the children in a discussion about her departure was met by anger in some students and silence by others. The Head Start Program Performance Standards require that all toddlers and preschool children and assigned classroom staff, including volunteers, eat together family style. Ms. Saunders, the mental health consultant saw this as an opportunity for emotional growth. She suggested that Ms. Marano discuss her departure with the group and then follow up with discussions at lunch and snack times with small groups or individual children. At times, Ms. Saunders joined the class during meals to help the children open up about their anxiety over their teacher's departure.

In some instances, mental health consultants are available to provide brief assessment and treatment services for the children. Teachers often identify children who could benefit from brief, preventive intervention. The most frequent referrals are for children with behavior problems or those exhibiting symptoms of depression or anxiety.

Philip was referred for brief treatment after his teachers became more aware of his isolation and self-deprecating remarks and behaviors. His mother, depressed and overburdened, was unable to offer him much support. She frequently referred to him as "bad," comparing him negatively to his younger brother and openly expressing a wish to be rid of him.

In the early phase of treatment, Philip repeatedly depicted a mother rejecting and killing her son, then running off with her younger child. The therapist openly discussed his mother's difficulties with Philip; emphasized and attempted to engage his strengths and skills, particularly his keen intelligence; as well as supported and facilitated his creative use of materials and his dramatic and symbolic play. In addition, the therapist helped Philip's teachers identify and support his strengths and need for nurturance.

Initially, work with Philip's mother proved difficult, as her depression left her detached from both his and her own feelings. She did, however, support his treatment and the

classroom interventions and, gradually, she began to identify with the positive view of Philip communicated to her by his therapist and teachers.

### ***Conclusion***

The early childhood consultation model offers a comprehensive approach to children's social and emotional development, allowing teachers, parents, and mental health professionals to work together to identify and respond to children's needs, plan classroom interventions, and support the effort of families to develop coping strategies.

Children and families benefit from the combined focus on children's social and emotional development and early intervention efforts aimed at preventing more serious problems from emerging later in childhood. Further, an effective mental health collaboration can serve to enhance a program's resilience and to reduce stress experienced on the part of staff by joining together to face the day-to-day challenges of meeting the educational and emotional needs of the young children both serve.

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# **Working with Mental Health Professionals**

by Beth L. Green, Maria C. Everhart, and Lynwood Gordon

The increasing numbers of young children with challenging behaviors and emotional problems have led many child care providers and early childhood education programs to employ or contract with mental health professionals (Lavigne et al. 1996). Head Start programs, for example, are required by the Head Start Program Performance Standards to utilize the services of mental health professionals with sufficient frequency to meet the needs of children and families. However, there has been little research to help program managers make informed choices and answer their questions:

- What services are most important to support staff and families?
- Who might provide them?
- How to make the best use of limited program resources?

In 2002, a Mental Health Services Survey was conducted to address these important questions. A nationally representative sample of over 950 Head Start directors, teachers, parents, mental health coordinators, and consultants was surveyed about program structure and mental health services; their beliefs, attitudes, and practices; and perceived effectiveness of mental health services and supports.

The key findings are summarized in this article and provide guidance to Head Start and other early childhood programs about how to promote the mental health of children, families, and staff. A list of selected findings is available at <http://eclkc.ohs.acf.hhs.gov/>; the research report is available at <http://www.rtc.pdx.edu/PDF/pbMHConsultHS.pdf>.

## ***Promising Practices***

Growing evidence shows that organizations that provide effective early childhood mental health services share a set of core principles or promising practices (Simpson et al. 2001). The ten principles describe effective services as: strengths-based, individualized and comprehensive, relationship-based (that is, focused on building positive, nurturing relationships with each child and family), family-focused, preventative, inclusive, culturally sensitive, integrated, and promoting staff wellness and strong community partnerships.

The Head Start staff and mental health professionals who indicated that their mental health services were implementing these promising practices more completely also reported that their services were more effective—both in reducing children’s problem behaviors and in increasing their positive and pro-social behaviors. Moreover, best practices were related to staff perceptions of program outcomes independent of how much money was spent on mental health services or how frequently these services were provided.

Higher staff ratings for program outcomes were consistently linked to two principles: cultural sensitivity and family focus/parent involvement. The ability of staff and consultants to recognize and be sensitive to cultural variability in approaches to and beliefs about mental health was important over and above all other promising practices.

Those programs where staff and consultants valued and were able to more successfully involve parents in working collaboratively to address children's mental health issues were also perceived as being more effective.

The only principle that was not consistently associated with staff perceptions of positive outcomes was inclusion. Some staff who strongly endorsed all other promising practices thought children with challenging behaviors would be best served outside the regular child care environment. Clearly, more support and training around the issue of inclusion are needed.

### ***Effective Consultants***

The survey asked about the characteristics of the mental health consultants and the programs they worked with. As reported by staff, some characteristics turned out to be surprisingly unimportant to program outcomes, including total number of hours per child of consulting provided, percent of program's budget spent on mental health services, size and location (urban vs. rural) of program, primary race/ethnicity of families served, and credentials and education of the consultant.

So, what was important? Three findings emerge.

1. The experience of the mental health professional in working with both young children and low-income families. Not surprisingly, programs struggled to find mental health professionals with expertise in both areas.
2. The ability of consultants to make a long-term commitment to the program. Those with longer-term relationships were generally perceived as being more effective.
3. The consultants' approach to service delivery. Consultants who were able to provide services consistent with the promising practice principles and whose approach reflected the Head Start program philosophy were seen by staff as being more effective.

### ***Effective Consultation Services***

Cohen & Kaufman (2000) define two general types of services that can be provided by an early childhood mental health professional. One is a more traditional, problem-focused service that targets the specific needs of a child or family, sometimes referred to as individual consultation. Services include screening, assessment, or treatment of individual children or family.

Another type of service, called program-level consultation, aims to improve overall program or classroom quality and to help the program and its staff address broad issues that affect more than one child, family, or worker. Activities include working with teachers and family service advocates, training staff, attending management team meetings, and advising on program policy.

High levels of either type of service were associated with perceptions of positive outcomes for children. But there were differences in outcomes for staff. When mental health consultants worked at the program-level, staff felt better about their jobs, and in turn, they were better able to successfully work with children with challenging behaviors. The survey findings suggest that while both strategies can work well for children,

programs that utilize mental health professionals to provide program-level consultation may be getting “more bang for the buck.”

In addition, consultants who were integrated into day-to-day program functioning seemed to be more effective and to provide more services regardless of how many hours they were paid (Green et al. 2004).

### ***Leadership and Shared Vision***

Program management and leadership play an essential role in setting the tone for how an entire program thinks about and approaches early childhood mental health issues. Results suggest that program leaders should pay particular attention to three aspects:

- ensuring that all staff share a similar vision for early childhood mental health efforts that is strongly rooted in best practices;
- becoming visible advocates for community resources related to early childhood mental health; and
- structuring and facilitating the work of mental health professionals through integrated, program-level consultation.

The effect of strong program leadership around mental health issues supported more positive staff-consultant relationships, which led to staff perceiving more positive program outcomes.

### ***Conclusion***

Finding ways to effectively address children’s mental health issues remains a challenge to many early childhood programs. But, the Mental Health Services Survey shows that many Head Start programs have established successful approaches to achieving positive outcomes for children and staff. These programs embrace promising practices, use effective consultants, provide an integrated, program-level approach, and are supported by leaders with a commitment to mental health services.

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# **Unpacking the Meaning of Infant and Toddler Behavior**

by Jennifer Boss, Kim Diamond-Berry, and Tammy Mann

How does an infant tell us what he wants? When a young toddler points and grunts, what is she saying to us? Why do 2-year-olds bite other children?

For adults who are used to relying on words to communicate and understand one another, deciphering the “language” of infants and toddlers can sometimes be a challenge. But it is precisely through their behavior—gestures, looks, babbles, and cries—that infants and toddlers communicate with us. It is incumbent upon the adults in the babies’ world to decode this mysterious behavior and make sense of it.

Once we understand what the behavior is communicating, we can respond appropriately. Of course, young children do not behave in a vacuum. They behave in the context of their relationships, their environment, and their developmental level. Understanding this context will allow us to unpack the meaning of infant and toddler behavior.

## ***Behavior Within Relationships***

The first step in making sense of a young child’s behavior is to look at the quality of the relationships with important adult caregivers in the baby’s life. Parents, as well as Head Start and Early Head Start (EHS) teachers and caregivers, have important relationships with infants and toddlers. These early relationships, whether they are healthy or compromised, greatly influence how a baby or young toddler expresses himself in the world.

If the relationship between a child and an adult grows in a healthy way, their interactions are characterized by mutual understanding and effective communication. For example, when a 2-month-old discovers that his smile elicits enthusiastic smiles and warm hugs from a loving adult, he might smile even more broadly and enthusiastically at adults with each encounter. When the adult continues to respond to his smiles or attempts to communicate with more positive feedback, a cycle develops with each partner knowing what to expect from the other.

On the other hand, if the baby’s attempts at communicating with adults are consistently ignored or met with negative feedback, he may learn that relating to adults is not pleasurable and does not meet his needs. In extreme cases, the baby might begin to turn away from an adult’s gaze, or seem listless, quiet, and depressed. These two contrasting qualities of relationships lead to very different behavioral expressions by the baby.

## ***Behavior Within Development***

Another important way to understand early behavior is to pay attention to the developmental domain the child is currently mastering. As children progress through the different domains of development (cognitive, social, emotional, and physical), we expect certain behaviors. For example, a child who is working to master language may begin with crying, gurgles, coos, and babbles. When adults respond positively to these behaviors, the baby adds more sounds and gestures as she grows. The baby learns how language is a powerful tool for getting attention and communicating her needs. Later, the

baby will become more intentional with her gestures (e.g., grasping, grabbing, hitting, pointing) and better able to expand the dialogue with adults.

These increasingly complex behaviors occur in a predictable sequence and are influenced by her significant relationships. When we understand the infant or toddler's development we can better understand the child's behavior and support her emerging developmental skills with awareness and sensitivity.

Development, however, does not proceed in a linear fashion. There is a natural ebb and flow to early childhood development, with each area of development progressing at its own pace. Children may progress quickly in one area of development and seem to remain static in others, or it may seem that they "take two steps forward and one step back" as they master new skills.

Children need time and experience to practice emerging skills and may approximate new skills before they are fully able to master a task. For example, an 8-week-old who has recently discovered her hand but who has limited gross motor control, may spend several minutes banging her hand into her face while trying to maneuver her fist into her mouth. A toddler who is developing his language skills but does not yet have the ability to understand and clearly express his emotions, may resort to biting his classmates when he is frustrated or anxious. Infants and toddlers are growing and developing at a rapid pace and need many opportunities to practice new skills in order to master them.

### ***Individual Differences***

We know that each child has a unique way of understanding and relating to his or her world. Temperamental differences in young children lead to differences in behavioral expressions. A 30-month-old who has a quiet, slow-to-warm temperament may need extra time in the morning to get accustomed to the high activity level in the classroom. This child may be clingy with his parents and fussy during drop-off. In contrast, a 30-month-old who has a feisty temperament and enjoys the high activity level of the classroom may enthusiastically run into the classroom during morning drop-off, eagerly looking for her friends and ready to jump into the activities. In both of these examples, the temperamental preferences of the children give you clues as to the meaning of their behavior—"I'm clingy and fussy because the activity level of the class is too stimulating for me" or "I'm active and busy because the activity level of the class excites me."

### ***Impact of the Environment***

The environment also plays a factor in how children express themselves through their behavior. The quality and layout of the physical environment (e.g., an EHS classroom, the home, or an outdoor play area) can have a great impact on children's behavior. In some cases, problematic behavior is easily influenced by environmental factors, and the behavior will improve by intervening with the environment rather than the child (U.S. Department of Health and Human Services 1996). For example, lowering the stimulation in the classroom may help temper the clingy and fussy behavior of the 30-month-old with a slow-to-warm up disposition. Planning some quiet activities in the early morning, even playing some relaxing "mood" music, may ease the child's transition.

In addition to the physical space, the presence of the adult caregiver has an impact on the child's behavior. In an early childhood program, the behavior of the staff sets the climate or culture of the classroom, which in turn has an impact on the behavior of the children. Understanding how the environment (both the physical space and people in the environment) influences infant and toddler behavior is a critical part of unpacking the meaning of behavior.

### ***Implications for Head Start and Early Head Start Programs***

The Head Start Program Performance Standards (1998) require ongoing observation and gathering of information about children's development and behavior from a variety of sources [45 CFR 1304.20(b)(3) and 1304.20(d)]. Head Start and EHS programs gather information about a child's development through the required screening process [45 CFR 1304.20(b)(1-3)] and use the information from ongoing assessment procedures to plan for children's needs [45 CFR 1304.3].

Infant and toddler behavior is influenced by numerous factors. The task for Head Start and EHS staff is to look closely at each of these factors, gather as many clues as possible, and develop fair and accurate assessment of the child's behavior.

When young children present challenging behavior, it can leave teachers and caregivers unsure of how to respond. Caregivers are cautioned against assuming the problem lies solely within the child. Instead of thinking of the child as "bad," the caregiver might ask herself, "What are this child's important relationships like (including the relationship with the caregiver)? What developmental tasks is she trying to master? What is her temperament like? How does she behave in a variety of environmental settings—in the EHS classroom, at home, with her parents, with the teachers?"

By observing and asking questions, caregivers have clues that can aid in understanding infant and toddler behavior, making it possible to respond in a way that lets the child know she is an important person whose behavioral "language" is heard and understood. For more information on understanding infant and toddler behavior, see the resources available at EHS/NRC @ ZERO TO THREE (<http://www.ehsnrc.org/AboutUs/Index.htm>)

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# Understanding Attachment

By Alice S. Honig

Sitting on the beach close to his mother and baby sister, 3-year-old Aaron digs in the sand with his shovel. He looks up and sees what appears to be a huge metal monster rolling toward them. Although the path to safety lies toward the boardwalk, Aaron drops his shovel and leaps into his mama's lap, burying his face in her shoulder. His deep, secure attachment to his mother makes her the preferred source of safety—even when reason tells him that to escape “the monster” he should run away. Patting him soothingly, Aaron's mother explains that the machine is cleaning the beach and will certainly swerve around them, which in fact it does.

Child care providers and early childhood teachers hear a lot about attachment and how important it is for the emotional well-being of infants, toddlers, and preschoolers. But what exactly do we mean by attachment? What is meant when we say that Aaron is securely attached to his mother?

## ***What Is Attachment?***

The term attachment describes a strong emotional bond between a baby or young child and a caring adult who is part of the child's everyday life—the child's attachment figure. It is usually an affectionate or loving bond: the attachment of a child to his mother comes immediately to mind. However, a baby is not born with this attachment to his mother; it develops over time. Each day as the mother looks into the baby's eyes while nursing him; as she carries him in a pack on her chest, talking to him while raking leaves; or as she holds him on her lap, including him while reading to an older sibling, the baby's attachment to his mother grows stronger.

But what happens if the caring adult is not the baby's mother? Can someone besides the mother become an attachment figure? What if the father or an aunt cares for the baby each day while her mother is away at work? What happens if the baby is cared for in a center or a family child care home by an adult who is not even related to her? Such situations are not at all unusual; many mothers work even when their babies are quite young. In these cases the baby will most likely become attached to the other adult—in addition to being attached to mom and dad. The bond between a baby and her parent tends to be a strong one, but babies and young children are capable of forming attachments to more than one adult. When a provider showers the babies and toddlers in her care with warmth, caring, and individual attention, these children are very likely to develop a secure bond with her. Furthermore, children benefit from positive attachments to adults who are not their parents (Main & Weston 1981).

Attachment is a developmental system that builds slowly from a child's first days through his or her early years. It describes and explains people's enduring patterns of relationships from birth to death. From the infant's experiences and interactions during the first year with the key adult caregivers in her life—her attachment figures—she gradually builds up pictures of relationships between herself and others (Bowlby [1973] 2000). For the most part these internalized working models are not a part of the child's conscious thought, yet they have profound effects throughout life. The influence of these models plays a crucial role in the development of later personality. They are templates

that serve as guides for and interpreters of emotions, perceptions, and behaviors in all future relationships (Bretherton & Waters 1985; Belsky & Nezworski 1988; Brazelton & Cramer 1990; Bretherton 1991; Crowell & Waters 1994; Colin 1996; De Wolff & van IJzendoorn 1997; Koops, Hoeksma, & van den Boom 1997).

Another key realm influenced by attachment is self-regulation. Children's ability to regulate their emotions and behaviors depends on the security of their attachments to caregivers and the quality of care they receive (Shore 1997). A child who is upset shows self-regulation when she soothes herself and restores balance. For example, a baby in slight distress may calm herself by putting her fist in her mouth and sucking vigorously. Securely attached babies are more able to maintain physical and emotional balance than are insecurely attached babies (Matas, Arend, & Sroufe 1978; Sroufe 1979; Braungart-Rieker et al. 2001). Secure attachments also seem to prepare children to be confident and independent learners with strong social skills (Ainsworth & Bell 1974; Arend, Gove, & Sroufe 1979; Erickson, Korfmacher, & Egeland 1992).

The strength of attachment is such that the treatment and acceptance we grow up expecting from others corresponds to what we got from our own attachment figures. We tend to go through life feeling the way our attachment persons made us feel—be that happy or depressed, loved or neglected, at peace or in turmoil. The prospects are good that Aaron's loving, trusting relationship with his mother will predispose him to expect warm, healthy relationships with others in his childhood and throughout his life. Contrast Aaron's predisposition with that of a neglected or abused toddler. Based on her early experiences, she will likely expect cold, erratic relationships and little comfort in times of stress. These expectations may lead her to act in inappropriate ways in child care, such as showing anger or aggression toward an upset peer or not responding to warm adult overtures. Her difficult behaviors may ensnare an unwary caregiver and create a relationship fraught with punitive, unhappy interactions—like those the child has already come to expect. In the all-too-usual course of events, unhappiness and disappointment beget more unhappiness and disappointment.

Knowledge about attachment helps teachers, parents, and caregivers to understand how children's emotional behavioral styles and interactions are shaped and how the quality of early relationships affects later patterns of intimate relationships. This knowledge enables adults to temper their interactions to children's needs, thus influencing children's emotional security. Building secure attachment is a prime goal in early care and education; it is in fact the keystone for ensuring children's sound mental health (Honig 1993).

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- This article is excerpted with permission from Alice S. Honig's book, *Secure Relationships: Nurturing Infant/Toddler Attachment in Early Care Settings* (published in

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Understanding Attachment Sidebar:

#### Building Attachment

In this excerpt, Dr. Honig refers to the research findings of Ainsworth and her colleagues (Ainsworth, Bell, & Stayton 1971; Stayton, Hogan, & Ainsworth 1971) about maternal behaviors and infant attachment.

Mothers of securely [attached] infants are sensitive and responsive; they

- hold the baby in a tenderly careful way
- enjoy close cuddles and playful, affectionate interactions with the baby
- feed in tempo with infant needs and feeding styles
- give babies floor freedom to play
- interpret infant emotional signals sensitively
- respond promptly and appropriately to infant distress
- provide contingent feedback (respond immediately and purposefully to infant behaviors they want to reinforce or discourage) in face-to-face interactions during routines and play

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# Signs of a Young Child's Trust in Your Caregiving

by Alice S. Honig

Developing a bond between you and the babies, toddlers, or young children in your care is one of your major goals. You act quickly and warmly to comply with their needs, and you temper your responses to their individual styles. You show respect to children and shower them with praise in the wake of their good deeds. You use contingent feedback to support or alter their behaviors. You talk to them, hold them, hug them, read to them, and smile across the room at them. You communicate and work with their families in the interest of the children's well-being.

How can you tell when you have succeeded in forming a strong bond with a child? When the child:

- smiles with pleasure when you greet her warmly or admire her accomplishments
- reaches out to you to be picked up
- calls out to you to get your attention
- relaxes and molds comfortably to your body when you hold her
- leans into your body when you read to him
- accepts your gentle touches and warm gestures of intimacy
- climbs on you, clings to you, or even sucks on your knuckles to regain emotional balance
- looks up occasionally to check for your presence when playing across the room
- becomes stressed when he notices you are not in the room
- runs to you, her safe base, to "refuel," then returns to play
- turns to you for help in stressful situations
- takes your hand in new or unfamiliar circumstances
- calms down at your reassuring touch and words
- is cooperative and compliant with your requests and directions
- works longer at challenging tasks when you are near
- looks into your eyes when you crouch down to talk to him
- talks to you truthfully about the bad as well as the good

When babies and young children show a number of these behaviors, they are well along in forming a secure attachment to you, their warm, responsive, and reliable caregiver. And you have given them a gift that will serve them for a lifetime.

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# **Risk Factors for Emotional and Behavioral Problems**

by W. Douglas Tynan, Meredith Dreyer, and Meredith Lutz Stehl

Promoting young children's social and emotional development has been a goal of Head Start since its inception in 1965. The Head Start Child Outcomes Framework (2003) includes Social and Emotional Development as one of the eight areas (or Domains) of preschoolers' learning and development that programs must address. Self-Concept, Self-Control, Cooperation (with peers and adults), Social Relationships, and Knowledge of Community and Families are identified as Domain Elements that are important to social and emotional growth. When Head Start staff intentionally support children to develop a strong sense of self, regulate their behavior, make friends, and learn about the social world, they are preparing children to be successful learners in school.

Some children exhibit challenging behaviors that are indicative of social and self-control problems. While those problems are sometimes attributed to a specific cause or diagnosis, there is a growing realization that usually there is no single cause and that the best programs address several risk factors at culturally sensitive and appropriate levels of intensity. To understand emotional and behavioral difficulties in children, we can start by looking at the factors involved and plan appropriate interventions.

## ***What Are the Risk Factors?***

Risk factors include specific characteristics of the child, difficulties of the family, and factors in the community. They include:

- Constitutional factors of the child: complications during pregnancy or immediately after birth, strong family history of neuropsychiatric disorder, and sensory disabilities
- Skill development delays: low cognitive ability, attention deficits, delayed speech and language skills
- Emotional difficulties and social behavior problems: emotional immaturity, peer rejection, alienation, and isolation
- Family circumstances: stressful life events, conflict within the family, ineffective parenting skills, and mental illness within the family
- Environmental risks: neighborhood safety factors, extreme poverty, and unemployment

While most of us are aware of these risk factors and their impact on young children, sometimes we develop interventions that lose sight of some of the contributing factors. Perhaps the best way to address the problems is to link each risk factor associated with the child, family, and community with the appropriate interventions. When there is a good fit between the risk factors and the interventions, there is more likely to be a successful outcome.

## ***Risk Factors and Interventions***

Constitutional factors. We know that younger mothers and mothers in poverty are more at risk for premature delivery. Children born prematurely are at much greater risk for vision, hearing, and motor difficulties, which may impact their social and emotional functioning.

These children may have difficulty learning to self-regulate. We certainly cannot undo constitutional factors, but knowing a child's early medical history can help staff anticipate and plan for social and emotional delays of the children in their care.

A family history of close relatives having neuropsychiatric disorders also may predispose a child to having some behavioral difficulties. Well-designed behavior interventions that recognize these contributing factors and emphasize positive behavior support practices can be very effective with children who exhibit challenging behavior in Head Start programs. (See the article "A Change of Focus with Positive Behavior Support" in this Bulletin.)

**Skill delays.** The Center for the Social and Emotional Foundations of Early Learning (CSEFEL at <http://www.vanderbilt.edu/csefel/>) is funded by the Office of Head Start and the Child Care Bureau. The Center is a national resource center that promotes the social and emotional development of young children as a means of preventing challenging behaviors. The Center recommends classroom strategies that emphasize clear structure in order to teach children to communicate, follow directions, and cooperate and play with peers more appropriately. We know that screening, diagnosis, and intervention are critically important to improve communication and decrease behavior problems for children with significant speech and language delays.

**Emotional difficulties and social behavior problems.** Development of self-control, cooperation, and social relationships are goals specified in the Head Start Child Outcomes Framework and thus need to be addressed by programs serving preschoolers. The What Works Briefs and other materials from CSEFEL describe a curriculum that promotes self-control and interpersonal skills in young children.

**Family circumstances.** These risk factors are addressed by therapies that treat the parent-child relationship and work to improve parenting skills, decrease conflicts among adults, and thus encourage parents to interact more effectively with their children. Screening parents for depression, the most common adult emotional disorder, and referral for treatment can also have a significant positive impact on children's emotional development.

**Environmental risks at large.** Although mental health interventions do not directly address the risk factors of neighborhoods, racism, and extreme poverty, we need to be aware of their impact. There are a number of ways we can structure our services so these factors do not disrupt service delivery. Making sure that transportation is available, scheduling appointments at convenient times for parents, providing culturally sensitive interventions, and working with existing community organizations to deliver programs at sites that are accessible, acceptable, and safe for families are all ways of addressing this last set of risk factors. We can work with families to make sure that their basic needs are met and help them to set goals to improve their employment or economic status.

## ***Conclusion***

Current research tells us that the origins of behavioral difficulties stem from many factors and that behavioral difficulties do respond to treatment. The challenge for the future is to develop effective treatments that address not only the specific problem, but also fit within the context of other risk factors.

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## **Prevalence Data on Mental Health Problems**

### ***National Prevalence Data***

Research conducted over the past two decades has produced a range of findings about the prevalence rate of mental health problems in children. For instance, Campbell (1995) estimated that approximately 10-15% of all typically developing preschool children have chronic to moderate levels of behavior problems. Similarly, other researchers (Briggs-Gowan, et al. 2001) found 10-15% of one- and two-year-old children experience significant social and emotional problems. However, another study found the prevalence of young children with behavioral or emotional challenges to be as high as 30-50% (Qi & Kaiser 2003).

There are many reasons why the findings vary. Studies may define mental health problems differently (identify different symptoms and criteria); they study different populations (geographically, demographically); and they use different measurement techniques (parent surveys, clinical diagnoses).

Despite the variations in the prevalence findings, research consistently suggests that children from low-income families are more vulnerable to developing behavior problems than children from the general population and that behavior problems in early childhood remain stable over time and often predict additional problems (Qi & Kaiser 2003). The research on prevalence of young children with mental health problems underscores the critical importance of Head Start's mental health services.

### ***Head Start and Early Head Start Data***

Head Start and Early Head Start (EHS) programs are required to report on certain indicators of the need for and delivery of mental health services for children enrolled in their programs. Data collected from Head Start's FY 2006-07 Program Information Report (PIR) indicate that:

- Mental health professionals provided consultation to staff regarding children's behavior/mental health for over 143,000 Head Start and EHS children (13.5% of all enrolled children); for over 47,000 (nearly one-third) of these children, staff received three or more consultations.
- For over 60,000 children, (5.7% of all enrolled children) at least one behavioral/mental health consultation was provided to a parent by the program's mental health professional; for over 25,000 (nearly half) of these children, parents received three or more consultations.
- About 22,700 children (2.1% of all enrolled children) were referred for mental health services outside of Head Start or EHS; about 16,700 (nearly three-quarters) of these children received mental health services from an external provider.

Compared to the national prevalence data, the PIR data may underestimate the true number of Head Start and EHS children who have mental health needs. Some possible reasons are self-reporting and insufficient screening and diagnosis. Head Start and EHS programs are committed to doing a better job of identifying needs and connecting children and families to appropriate mental health services.

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# The Power and Value of Play

by Amy Hunter

Play is essential to a child's physical, social, emotional, and cognitive development. It is the outward expression of children's inner, emotional life. Play also offers young children, including infants and toddlers, many rich learning opportunities, such as learning how to:

- Organize and make sense of their experiences. As I roll this ball, I'm discovering how to control and use my body.
- Discover and explore the world. When the ball rolls away and under the table, I am learning how things move and fit in space.
- Relate to others. I feel delighted and powerful when I point to the ball and you roll it back to me.

Play is so critical to children's development that the American Academy of Pediatrics has released a clinical report that outlines the importance of play and encourages pediatricians to support parents in encouraging children to participate in child-directed, unstructured play (Ginsburg et al. 2007).

Parents and caregivers can understand a great deal about what children are feeling and thinking by watching their play. Their play reflects themes common to their stage of development as well as the individual's own experience. Infants and toddlers who are not yet capable of using words can use play to demonstrate and express how they feel. Older, more verbal children may feel safer playing out their angry, confusing, or upsetting feelings than speaking about them. Because play is such a central and powerful activity for young children, it is widely considered the appropriate therapeutic medium for helping young children resolve conflicts or difficulties.

The following vignettes illustrate a few ways in which young children use play to learn and/or to heal and cope with challenges.

## **Kadyn**

Five-month-old Kadyn delights in peek-a-boo. As her caregiver, John, covers his face, Kadyn kicks her feet and shows a curious interest. She likely wonders, "Where did John go?" As John uncovers his face, Kadyn's eyes widen, and she smiles, coos, and giggles, as if to say, "more, more, more." Kadyn and John play this game of peek-a-boo over and over, day after day.

What is Kadyn learning in this very familiar game? She is beginning to learn object permanence. In other words, she is learning that when John is hidden, he didn't really go away. Kadyn is learning about predictability and the give-and-take of social games. Emotionally, she is learning that playing games with an attentive and caring adult is enjoyable. Through this interaction, Kadyn is learning and internalizing that she is a worthwhile, loveable baby with whom her caregiver likes to spend time. She is learning the meaning of language as John repeats words with his actions. Over time, John makes peek-a-boo more complex by hiding other objects and helping Kadyn to hide herself. As her mobility increases, Kadyn uses her gross and fine motor skills to grasp and move the

blanket and to actively search for objects. Kadyn is practicing problem-solving skills as she figures out where to search. She is refining her visual discrimination skills as she distinguishes the differences between objects.

### ***Tommy***

Three-year-old Tommy's favorite game was "I scare you." In this game, Tommy would "hide," and I, his play therapist, would "look" for him, asking out loud if he was "behind the desk" or "behind the couch." He would giggle and tell me he wasn't in any of those spaces. As I would gradually approach his "secret hiding spot," he would jump out and "scare" me. He got a thrill from "surprising" and "scaring" me. Sometimes when I went to find Tommy, he would explain he was "dead," only to come alive and scare me a few seconds later. Tommy played this "scare" game over and over, week after week in our therapy sessions.

At home, Tommy had observed his mother endure domestic violence, and he often hid. Although he was too young to express his complex feelings using words, he likely felt helpless and scared. As Tommy's therapist, I encouraged him to play out his game in the safe space of the therapy room. By scaring me, Tommy was playing a powerful role in which he was no longer scared and helpless but instead was in control. Tommy was using play to help him develop a better understanding of the scary things he experienced.

### ***Jacob***

Four-year-old Jacob plays out an elaborate scene of "cooking" for friends. He "reads" the recipe, measures the "ingredients" with a measuring cup, and stirs the bowl. As he tells his fellow players where to sit, he turns to another child standing on the outskirts and tells her, "You can't come to my party." To another child, Jacob says, "We already have four people," referring to a classroom rule.

Through play, Jacob is practicing tasks and roles he has observed at home. He is using abstraction, verbalization, as well as pre-math and pre-literacy skills. The children are learning and experimenting with rules, social roles, and social skills. Language skills are being developed. Emotional skills are being tested as the children are challenged by directions, words, and actions that they don't like. Negotiations take place to attempt to problem solve. Pretend play, like Jacob's, has been found to be directly and positively linked to school readiness.

### ***Sienna and Friends***

Five-year-old Sienna and her friends often gravitated outside in the direction of stacked crates. They would climb onto this precarious structure and try to balance. Sometimes the children on the ground would shake the structure while the child on top tried to maintain her balance before tumbling off.

The community had recently experienced a powerful earthquake, and residents were now living in a temporary shelter. A mental health consultant working with the community wondered if the children were acting out being shaken and out of control. By recreating their own "earthquake," they were attempting to integrate, understand, and master their experience.

At the consultant's suggestion, a gym was used to create a safe place where the children could build precarious structures with safe materials and mats to fall onto. The children were encouraged to talk about their experience and to paint, draw pictures, and make books about their experience. The consultant talked with teachers, parents, and shelter staff about ways to talk to the young children about the earthquake.

### ***How to Support Play***

In today's push for academic and cognitive outcomes for even the youngest children, the value of the learning that takes place from unstructured, child-initiated play is often lost. Parents and caregivers may need guidance about how they can support play. Useful strategies include:

Recognizing the value of play. Maximize children's learning by understanding and describing to others that what looks like play is in fact how children learn, explore, and discover. Facilitate children's development by validating and respecting children's use of play as a vehicle for their social, emotional, physical, and cognitive development. Providing opportunities for young children to imitate and explore in the context of secure, safe, nurturing, and consistent relationships. As you offer acceptance and interest in a young child's play you will be creating interactions that build a positive relationship.

Following the child's lead. Become involved only as you are invited to do so. Respond to the child's inquiries, but do not take over the direction of the play. Your interest communicates: "What interests you is important to me. You are important to me."

Observing and documenting the child's play, including his or her actions and verbalizations. Look for patterns or repetition in children's play. Notice the feelings that the child is expressing. Use reflective supervision, consultation, or staff meetings to explore the potential meaning of play for a child or group of children.

Allowing repetitive play. Young children repeat play in order to master a challenge or task. The more you allow time for the child to master the challenge or skill, the more likely she will take on new challenges.

Accepting expressions of intense feelings. Avoid judging the child's language or play. If a child angrily says, "I'm going to hit you," avoid comments, such as "That's not nice," "You're being mean," or "Play nicely." Instead, validate the child's feelings. Say, "It sounds like you're really angry." Encourage safe play, such as offering paint to create an angry picture or providing dolls to act out the situation.

Trying to understand the value, meaning, and cultural context of a child's play before imposing limits or restrictions. For example, gun play, while threatening or symbolically unsafe, may reflect children's experiences as witnesses to hunting, gun activity, or violent television, movies, or video games. Consider ways to explore the play or redirect it to be safe for all children. Ask about what may happen next or suggest rescue props for the injured. Ask how the injured feels, how they can make peace, and how they might solve the problem in other ways.

Play is essential to children's social and emotional development. It offers them opportunities to develop their interpersonal skills and a safe place to express their

While all caregivers can learn to facilitate young children's play, some children and caregivers may benefit from a trained play therapist who can help caregivers understand children's play as well as help children with the way they think or feel, develop problem-solving skills, and resolve conflicts.

For more information on play therapy, visit the Association for Play Therapy at <http://www.a4pt.org/ps.playtherapy.cfm?ID=1158>.

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## **Trauma in the Lives of EHS Children**

by Neena Malik, Sherryl Heller, and Rachel Chazan-Cohen

Ruby was a 2½-year-old enrolled in Early Head Start who suddenly began exhibiting kicking and biting behaviors. She and her mother, Karen, had recently moved after a violent episode involving Ruby's father. During a heated argument, while Karen was holding Ruby, Ruby's father pushed Karen, nearly causing mother and daughter to fall down the stairs. Karen was not sure if Ruby knew what happened, since she never talked about it. EHS staff worried about Karen and Ruby and were having a hard time managing Ruby's behavior in class.

Trauma is a dangerous or threatening act or series of events that are beyond what a child would be expected to experience in the course of everyday life. In recent years, the early childhood field has come to recognize the implications of trauma for young children. Research shows that traumatic events have significant effects on young children, whether the trauma is a single event or an ongoing stressful situation. Both Early Head Start (EHS) and Head Start, as child development and family-focused programs, are uniquely able to help families recognize how trauma affects their lives and to support their developing coping strategies.

### ***Research on Trauma***

The Early Promotion and Intervention Research Consortium (E-PIRC) projects were designed to develop and test approaches to supporting the mental health of infants, toddlers, and their families in EHS. The findings from these studies also are relevant for older children in Head Start programs and their families. The five E-PIRC projects were partnerships between academic institutions and EHS programs funded by the Head Start Bureau (now OHS) and the Office of Planning, Research, and Evaluation (OPRE). (See the article "The Early Promotion and Intervention Research Consortium (E-PIRC)" in this Bulletin.)

Findings from two E-PIRC studies: *Infusing Infant Mental Health Services in Early Head Start through a Research-Based Collaborative Partnership* conducted by the University of Miami and *High-Risk Adolescent Mothers and Their Children: Comparing Two Preventative Interventions* conducted by Tulane University are highlighted here. They provide guidance to programs serving young children.

### ***Prevalence of Trauma in EHS Families***

The University of Miami E-PIRC study found that 71% of the young children in the study had experienced at least one trauma. Many children experienced more than one trauma.

- 38% of children experienced a serious illness or injury.
- 23% experienced a prolonged separation from their primary caregiver and/or had experienced eviction and/or homelessness.
- 21% experienced the death of a close relative.
- 11% experienced the serious injury or illness of a close relative.
- 9% were in or witnessed a serious accident.

Children also were exposed to violence in the community and home.

- 39% of parents reported that people in the family threw objects, hit each other, or lost their tempers.
- 30% of children witnessed violence in their communities/neighborhoods.
- 15% witnessed a close relative being attacked or beaten.

### ***Trauma Symptoms in Young Children***

The University of Miami study found that 44% of the children were reported by parents to be experiencing trauma symptoms. The children evidenced:

- Re-experiencing: playing out memories of the event in verbalization, play, or behavior
- Sleep problems: trouble falling asleep and nightmares
- Eating problems: over-eating or finicky eating
- Regression in developmental functioning or acting like a baby
- Withdrawal: talking less, avoiding interactions, seeming less joyful
- Onset of new fears
- Aggressive outbursts or increase in activity level
- Increased clinginess/separation anxiety
- Preoccupation with the traumatic event: bringing up the episode in ways that are repetitious, pressured, or uncontrollable

The E-PIRC research from the University of Miami and from Tulane University helps inform EHS and Head Start staff about how to support children who have experienced trauma, their families, and the staff who care for them.

### ***Staff Interactions with the Child***

When interacting with the child, the following principles can be helpful:

- Have patience. By being understanding, staff can provide extra support to children.
- Support the child emotionally. When young children experience trauma, they can lose control. Taking them aside, patiently talking with them in a soothing way, and allowing them a few minutes alone or in a quiet spot will help them regain emotional control. Some children, both EHS and Head Start children, may need physical comfort. When the child calms down, praise them for regaining control, helping to reinforce the positive behavior.
- Help children label how they feel. Give children words to express their feelings and gain control.
- Follow the child's lead. An out-of-control child may be telling us he needs nurturing, a few moments alone, or help saying how he feels.
- Provide safety and trust with predictable routines and calm interaction. A calm word or two to a child will help focus her, calm her down, and make her feel cared for. Maintaining predictable routines and schedules can also help the child feel secure.

- Promote children’s play as an opportunity to express their feelings and gain mastery over events in their lives. Make props available to support their play. Also, encourage children to use drawing, painting, dancing, or other artistic avenues to express their feelings.
- Prepare them for change or transition, even in everyday activities. Quick, gentle reminders can help with a child’s ability to control his behavior.
- Understand regressive behavior. When a child who has behaved in an age-appropriate way regresses in areas such as language, sleeping habits, eating habits, or behavioral control, she may have had a trauma and needs some extra nurturing or possibly some professional intervention.

When Ruby would lose control, staff learned to take turns, depending on who felt most patient at the time. Staff soon realized that her behavior was not manipulative, but an indication that she needed help and comfort. They would gently pick up Ruby after she fought with another child or if she was having a tantrum. They separated her from others and gently helped her say what she felt. Sometimes they asked Ruby what she needed to feel better, and she sometimes was able to say she wanted a hug, a book, or a drink of water. To help Ruby deal with transitions, staff emphasized their everyday practice of telling the whole class when they were going to go out to play or when they would need to clean up.

### ***Staff Interactions with the Child’s Parent***

When interacting with the parent, remember that parents may also have been traumatized. They may need support and perhaps a referral to a mental health specialist. Parents may also need patience and help with understanding child behaviors. Staff should support the parent-child relationship by helping parents use the same principles with children that are listed above.

Ruby’s mother was traumatized, too, and didn’t quite realize how traumatized Ruby was. But when a parent feels unsafe, a child feels it, too. Staff helped Karen realize that Ruby probably suffered some consequences of the trauma. Staff also praised Karen and told her how impressed they were that she was able to protect Ruby so well. They were gentle and patient with Karen when she had trouble with Ruby. They suggested to Karen that she talk to the social worker to get some support for herself.

### ***Supporting Staff***

Staff who work with children and families who have experienced trauma may experience compassion fatigue and/or sadness. They may experience some of the same symptoms as the traumatized families they serve: nightmares, sense of disconnection from loved ones, work addiction, sense of hopelessness, heightened startle response, increased sensitivity to violence, and professional burnout.

Staff can support one another through reflective supervision, peer support, and self-care strategies. These strategies include: avoiding professional isolation, knowing your vulnerabilities, knowing when to say “no,” respecting your boundaries, balancing work

and personal life, developing realistic self-expectations, and addressing your own feelings.

In Ruby's case, program staff recognized how hard it was to care for her along with all the other children. After talking with one another and their supervisors, they decided to take turns working with Ruby and her mother. They paid attention to how they themselves felt. Talking about how frustrated or sad they felt helped them to support one another and helped them to acknowledge the difficulties without feeling guilty.

## ***Conclusion***

Trauma impacts children, parents, and program staff. Paying close attention to behavior changes in EHS and Head Start children can help staff recognize signs of trauma and provide appropriate support to the child, family, and other program staff as they cope with life's uncontrollable events.

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## **Three Sources of Resilience**

by Edith Grotberg

Day in and day out, all around the world, children encounter difficult situations in their families and communities. When children face illness, separation, death, or natural catastrophes, they feel lonely, fearful, and vulnerable. These feelings can overwhelm them and diminish their capacity to learn and grow. But when children have the skills, attitudes, beliefs, and resources of resilience, they can prevent, minimize or overcome these traumas.

Resilience may be described as the human capacity to face, overcome, and be strengthened by or even transformed by the adversities of life. Although some languages do not have a word for resilience, most people around the world understand the idea. They understand that people overcome adversity with courage, skills, and faith.

### ***Taking an International Perspective***

The International Resilience Project set out to examine what parents, caregivers or children do that promotes resilience. Participants from 30 countries were asked about their own experiences of adversity and their reactions (see the checklist in the Bulletin pull-out). A total of 589 children participated as well as their families and caregivers. Boys and girls were equally represented; half were 9-11 years and the remainder were 6 or younger.

### ***Taking a Close Look at Resilience***

The findings suggest that every country in the study was drawing on a common set of resilience factors to promote resilience in children. The project identified three factors: I have, I am, I can.

The I have factors are the external supports and resources that promote feelings of safety and security. Originating in early childhood, these factors are the core for developing resilience.

The resilient child says I have:

- People around me I trust and who love me, no matter what
  - People who set limits for me so I know when to stop before there is danger or trouble
  - People who show me how to do things right by the way they do things
  - People who want me to learn to do things on my own
  - People who help me when I am sick, in danger or need to learn
- 
- The I am factors are the child's internal, personal strengths. These are feelings, attitudes, and beliefs within the child.
  - The resilient child says I am:
    - A person people can like and love
    - Glad to do nice things for others and show my concern
    - Respectful of myself and others
    - Willing to be responsible for what I do

- Sure things will be all right

The I can factors are the child's social and interpersonal skills. Children learn these skills by interacting with others and from those who teach them.

The resilient child says I can:

- Talk to others about things that frighten me or bother me
- Find ways to solve problems that I face
- Control myself when I feel like doing something not right or dangerous
- Figure out when it is a good time to talk to someone or to take action
- Find someone to help me when I need it

Each of the I have, I am, I can factors suggest numerous actions that children, parents, and other caregivers can take to promote resilience. No one child or adult will use or need the entire pool of resilience factors. However, the more factors that are available to them, the more flexible they can be when they respond to adversity.

### ***Taking a Developmental Perspective***

At different ages, children rely more or less heavily on their I have, I am, and I can resources. As children grow, they increasingly shift their reliance from outside supports (I have) to their own skills (I can), while continually building and strengthening their personal attitudes and feelings (I am). Just as the resilience skills used by children vary at different ages, so must parents and other caregivers vary their resilience-promoting language and behavior to match the child's developmental stage.

Along with the child's family, Head Start staff can promote resilience in the first three years of life in many ways. They can:

- Provide unconditional love and express love both physically and verbally
- Acknowledge and label the child's feelings
- Balance the freedom to explore with safe supports
- Model behavior that communicates confidence and optimism
- Encourage the child to try things and do them on her own

The baby is lying in the crib, crying and kicking his feet. You do not know what is wrong. He just keeps crying and kicking.

You promote resilience if you pick him up and begin to soothe him while finding out if he is wet, too cold or too hot, needs patting on his back to remove air, or mainly needs comforting (I have). You help him calm down if he feels loved and cared for (I am) and if he can begin to calm himself down (I can).

The toddler is at the store with you. She sees some candy, grabs it, and starts to eat it. When you try to take it away, she shouts, "No! Mine, mine!"

You promote resilience if you remove her from the situation so you do not disturb others, explain calmly that she cannot take things without your permission, and give her

something else to hold onto (a shopping item). You help her understand limits of behavior (I have), help her feel responsible for her own behavior (I am), and communicate with her as she listens (I can).

For preschoolers, 3-5 years of age, Head Start staff, along with the child's family, can promote resilience in numerous ways. They can:

- Express love verbally
- Praise the child for accomplishments
- Encourage the child to take independent action
- Offer explanations along with rules
- Show empathy and caring

A mother had to go to another city to find a job and could not take her four-year-old daughter because there was no one to care for her and she could not afford child care there.

You promote resilience if you explain to your daughter that you are going to take a job so you can have money to rent a place for both of you. You tell her how much you love her and that she will stay with your sister and still continue to go to Head Start (I have). You let her protest and assure her you love her (I am) and will talk with her on the phone. You let her ask questions and express feelings (I can), but help her understand that this is a necessary move.

How parents and other caregivers respond to situations and assist a child to respond can either promote resilience or inhibit it. Adults who promote resilience encourage children to become increasingly autonomous, responsible, empathetic, and altruistic and to approach people and situations with hope, faith, and trust. They teach them how to communicate with others, solve problems by accessing family and institutional supports, and successfully handle negative thoughts, feelings, and behaviors. As children grow and develop these skills, they increasingly become more active in promoting their own resilience.

### ***What Can We Do?***

The International Resilience Project found that children learned resilience from their parents and other adults up to the age of 11; after that, they learned from their peers. Income level did not seem to matter; poor parents taught resilience as often as other parents.

One surprising finding emerged. Adult caregivers promote resilience only about one-third of the time. There are many lost opportunities at home and in school settings. Too many adults inhibit or thwart the development of resilience, leaving children feeling helpless, sad, and unloved. The message is loud and clear: We need to do better to help our children develop resilience.

This article was adapted from *A Guide to promoting resilience in children: Strengthening the human spirit* by Edith Grotberg. Published in The Hague by the Bernard van Leer Foundation in 1995.

# Post-Traumatic Stress Disorder in Children

by J. Oni Dakhari & Colleen Sherman

Post-traumatic Stress Disorder (PTSD) is a condition that may develop after experiencing or hearing about trauma. PTSD research, historically focused on adults, is now investigating infant, toddler, and preschool populations. Research suggests that children as young as 18 months are developmentally capable of PTSD (Pfefferbaum 1997).

Common symptoms displayed by young children include:

- sleep problems; irritability (e.g., tantrums)
- separation anxiety; aggression and new fears (e.g., hitting, kicking, fear of the dark)
- numbing or avoidance of trauma reminders; being always on the lookout for danger (e.g., exaggerated startle response)
- loss of or regression in developmental skills (e.g., speech, toileting, acting younger)
- re-experiencing (e.g., compulsive re-enactment of the trauma, recurrent statements or questions about the event, repeated nightmares linked to trauma)

Caregivers play a vital role in observing behavior, providing support, and recommending professional services. Caregivers suspecting PTSD symptoms are encouraged to listen and be available to children to talk about scary and confusing feelings and to respond to children's questions calmly. They need to use age-appropriate language and keep in mind the child's individual situation (e.g., sensitivity, social support, chronic life-adversity, family functioning, trauma history/subsequent trauma).

Caregivers also should remember that children at different developmental levels respond differently to trauma. Even so, children at similar developmental levels can react differently to the same event, and a child's response may change over time. As much as possible, caregivers should provide consistent and caring but firm discipline and try to keep normal routines.

While aspects of PTSD can be expected or even an adaptive response to trauma, children who are developing signs of PTSD should be referred early for mental health services to maximize adjustment.

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## Helping Preschoolers Develop Self-Concept and Self-Control

This article is adapted from *The Head Start Leaders Guide to Positive Child Outcomes* (Head Start Bureau 2003). The Guide includes descriptions of each of the 8 Domains of the Child Outcomes Framework and suggestions for effective teaching practices. The Outcomes Framework provides a comprehensive set of learning and developmental goals for 3- to 5-year-olds in Head Start. The Domain of Social and Emotional Development includes the Domain Elements of self-concept and self-control. As teaching teams help preschoolers develop an understanding of self, demonstrate independence, express confidence (self-concept), and learn how to express their feelings, how their actions affect others, and how to follow rules (self-control), they will be promoting the mental health and resilience of young children.

- Promoting young children’s social and emotional development is vital for three interrelated reasons:
- Positive social and emotional development provides a base for life-long learning.
- Social skills and emotional self-regulation are integrally related to later academic success in school.
- Prevention of future social and behavioral difficulties is more effective than later remediation.

A major developmental task of the first five years of life is the development of self-regulation in its broadest sense. In fact, “providing the experiences that allow children to take over and self-regulate in one aspect of their lives after another is a very general description of the job of the parents, teachers, and protectors of children that extends throughout early childhood and into the adolescent years” (Shonkoff & Phillips 2000, p. 94). This process begins in infancy as babies learn to regulate their crying, sleeping, and other behavior patterns. It extends during the preschool years to more complex self-regulation—the ability to control emotional states, to learn to delay gratification, to build relationships with other people, and to modulate other functions essential for healthy development (Shonkoff & Phillips 2000). These developmental tasks are best accomplished during the preschool years because building positive social skills and healthy emotional relationships in young children is much easier than later trying to correct behavior and adjustment problems.

In the school years too, social and emotional development is linked to academic success. A recent review of research on social and emotional risk and protective factors that predict early school problems or success found that “children who do not begin kindergarten socially and emotionally competent are often not successful in the early years of school—and can be plagued by behavioral, emotional, academic, and social development problems that follow them into adulthood” (The Child Mental Health Foundations and Agencies Network [FAN] 2000). The review describes a child who is socially and emotionally healthy and school-ready as someone who is confident and friendly, has good peer relationships, and is able to tackle and persevere at challenging tasks. The child also has effective communication skills and the ability to listen to instruction (FAN 2000).

Promoting young children’s social and emotional development is a major responsibility of any early childhood program. Because so many Head Start children experience emotional and social risk factors, the Head Start program has the added responsibility of taking steps to help children develop skills that contribute to resiliency. These steps include providing warm, positive relationships with teachers and other adults, helping children make friends with other children, and developing their interests and abilities.

### ***Domain Element: Self-Concept***

Self-concept—children’s stable perceptions about themselves despite variations in their behavior—is forming during the preschool years as children gain in reasoning and the ability to make comparisons between themselves and others. Their self-esteem, which comes in part from their perception of their own worth, is also in its formative stages during these years.

Children are often overconfident about their own abilities in these years because their skills are developing rapidly. They often misjudge their capabilities in relation to others. Every child in the preschool class may state confidently, “I am the smartest” or “I am the fastest runner.” At the same time, their blossoming egos are fragile. Young children quickly become discouraged if they experience too much frustration or failure. During the preschool years, children develop a positive self-concept not only by being told they are special, but by taking initiative and succeeding at challenging tasks and by receiving specific adult encouragement related to a task or accomplishment. Therefore, it is important for the teaching team to observe children and track their progress in order to provide learning experiences that are appropriately challenging and that instill genuine feelings of success.

Teaching strategies that promote self-control include:

- Making sure the learning environment is welcoming to every child and reflects his identity and culture.
- Organizing the environment so children can independently choose their own activities for part of each day.
- Acknowledging and encouraging children’s efforts and accomplishments using specific feedback. For example, say, “You wrote your M” or “Thank you for helping Keisha with her coat,” rather than offering nonspecific praise such as, “That’s really nice.”

### ***Domain Element: Self-Control***

The preschool years are the prime time for children to acquire self-control, the ability to recognize and regulate their own emotions and behaviors. By preschool, most children have acquired sufficient language to begin using speaking and listening skills to solve social problems.

Teachers of young children frequently report that their toughest problem is dealing with children exhibiting challenging behaviors—children who are hostile, are physically aggressive, and do not follow the classroom rules. When children exhibit these behaviors, it is very easy for teachers to automatically react. The teachers’ understandable impatience and frustration can undermine their ability to think strategically about how to

Teaching strategies that promote the development of self-concept include:

- Providing a sufficiently engaging curriculum and variety of learning experiences to ensure that children are not bored or aimlessly wandering. Often teachers think they cannot provide interesting learning experiences until the children are under control, when, in fact, the real problem is that the children are out-of-control because there is nothing interesting to do.
- Getting to know each child, establishing relationships with parents, and supporting their strengths as well as their needs.
- Giving time and attention to children when they are behaving appropriately. Be sure to “catch them doing something right” and those desirable behaviors will increase.

As Head Start children develop a positive self-concept and self-regulation skills, they are building a foundation for their mental health and for their success in school.

The Center on the Social and Emotional Foundations for Early Learning (CSEFEL) has numerous resources available to assist staff in exploring environment, schedule, learning experience, and their interactions with children. Visit CSEFEL’s Web site at <http://www.vanderbilt.edu/csefel> or call 866-433-1966.

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## **Social & Emotional Development: Head Start Child Outcomes Framework**

Released in 2000, the Head Start Child Outcomes Framework is intended to guide Head Start programs in their curriculum planning and ongoing assessment of the progress and accomplishments of preschool children. The Framework also is helpful to programs in their efforts to analyze and use data on child outcomes in program self-assessment and continuous improvement. The Framework is composed of 8 general Domains, 27 Domain Elements, and numerous examples of specific Indicators of children's skills, abilities, knowledge, and behaviors. The Domains include Language Development, Literacy, Mathematics, Science, Creative Arts, Social & Emotional Development, Approaches to Learning, and Physical Health & Development. The Domain of Social & Emotional Development is linked to a child's mental health.

### ***DOMAIN: Social & Emotional Development***

#### **Domain Effect: Self-Concept**

Indicators:

- Begins to develop and express awareness of self in terms of specific abilities, characteristics, and preferences.
- Develops growing capacity for independence in a range of activities, routines, and tasks.
- Demonstrates growing confidence in a range of abilities and expresses pride in accomplishments.

#### **Domain effect: Self-Control**

Indicators:

- Shows progress in expressing feelings, needs, and opinions in difficult situations and conflicts without harming themselves, others, or property.
- Develops growing understanding of how their actions affect others and begins to accept the consequences of their actions.
- Demonstrates increasing capacity to follow rules and routines and use materials purposefully, safely, and respectfully.

#### **Domain Effect: Cooperation**

Indicators:

- Increases abilities to sustain interactions with peers by helping, sharing, and discussion.
- Shows increasing abilities to use compromise and discussion in working, playing, and resolving conflicts with peers.

- Develops increasing abilities to give and take in interactions; to take turns in games or using materials; and to interact without being overly submissive or directive.

### **Domain Effect: Social Relationships**

Indicators:

- Demonstrated increasing comfort in talking with and accepting guidance and directions from a range of familiar adults.
- Shows progress in developing friendships with peers.
- Progresses in responding sympathetically to peers who are in need, upset, hurt, or angry; and in expressing empathy or caring for others.

### **Domain Effect: Knowledge of Families & Communities**

Indicators:

- Develops ability to identify personal characteristics, including gender and family composition.
- Progresses in understanding similarities and respecting differences among people, such as genders, race, special needs, culture, language, and family structures.
- Develops growing awareness of jobs and what is required to perform them.
- Begins to express and understand concepts and language of geography in the contexts of the classroom, home, and community.

# **National Mentoring Children of Prisoners Program**

by Ricco Hall

As many as 2 million children and youth in this country have at least one parent in a correctional facility. These youngsters are at risk—economically, socially, academically, and emotionally.

Research has found that the long-term physical absence of a parent has profound effects on a child's development. For instance, children of incarcerated parents are significantly more likely to become involved in the juvenile and adult criminal justice systems.

Witnessing and living with the arrest and incarceration of a parent are devastating events for children and families. The living conditions, family configurations, and problems faced by the parents make it likely that significant numbers of children of prisoners will suffer emotional and behavioral difficulties. Family relationships are often strained, and any existing stability may be compromised. As a result, the majority of the children of prisoners experience multiple changes of caregivers and/or living arrangements.

It has been demonstrated that mentoring is a potent force for improving youth outcomes. Mentoring increases the likelihood of regular school attendance and academic achievement. It also decreases the chances of engaging in self-destructive or violent behavior. A trusting relationship with a caring adult will provide stability and often have a profound, life-changing effect on the child.

The Mentoring Children of Prisoners (MCP) program was introduced by former President George W. Bush in his 2003 State of the Union Address. The program is administered by the Family and Youth Services Bureau, Administration for Children and Families in the U.S. Department of Health and Human Services (HHS). In Fiscal Year 2007, the MCP program was funded at \$50 million; the three-year grants support approximately 238 grantees across the country. By the end of FY08, the MCP program served 100,000 children ages 4-18. As former HHS Secretary Michael Leavitt said, "With these grants, we are helping train mentors and match them with children in need, because every child needs an enduring relationship with a caring adult."

## ***What Are MCP Programs?***

Local MCP mentoring programs recruit, screen, train, and oversee volunteers who want to serve as positive role models. MCP mentors provide one-on-one time and are trained to encourage older children and youth to fully participate in school and become involved in civic and other community activities. Mentors provide safe and trusting relationships.

MCP programs require that mentors commit to spending at least one hour per week with their assigned child for a period of at least one year. MCP programs are required to provide ongoing support and oversight of the mentoring relationship to ensure that young people are receiving appropriate support and are benefiting from the mentor match.

Further, programs are required to monitor key outcomes on children and youth served by the initiative—including school performance and avoidance of risky behavior.

With the reauthorization of the MCP in September 2006, a voucher demonstration was added to the program. More children will be able to be served throughout the country and

## ***Success Stories***

Several MCP programs report having worked with Head Start families. In one case, a 5-year-old Head Start child was matched with a mentor. The child's father was in prison, and the boy was exhibiting challenging behavior in the classroom. Head Start staff were concerned about his social, emotional, and cognitive development. Working closely with the child's mother, Head Start staff helped arrange mentoring through the local MCP program.

Each Sunday afternoon, the mentor picked the child up from his home. Sometimes they went for ice cream and to the park; sometimes they went to the library or went fishing. Head Start staff and the child's mother spoke regularly about his progress. After six months of a steady routine with the mentor, the child's teacher reported that his classroom behavior had improved dramatically. He had become much more respectful and helpful to other children and to the teacher during activities. The mother and teacher were very impressed by the turnaround and credited the MCP with providing support to the child.

Another Head Start program contacted the local MCP to work with an older brother of a Head Start child. The father was incarcerated, the mother had left the area, and the children were living with their grandmother. The older boy was defiant and uncommunicative. He fought with classmates and was told by friends and neighbors, "You're gonna be just like your daddy." His grandmother told the MCP staff that he needed a male mentor who could "teach him how to be a man and not be violent."

The mentor engaged the boy in playing basketball and watching local baseball games. After several months, they began focusing on the boy's homework and even visiting local museums. His school performance improved. His grandmother reported that he had begun to talk with her and his mentor about his feelings of anger or sadness. In addition, the home atmosphere became calmer and more positive which benefited everyone, including the younger Head Start child.

## ***What Can Head Start Programs Do?***

Mentoring services can be offered to preschoolers in Head Start or to their older siblings. Family Service Workers or other Head Start staff can explore the availability of this program in their own community by contacting the National Clearinghouse on Families and Youth at (301) 608-8098 or email: [info@ncfy.com](mailto:info@ncfy.com). For general information regarding the MCP program, visit the Family and Youth Services Bureau Web site at: <http://www.acf.hhs.gov/programs/fysb/content/youthdivision/programs/mcpfactsheet.htm> For additional information on how Head Start programs can work with children and families with an incarcerated father, see the article "Fathers for Life: Strengthening Families and Fatherhood" in this Bulletin about an Innovation and Improvement Project in Missouri dedicated to helping incarcerated fathers and their children.

After this article was accepted for publication, the following information was made available: There are several Head Start—MCP grantees, including the Sunbelt Human

Advancement Resources (SHARE) located in South Carolina. The program received high level praise when former President George W. Bush and former ACYF Commissioner Joan E. Ohl visited MCP grantees across the country. Additional collaborative efforts to further enhance the MCP missions and goals have been underway since funding began. ACYF hopes to have a FY09 Program Announcement/Competitive Process Selection to award a new group of FY09-12 MCP grantees.

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# **Should I Be Worried? Supporting Language Acquisition**

by Sylvia Y. Sánchez and Eva K. Thorp

It's story time in Ms. Carol's Head Start class. Most of the preschoolers come eagerly to the library corner and find a cozy spot on the rug. But Elena, who has been playing alone with dolls, appears to be roaming aimlessly. Eventually, she sits down at the back of the group, at least four feet from the others. Ms. Carol invites her, "C'mon Elena, we'd love to have you join the group for our story." But Elena shakes her head "no" and stays where she is without any expression or apparent interest in the story. Ms. Carol reads the story and engages in animated conversation about it with the children. Elena doesn't participate. Her teacher is worried and wonders if something is wrong with Elena. She doesn't seem to have any friends and most of the time seems disinterested in the activities.

Ms. Carol is right to be concerned about behaviors that seem so different from what she is used to in the 4-year-olds she teaches. Yet, it is important to know that Elena has only been in this class for a short time. It is the first time that she has been exposed to a structured classroom environment in which only English is spoken and where no one speaks her home language. In fact, the program does not have any staff who speaks Elena's home language.

However, this does not mean that it is OK for Elena to be uninvolved. The teaching staff needs to find ways to include Elena and to support her healthy social and emotional development during this transition. What does Ms. Carol need to know to better understand Elena's behavior and to support her learning and development?

## ***What Is It Like for Elena Right Now?***

First, it helps if Ms. Carol, like any caring adult who comes into contact with Elena, can "put herself in Elena's place." If the teaching staff can understand the challenges that Elena faces when she comes to Head Start, then they are better able to find solutions. Elena has a mix of feelings and thoughts about being away from her family and adjusting to the classroom.

- Elena is transitioning from the familiar environment of home and the comforting sounds of her home language. She misses her family when she is in Head Start, but she tries not to cry or worry when she is apart from them.
- She is in an environment with new people, new expectations, and a new language. The words, the teachers' cues, the daily schedule, the materials, all seem familiar to the other children, further compounding her sense of insecurity.
- It is very hard work for Elena—or any child—to make sense of her new surroundings and grasp concepts in an unfamiliar language. She exerts a lot of mental energy while she is in Head Start; understandably, she gets frustrated and tired from her efforts.
- The relationships that would typically help Elena transition are not available. Her parents are unfamiliar with the expectations of a preschool classroom. As helpful as the teachers and other children want to be, they do not speak her language. At home, she is very social and talkative; in the classroom, she is lonely and quiet.

## ***What Does Ms. Carol Need to Know About Second Language Learners?***

Like many Head Start teachers, Ms. Carol knows a lot about first language learning. She has found effective ways to promote the children's language and literacy development in Head Start. But she is not so sure about how children learn a second language and what strategies would help Elena learn English. Ms. Carol needs to know what research says.

- Learning a second language takes time and there are wide individual differences in the rate of learning a second language (Genesee 2007).
- For most children, learning a second language is not a serious cognitive challenge; the human brain is able to learn two languages as easily as one (Genesee 2007).
- Young children learn a second language by being exposed to meaningful, sustained, rich, and varied language. They do not need specific "lessons," nor do they need drill-and-recital (Stechuk & Burns 2005).
- The demands of being in a new language environment can result in behaviors that may look suggestive of a mental health problem. For example, most children learning a second language go through a silent or observational period (Tabors 1997) when they are gathering information about the new language. Like Elena, they communicate nonverbally.
- The process of acquiring two languages from a very early age has cognitive as well as social benefits (Bialystok 2001). Being bilingual is an asset starting at an early age.
- Children do not confuse their first and second languages, even though they may interchange vocabulary. Referred to as code-switching, this is typical behavior and not a cause for concern (Stechuk & Burns 2005).
- The home language should be maintained while children are learning another language (as required in the Head Start Program Performance Standards (45 CFR 1304.21(a)(3)(i)(E)). Second language learning is an additive process and should never take away from the home language.

## ***What Can Ms. Carol Do to Support Elena?***

Ms. Carol and all the Head Start staff are eager to help Elena have a positive experience. They know how the program can benefit children and families. Ideally, Ms. Carol would be working with another teacher in her class who could actively support Elena's first language. But, this is not the case. Yet, there are many strategies the teaching team can use to support Elena's transition and promote her development.

- Get to know Elena and her family. If possible, use an interpreter to talk with her family about her likes and dislikes, her play at home, her favorite foods, and so on. Observing Elena during a home visit, as well as in the classroom, will provide clues.
- Take into account what Elena already knows—"her background knowledge"—to plan curriculum experiences to help her learn new information (Stechuk & Burns 2005). Incorporate already familiar objects and concepts into Elena's learning experiences, so she will be able to learn the new vocabulary.
- Use simple phrases in her home language, such as friendly greetings in the morning, to ease her separation from her family and prepare her transition into the classroom.

- Bring the home language and culture into the classroom. Record familiar songs or stories. Display photos of Elena’s family and include cooking utensils, musical instruments, and other cultural objects in the room.
- Provide many meaningful opportunities for interaction and active involvement. A nonverbal period does not mean the child should be left alone. Bring Elena into activities that are pleasurable for all children.
- Convey messages of acceptance and validate her feelings. Read Elena’s nonverbal cues for expressions of joy, interest, and curiosity and label them.
- Give Elena some simple, telegraphic phrases that will help her communicate and give her a sense of competence in the classroom. For example, “Where is ...?” “My turn...” “I want...”
- Physical closeness is essential to relationship building. It is easier to communicate if Ms. Carol and Elena are near each other. Stories can be read from the location where Elena is sitting.

### ***How Can Ms. Carol Know When Behavior Indicates More Than a Language Issue?***

Researchers have pointed out that some common behaviors associated with language acquisition may be misinterpreted as challenging behaviors (Tabors 1997). So a first step is for Ms. Carol and other Head Start staff to be knowledgeable about the process of second language learning. Recognizing the child as an individual is important too—Elena is developing at her own rate with her own areas of strength.

Clues that might indicate that Elena is struggling with more than second language acquisition include:

- A prolonged silent or observational period, beyond the typical 3-6 months (Roseberry-McKibbin 1995) and little evidence of progression into the next stage where she begins to use some English.
- A noticeable increase in Elena’s withdrawn behavior in the classroom or displays of aggression or other challenging behaviors.
- A marked difficulty in saying goodbye to her family when she comes to Head Start.
- A report from the parents that Elena’s behavior at home is changing or that development in her first language is not progressing as expected.

It would be important for the teaching team to work with the family, the Head Start mental health coordinator, the disabilities manager, and other specialists to assess the situation. In order to support Elena and to provide intervention, if necessary, the staff should be well-informed about the process of first and second language acquisition, as well as the impact of language differences on child behavior.

Editor’s Note: The Improving Head Start for School Readiness Act of 2007 designates funds to support staff training and child counseling and other services to meet the needs of special populations, including dual language learners. It also emphasizes improving outreach and increasing enrollment and quality of services to these children and their

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# Using Storytelling to Support Mental Health

by Dee Wetzel, Angela Branch, and Nina Salomon

“Storytelling is a social experience that allows a connection to develop between the teller and the listener” (Smyth 2005).

Storytelling is a powerful approach to sharing information that Head Start families can use to describe their experiences. What are the benefits?

- For programs, it is a way to learn meaningful information about families, while allowing families to view their stories from a positive, strengths-based perspective.
- For parents and the Head Start program, it creates meaningful relationships.
- For staff, it allows them to identify true family needs and interests, leading to more significant partnerships with parents.

Everyone benefits from storytelling when it is part of a program’s proactive approach to mental health. Building significant relationships with parents and helping them to see their strengths and needs in new ways, which happens with storytelling, promotes parental well-being and in turn, their children’s mental health. In Migrant and Seasonal Head Start (MSHS) programs, the storytelling approach has proved profoundly meaningful for staff and parents in developing Family Partnership Agreements. This approach can easily be used in all Head Start and Early Head Start programs.

There are features of storytelling that contribute to its success. The storytelling approach is based on unconditional positive regard and uses open-ended questions, active listening, empathy, reframing, and looking for strengths to elicit family stories.

## ***Unconditional Positive Regard***

Unconditional positive regard is an attitude of acceptance and valuing of families. Parents are automatically valued for who they are and what they bring to the program and to the education of their children. Families are considered experts about themselves and their children, and the Head Start staff are their guides.

One employee from Agri-Business Child Development MSHS commented on the storytelling process:

The important thing you have to recognize is that it’s not your story. It’s not going to be told the way you want but the way the family wants to tell it to you (AED DVD 2003).

## ***Open-Ended Questions***

In developing meaningful relationships with families, it is important to engage in a dialogue with them rather than asking for a set of information that can result in short answers with little back-and-forth conversation. Open-ended questions elicit stories and conversation and create an atmosphere demonstrating that staff is interested in learning about the parent and family. For example, you can elicit more information and begin to cultivate a more meaningful relationship by saying: Every family has a story that is unique to them. Can you tell me about the most important people in your life?

## ***Active Listening***

Active listening means being fully present and engaged with the family or the individual with whom one is talking. The lives of staff and parents are extremely busy and fast-paced. Sometimes while talking with families, the mind can be somewhere else thinking of other things. Active listening means clearing the mind of all the other distractions and truly sitting and listening to what the speaker is saying. When staff take the time to focus their attention and energy solely on what parents have to say, active listening sends a very positive message to families that they are extremely valuable and important.

## ***Empathy***

Empathy refers to being able to communicate to the family that their feelings are being understood. When taking an empathic stance, staff shows families that their feelings are understood in a way that helps them advance through the emotion. The key to empathy is that the listener reflects back the emotion that is hidden beneath the words. Empathy is expressed in this example:

Parent/family: I went to the doctor with my daughter; she's only 6 months old, and she's very sick.

Listener: It sounds like you were very frightened and concerned when the doctor told you about the baby's illness.

## ***Reframing***

Often families get caught in the day-to-day struggle and do not realize they are doing amazing things every day. Reframing is a process whereby the listener is able to help families see the positive by reflecting back what they have said using different words. This allows them to hear their story in a new way and is extremely powerful in helping families to see their strengths despite adversity. Reframing provides families with "Ah ha!" moments whereby they recognize that there is something positive and amazing about their lives no matter what their circumstances. This helps families to focus on their strengths and enables them to feel powerful and capable of influencing their current and future life situations. An example of reframing might be:

Parent/family: It made me sorry for having been drinking (in the past), because if I hadn't been drinking, I'd have all that money to go see my mother (when she was sick).

Listener: But you know that the fact you went to see her there (in Mexico) and that your mother could see you healthy, sober, that also must have given your mother satisfaction (AED DVD 2003).

## ***Looking for Strengths***

In working with families, it is important to ask what has helped them get through difficult times. Many Head Start families have endured overwhelming hardships, demonstrating great strength and resilience. When parents are asked what has helped them get through challenging times, they provide many answers, including friends, faith, togetherness, and love of family. It is important to honor, respect, and learn about the unique strengths of each family. This, in turn, promotes the creation of meaningful partnerships with parents

I see parents blossom when they discover the skills to tap into their strengths and when they recognize their resiliency within that keeps them growing (AED 2003).

### **Summary**

The techniques shared here for supporting mental health through the use of storytelling—unconditional positive regard, open-ended questions, empathy, active listening, reframing, and looking for strengths—are universal techniques that can be applied in any situation. All human beings have stories to tell, and embedded within those stories are rich lessons and strengths that can be used to help parents view themselves and their families in a new, more powerful way. This process helps to promote parental mental health and self-esteem and, in turn, supports the development of positive self-esteem in their children.

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# Maternal Depression in EHS and Head Start

by Rachel Chazan-Cohen and Maria Woolverton

As a comprehensive child development program, Head Start has long been concerned with supporting the social and emotional well-being of children and families and with providing and/or accessing services for those families with mental health needs. In fact, the Head Start Program Performance Standards requires each program to obtain a mental health consultant (1304.52), as well as timely and responsive services (1304.24), and family-centered mental health services and education (1304.40).

This article presents research-based information on maternal depression in Early Head Start (EHS) and Head Start families and on the programs' role in helping families struggling with maternal depression.

This information comes from three sources: 1) the Early Head Start Research and Evaluation Project (EHSREP), a random assignment evaluation of EHS; 2) the Head Start Family and Children Experiences Survey (FACES), a descriptive study of children and families in Head Start; and 3) the Survey of Early Head Start Programs (SEHSP), a survey about programs' management systems and services.

Why focus on maternal depression? The answers are that depression is among the most prevalent mental health concerns, especially for low-income families served by Head Start programs, and there is broad literature on the detrimental effects of maternal depression for children and families.

## ***Findings***

Prevalence of maternal depression is high in Head Start programs. Rates are highest when children are younger. A short form of the CES-D was used in EHSREP and FACES. (For more information about the instrument, refer to the end of this article.)

- The EHSREP found that at entry into EHS, over half (57%) of mothers reported elevated symptoms. The rate falls to 38% when children are 1 year old and about one-third at age 3 (32%) and at age 5 (31%).
- FACES data show that when children begin preschool Head Start, just over a quarter (26.5%) of mothers reported elevated symptoms. There were no significant differences in rates of depression based on race or ethnicity in the FACES study.

## ***Outcomes***

Depression is associated with family risk factors, as well as with parenting, child outcomes, and family participation in Head Start services.

However, the EHSREP and FACES support the common wisdom that families struggling with maternal depression can be challenging for program staff to engage and that depression can be harmful for parenting and for child functioning.

- Families struggling with maternal depression also report lower household incomes and are more likely to be headed by a single woman. They also report higher rates of family violence and are more likely to report that a household or family member is involved in criminal activities.

- Depressed mothers are observed to be more negative in play with their children than non-depressed mothers. They report engaging in fewer activities with their children and having more stress associated with parenting. They also report more authoritarian parenting styles and are more likely to report spanking as a discipline technique.
- Families struggling with maternal depression have less involvement with Head Start and were found to participate at lower levels in EHS.
- Children of depressed mothers were reported (by mothers and teachers) to have higher rates of problem behaviors, as well as lower rates of positive social behavior and creativity.
- Children of depressed mothers also fared worse in direct child cognitive assessments; this was true for toddlers and for preschoolers. For preschoolers, depression was associated with less optimal emergent literacy as well as math skills.

### ***Access to Services***

Head Start programs are required to have mental health consultation.

- In fact, the SEHSP found that nearly all programs (96%) have their own mental health specialists, on staff or as consultants, and many (80%) programs also have partnership agreements with community mental health providers. Most (92%) programs report screening families for mental health concerns and report referring families for mental health services (98%).
- However, the EHSREP found no impact on families receiving mental health services while they were in the program. By the time of exit from the program, just under a quarter (23%) of families in EHS reported that someone in the family had received treatment, a rate similar to the control group.
- Use of mental health services was slightly higher for families where mothers were depressed when they enrolled in EHS. Roughly one-third (32%) of mothers who were depressed at enrollment reported that at least one family member had received mental health services.

### ***Addressing Maternal Depression***

- Overall, the EHSREP found that EHS did not reduce symptoms of depression. However, for women who were depressed at the time of enrollment into EHS, the program did reduce depressive symptoms and improve parenting and the parent-child relationship. The program may protect children from some of the negative effects of maternal depression.
- A follow-up of the EHSREP sample in the spring prior to the children entering kindergarten found an overall reduction in depressive symptoms for mothers who had previously participated in EHS. Additional analyses revealed that impacts of the program for parents and children, ages 2 and 3 years, led to this later emergence of an impact on maternal depression (Chazen-Cohen et al. 2007). For children, the earlier impacts of the program on reducing parent report of aggressive behavior, as well as direct assessment of cognitive functioning, were most important. For parents, it was program impacts on reducing parenting distress and spanking that were most important.

- FACES findings also indicate that Head Start may protect children from the negative outcomes, both cognitive and behavioral, associated with parental depression. Having a parent who reported positive experiences with Head Start, who had higher satisfaction with Head Start, or who was more involved with Head Start, lessened the associations between family risk factors (including depression, violence, and domestic violence) and child outcomes.

## **Conclusion**

The research has shown that maternal depression is common in the EHS and Head Start population where families are more likely to face challenges and adversities than the general population. By studying and understanding the rates of depression among mothers of infants, toddlers, and preschoolers, Head Start will be better able to develop approaches to address maternal depression and develop interventions to promote the well-being of children and families.

For more information on these studies, visit their Web sites.

For EHSREP: The Early Head Start Research and Evaluation Project, see [http://www.acf.hhs.gov/programs/opre/ehs/ehs\\_resrch/index.html](http://www.acf.hhs.gov/programs/opre/ehs/ehs_resrch/index.html)

For FACES: The Head Start Family and Child Experiences Survey, see <http://www.acf.hhs.gov/programs/opre/hs/faces/index.html>

For SEHSP: The Survey of Early Head Start Programs, see [http://www.acf.hhs.gov/programs/opre/ehs/survey\\_ehs/index.html](http://www.acf.hhs.gov/programs/opre/ehs/survey_ehs/index.html)

For information on depression among Latina mothers, see the article entitled, “Depressive Symptoms in Latina Mothers,” in this Bulletin.

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## **The Measure of Depressive Symptoms Used in FACES and EHSREP; A Short Form of The Center for Epidemiologic Studies-Depression (CES-D-SF)**

The CES-D-SF measures symptoms of depression. While it does not indicate a diagnosis of clinical depression, it does discriminate between depressed patients and others. The 12 items on the short form are taken from the full 20-item CESD scale (Radloff 1977; Ross et al. 1983). Items are coded by the number of days in the past week the person had a particular symptom: rarely or never (less than one day) =0; some or a little (1-2 days)=1; occasionally or moderate (3-4 days)=2; and most or all days (5-7 days)=3. Scores range from 0 to 36 and scores of greater than or equal to 10 indicate the cutoff for possible depression.

1. Bothered by things that usually don't bother you
2. You did not feel like eating; your appetite was poor
3. That you could not shake off the blues, even with help from family or friends
4. You had trouble keeping your mind on what you were doing
5. Depressed
6. That everything you did was an effort
7. Fearful
8. Your sleep was restless
9. You talked less than usual
10. You felt lonely
11. You felt sad
12. You could not "get going"

## **Profile of Parental and Caregiver Mental Health**

The connection between the mental health of young children and that of their parents or other caregivers has been well established. When they feel supported, satisfied, and fulfilled in their relationships and work, they are better able to provide sensitive, responsive, individualized care for children. Head Start plays a vital role in supporting and promoting the mental health of parents and other caregivers.

The statistics below describe the prevalence and interconnectedness of mental health-related problems (including depression, substance abuse, and trauma) among certain populations, including mothers and fathers.

### ***Mental health disorders are common***

- One in four adults in our nation suffer from a diagnosable mental health disorder. (Source: Out of the shadows: Exploring the barriers to mental health, prevention, and treatment, American Public Health Association, 9/28/2006, National Press Club, Washington, DC (David Satcher, former Surgeon General speech) )
- Mental health disorders are the leading cause of disability for people ages 15-44. (Source: IBID)

### ***Depression is the most prevalent mental health disorder, and women are disproportionately affected.***

- Depression is most prevalent among women in child-bearing years (i.e. ages 16 – 43).
- Poverty significantly impacts rates of depression. Women from low-income groups are roughly twice as likely to suffer from depression. (Source: Miranda, J. & B.L. Green. 1999. The need for mental health services research focusing on poor young women. The Journal of Mental Health Policy and Economics. 2: 73-80.)
- 48% of mothers in Early Head Start meet the criteria for depression. (Source: U.S. Department of Health and Human Services. Administration for Children and Families, Head Start Bureau. 2003. Research to practice: Depression in the lives of Early Head Start families. Early Head Start research and evaluation project. Washington, D.C.: Author.)
- Depression in fathers increases if a mother is depressed (24% – 50% of men experienced depression when their partners were experiencing postpartum depression). (Source: Goodman, J. 2004. Paternal postpartum depression, its relationship to maternal depression and its implications for family health. Journal of Advanced Nursing. 45 (1): 26-35)
- Depression is one of the most treatable disorders; treatment is successful 80% – 90% of the time.

### ***Substance abuse is common and is often ignored.***

Results from the 2005 National Survey on Drug Use and Health,(Source: Substance Abuse and Mental Health Services Administration. 2006. Results from the 2005 National

Survey on Drug Use and Health: National findings (Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD. Available at <http://www.oas.samhsa.gov/NSDUH/2k5NSDUH/2k5results.htm#Ch3>) sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), indicated that:

- 9.1% of the U.S. population aged 12 or older experienced substance dependence or abuse.
- Rates of substance dependence or abuse are higher among specific populations, including: young adults (21.8%); American Indian or Alaska Native adults (21%); adults who did not finish high school and/or had little college (10.2% – 10.3% respectively); persons who were unemployed (17.6%); and adults who were on probation or supervised leave (33.7%) or parole (37%) from jail.

Only 1.6% of the population received some kind of treatment for substance abuse.

***A strong association exists between depression, substance abuse, and trauma; yet trauma is often untreated in parents.***

- Although there are no national prevalence rates on parents' traumatic experiences, it is believed that parents' current or childhood traumas, along with maternal depression, parental substance abuse, and domestic violence, can put young children at risk for poor developmental and emotional outcomes. (Source: Knitzer, J. & J. Lefkowitz. 2006. Helping the most vulnerable infants, toddlers, and their families. Pathways to early school success. Issue Brief No. 1. New York: Columbia University School of Public Health. National Center for Children in Poverty.)
- Trauma earlier in life is likely to impact adult functioning, especially parenting, yet mental health professionals do not always assess trauma histories sufficiently to consider the impact of trauma on parenting. (Source: Nicholson, J., K. Biebel, B. Hinden, A. Henry, & L. Stier. 2001. Critical issues for parents with mental illness and their families. Rockville, MD: U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Mental Health Services.)
- In a sample of 220 homeless mothers with young children, more than 33% of mothers experienced Post-Traumatic Stress Disorder (PTSD). (Source: Bassuk, E.L., J.C. Buckner, J.N. Perloff, & S.S. Bassuk. 1998. Prevalence of mental health and substance use disorders among homeless and low-income housed mothers. American Journal of Psychiatry. 155(11): 1561-1564.)
- In a study of children in EHS, 71% had experienced or witnessed at least one trauma: a serious injury or illness, prolonged separation from their primary caregiver, homelessness, death of a close relative, or a serious accident. (See the article, "Trauma in the Lives of EHS Children" in this Bulletin.)

## **Family Connections: Intervention For Parental Depression**

by Catherine Ayoub, William Beardslee, Mary Watson Avery, and Caroline Watts

It is mid-morning in a Boston Head Start classroom and a group of children is having circle time. The teacher begins a song that asks each child, “How do you feel today?” A few respond by smiling and saying, “OK.” But then a child, who appears tired and a little sullen, answers, “Sad.” The teacher asks him, “Why are you sad?” He replies, “Because my mommy cries too much.”

Given their holistic two-generational approach, EHS and Head Start are ideal vehicles to address mental health concerns in the context of enhancing parenting and parent-child relationships.

The Family Connections project is an effort to develop a model to help Head Start and EHS families deal with depression and related adversity. Its goal is to build the strengths and long-term resilience of children and parents through enhancing programs’ capacity to engage all families, but especially where parents are struggling with depression.

Why depression? The prevalence is higher in low-income families. In EHS research, 48% of mothers at enrollment reported enough symptoms to be considered depressed; one-third of mothers of 1-year-olds and one-third of mothers of 3-year-olds were depressed as well (U.S. Department of Health and Human Services 2003). Numerous studies have reported significant negative impacts of parental depression on children. Children of depressed parents have higher rates of psychiatric disorders and are at increased risk for language and cognitive problems, insecure attachments, difficulties with managing emotions, social competence, and behavioral problems (Beardslee 2006, 2002). Yet, mental health professionals rarely see these young children, even if they are enrolled in early childhood programs and receive regular medical check-ups.

The Family Connections project works with Head Start staff to identify parents who might need extra support. The project also works with children in classrooms to improve their ability to cope with adversity and works with the community to develop resources and make use of referral systems. The program is based on three key assumptions:

- EHS/Head Start families and staff are often in difficult situations—including poverty, exposure to violence, and social isolation.
- Depression is a common response to such difficulties.
- These difficulties affect the ability of parents to effectively relate with other adults, their children or the children in their care, and with the EHS/Head Start community.

### ***The Family Connections Prevention Approach***

The Family Connections project is a joint effort of Children’s Hospital Boston, Action for Boston Community Development (ABCD), Dimock Community Health Center, Associated Early Care and Education, and Harvard Graduate School of Education. Family Connections was launched as a pilot site in summer 2002 at the Boston ABCD Jamaica Plain Head Start. In 2005, Family Connections received an Innovation and Improvement Project (IIP) grant from the Head Start Bureau (now OHS) to expand to

eight centers and provide two city-wide training conferences. Family Connections has identified several key strategies for addressing depression in Head Start families:

- Every interaction between staff and families is an opportunity to build trust and capacity.
- A focus on engagement with staff provides meaningful training and an emphasis on the importance of reflection and attention to one's own mental health.
- The promotion of stronger relationships and communication among parents, children, and staff at all levels is central to all training and consultation.
- Providing information about depression and related adversity to staff, parents, and children is an ongoing process that includes gaining knowledge, understanding the meaning for each person, and translating this learning into using better skills.

The Family Connections model utilizes preventive intervention strategies to provide services for children, parents, and EHS/Head Start staff along a continuum of need from prevention to intensive intervention. A pyramid (Figure 1) depicts how Family Connections uses the four EHS cornerstones—child development, family development, community building, and staff development—with each level building upon the others to provide a comprehensive approach for individual, group, and systems-level support. At the base of the pyramid is an all-encompassing approach for prevention aimed at staff. At the apex of the pyramid is intensive intervention targeting parents in need.

#### FIGURE 1: THE FAMILY CONNECTION PYRAMID

There are four tiers.

##### Tier 1: Clinical Intervention

Identification and referral for depression and parenting difficulties/ disconnections; extended outreach and crisis services

##### Tier 2: Targeted Prevention (At Risk Adults/Children)

Enriched prevention programming, mental

health outreach, promotion of school readiness and social skills, referral to specialized services in mental health

##### Tier 3: Universal Prevention (All Children and Families)

Education on depression; parenting education focused upon communication and relationship-building in families; classroom-based enrichment activities to support social and academic readiness; community networks to connect families to supportive prevention services

##### Tier 4: Community and Systems Development (All Head Start Staff)

Education on depression, mental health, and building resilience; professional skill development, including reflective practice and parenting skill support; classroom consultation; community connections to enrichment and family nurturing programs

END OF FIGURE 1

The preventative approach has two components. First, center-based strategies that include training and consultation for staff help build skills in dealing with children and their parents who struggle with depression. Second, home-based strategies are designed to increase parent engagement and include home visitation, outreach to hard-to-reach parents, and community resource networking and referral services.

Intervention is implemented by a team of two consultants, one with a strong mental health background and one with a strong early childhood background. Twice a week at each center, the consultants work with:

- Program managers and staff to share new skills, understanding, and meaning around dealing with difficult emotional issues, adversity, and depression
- Children to build positive interactions through on-site activities such as social skill building and play interventions that help children build friendships
- Parents in group and individual consultation on issues around parenting and dealing with adversity
- Organizations and institutions to improve access to quality mental health services within the community

### ***Lessons Learned***

After five years of fostering positive interactions for families facing adversity, we offer critical lessons learned through our work on the project.

- The importance of parent engagement cannot be underestimated. Leading with this message helps staff grasp that it is the key to much successful intervention.
- Readiness for each center should be defined clearly. Centers in transition or with leadership vacancies are often unable to devote the time and energy to the kind of staff change necessary for this ongoing preventive mental health work. Timing is everything in implementation; a variety of interventions and the speed of the process can be adapted to each center to get the best positive outcomes for staff and families.
- Consultants must carefully understand the uniqueness of each EHS/Head Start program.
- A critical skill for engagement is learning to use crisis as opportunity.
- Each child care professional develops competence in the mental health equivalent of medical first aid, through training in what we call “Mental Health First Aid.” They are then able to feel confident and informed about understanding, decision-making, consultation, and referral related to mental health issues.
- It is critical to engage the entire staff in the ongoing training process.
- Providing training around depression and mental health issues is not enough. Increased knowledge must be followed by consultation that supports on-site modeling and ways of developing and practicing new skills for staff.
- An important outcome of system-wide intervention that focuses first on staff learning and change is increased staff satisfaction.
- System-wide change is feasible and has the potential to effect the largest sustainable improvement in mental health practice within Head Start programs.

Back in the Boston Head Start classroom, the teacher asks calmly, “Why do you think your mother is crying?” He answers, “Because her brother died.” The teacher nods as she listens and then tells the children, “When someone dies, it can make us feel like crying.” She then turns her attention back to the boy. “It can also make you feel sad to see your mom cry.” As he nods emphatically, the teacher leans forward, touches his hand and says, “We’re going to give your mom a call to make sure she’s OK.” And with this, the boy turns to his right, ready to hear how the next child will answer how she feels that day.

## **Conclusion**

Building the capacity of EHS/Head Start staff and programs to better understand and respond to the needs of depressed parents and their children through a preventive intervention model, such as Family Connections, strengthens staff’s ability to engage depressed parents in services. In turn, this increases their parental functioning and improves their relationships with their children. As a result, the damaging impact of depression on children and families is reduced.

Materials developed from this project are expected to be made available on the Early Childhood Learning and Knowledge Center (ECLKC) Web site in 2009.

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## Will They Think I'm Crazy?

by My Linh Nguyen

A Head Start teacher struggles to deal with life's problems, but is afraid to talk about them because she does not want to be labeled "crazy."

A father of two children in Head Start struggles with depression, but fears that if he seeks help, his employer may find out, and he may lose his job.

Parents of a 3-year-old in Head Start struggle with their child's challenging behavior at home, but worry that if they discuss it with Head Start staff, they will be "blamed" for their child's behavior.

Immigrant parents struggle with adapting to their new life, but fear that seeking help during this transition would be viewed as a sign of "weakness" by their friends and family.

These are just a few examples of how the stigma and shame associated with mental health needs can keep people from accessing much-needed care and support. Whether young or old, male or female, rich or poor, many people worry that seeking help is a sign of weakness, failure, or severe illness. Not surprisingly, a government report states that stigma is "the most formidable obstacle to future progress in the arena of mental illness and health" (U.S. Dept. of Health & Human Services 2001).

Education about preventative mental health interventions as well as about direct services is key to reducing stigma. In fact, the Head Start Program Performance Standards states that programs must "promote children's mental wellness by providing group and individual staff and parent education on mental health issues" [45 C.F.R. 1304.24(a)(3)(ii)]. When people learn that mental health and mental illness are points along a continuum and that mental health issues often are brought on by difficult circumstances, such as the death of a loved one, then they are more likely to value and use resources. And when people learn that most mental health issues are treatable, they are more receptive to getting help.

Just as individuals have different views of mental health and effective treatments, cultural groups do too. Some populations believe that "problems" should be resolved within the family or that spiritual healing is the answer (U.S. Dept. of Health & Human Services, Office of Refugee Resettlement 2001). Mental health concepts may conflict with their own beliefs and values, and they may not be willing to accept mental health services. The stigma attached to seeking help for mental health issues looms large among some groups and may affect the individual's or the family's standing in their community (U.S. Dept. of Health & Human Services, Office of Refugee Resettlement 2001).

Public attitudes toward mental health must change before stigma can abate. Head Start programs can help staff and families by educating them that mental health is an aspect of overall health and well-being. When they learn to view mental health without stigma, they will be more likely to seek help for themselves or support others who need help.

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## Depressive Symptoms in Latina Mothers

by Linda S. Beeber

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

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

A Latina mother enrolled in Early Head Start described her silence in this powerful quote, a silence brought on by profound depressive symptoms. Despite her efforts and those of her husband, extended family, and her devoted Early Head Start (EHS) home visitor, the depressive symptoms had taken away her ability to talk to her toddler and introduce her to the greater world. For this family and especially for their toddler, the loss of this mother's ability to talk, sing, play, teach was a threat, especially to the toddler's ability to thrive and learn.

Fortunately, this mother's symptoms were recognized by the EHS home visitor. The mother received treatment and both the mother and family recovered. They are an example of the critical role infant-toddler programs can play in helping families get support and treatment for depressive symptoms. Yet many EHS Latina mothers remain at risk for developing symptoms of severe depression, which interfere with their parenting and predispose their infant to irritability and feeding problems, their toddler to severe tantrums and disregulated behavior, and both infants and toddlers to language, motor, and social developmental delays.

While any parent can struggle with serious depressive symptoms, the Latina mothers in the study, who were of Mexican origin and had been in the United States for about 5 years, were at high risk for depression and for threats to their parenting abilities. Most of these mothers spoke little or no English, and all were encountering severe stressors in the form of previous trauma and episodes of depression, poverty, substandard housing, dangerous neighborhoods, isolation, the pressures of separation from their extended families, and immersion in a new culture. As a result, these mothers exemplified well-supported risk factors for the development of severe depressive symptoms—"pile-up" of stressful life events, lack of social support, previous depressive episodes, loss of a sense of control and self-esteem, and demanding life roles. While an early childhood intervention staff person might easily identify the risk factors for a Latina mother, the recognition of depressive symptoms may be complicated by other factors.

For example, the EHS staff person who served as the interpreter and I, a psychiatric mental health nurse, had been meeting with a group of profoundly depressed EHS Latina mothers for several months to explore their depressive symptoms and tailor the intervention content to their needs. One day, toward the end of a very difficult group session when most of the women were sobbing, there was a loud knock on the door. When the EHS staff person went to answer the door, it was the bus driver who had arrived early to take the mothers home. I was startled to witness the transformation that took place right before my eyes: every mother was smiling broadly without a visible tear. After the EHS staff person talked briefly with the driver and he left, she shut the door—the mothers immediately resumed crying. In asking them about their behavioral turn-

about, they chuckled and shook their heads and said, “Linda, it is not safe to be depressed here.”

In the next meeting, I resumed the discussion. What these mothers revealed were deep fears of being put in jail or in some cases being abandoned by their husbands or subjected to treatment, which in their country could mean institutionalization and electroconvulsive (shock) therapy. To them, to outwardly show depression meant to risk being labeled as “crazy” or removed from their children and bringing disgrace to their family forever. For these women, suffering without revealing their depressive symptoms to the world was the wiser and safer route to take.

### ***Warning Signs***

The well-documented signs of depression—lack of joy, prolonged sadness, difficulty concentrating, excessive guilt, social withdrawal, low energy, too little or too much sleeping, frequent stomach upsets or headaches, and parenting difficulties—are seen in depressed Latina mothers. But these mothers may also exhibit a warning sign that may confuse EHS staff who are familiar with classical depression literature that cites weight loss as a sign of depression (American Psychiatric Association 2000). In our work with newly-immigrated Latina mothers who were struggling with depressive symptoms, mothers typically gained weight. There are multiple reasons, including a shift to U.S. food consisting of processed, high-carbohydrate diets; confinement to small living spaces; transition from rural lifestyles where walking was the primary mode of transportation; and a pattern of eating to reduce stress and depressive feelings.

Other early warning signs may appear in the infant or toddler as the behavioral and developmental problems mentioned previously. In particular, their language development may be delayed, especially if their depressed mothers rarely verbalize or interact with them. Infants and toddlers, like their depressed mothers, may show rapid or excessive weight gain. In our project, Latina mothers who were struggling with depressive symptoms conserved their energy by using feeding or food to calm the infant or occupy the toddler. At the same time, some mothers maintained the cultural belief that heavy babies were healthy babies. Thus, assessment of weight gain in the young children had to be done carefully with attention to the cultural values of the mother. Many of our mothers were breastfeeding, and thus, how much time spent feeding was a useful indicator of the amount of daily intake by the infant. Other factors such as living in small spaces and passive play (e.g., watching videos) probably contributed to weight gain in the toddlers.

### ***Program Strategies***

Comprehensive early childhood programs such as EHS serve an essential bridge for newly-immigrated mothers by offering support, socialization, guidance, and linkages to essential services. Optimally, the immigrant Latina mother maintains interpersonal ties to her primary ethnic significant others, while developing new mentors through acculturating and socializing her infant or toddler (Acevedo 1999; Munoz et al. 1985; Petterson & Albers 2001; Rhodes, Contreras, & Mangelsdorf 1994).

Sensitive parenting guidance given by a trusted staff person can help the mother deliberately choose which elements of her culture of origin to preserve and which elements of American mainstream culture to integrate into her childrearing practices

EHS and other child-focused programs can support the depressed Latina mother. The most critical step toward recognizing depressive symptoms in Latina mothers is the establishment of a trusting relationship in which the mother can relax her guard and show her “true face.” As the mother develops trusting relationships, it is crucial for EHS staff to be aware and have the ability to recognize possible symptoms of depression.

Programs can support such relationships by hiring fully-bilingual staff who are skilled in relationship-based work and by offering home-based options that reach mothers who may be unable to drive a car or use the bus system or who exercise a culturally-influenced belief that children should be reared at home. If a mother struggles with depressive symptoms and is socially isolated, she may be overlooked in a center-based program.

Timely mental health intervention can help the Latina mother regain the energy to talk, play, and provide an envelope of affection and protection in which the infant or toddler can explore, grow, achieve balanced acculturation, and achieve optimal mental health (Jones, Lamb-Parker, & Ripple 2001; Kisker et al. 2000; Roggman, Newland, & Coyl 2001).

This study was part of the E-PIRC Consortium, a group of five intervention studies that brought infant and toddler mental health services directly to participating EHS programs across the country.\* The project “EHS Latina Mothers: Reducing Depressive Symptoms and Improving Infant/Toddler Mental Health” was funded through an ACF/ACYF University-Early Head Start Partnership grant (ACF/ACYF 90YF0042/01) that brought a team of interventionists consisting of a psychiatric mental health nurse and an EHS bilingual staff person to work with Spanish-speaking depressed EHS mothers in their homes. The team was trained to work as a nurse-interpreter dyad.

\*For more information on the E-PIRC studies, see the article “The Early Promotion and Intervention Research Consortium (E-PIRC)” in this Bulletin.

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# Shared Caregiving and Its Implications

by Katie Sellers and Neil Boris

Family structures and the roles that caregivers play in a child's life vary. For an adolescent mother and child, the family structure may include many other family members who play a role in raising the child. Early Head Start (EHS) and Head Start's mission of supporting the social and emotional well-being of children and families begins with identifying the family structure.

Research shows that adolescent mothers are particularly likely to rely on a network of family members and close friends, called a kin network, to help them rear their children. Often the young child's grandparents, great-grandmothers, aunts, uncles, godparents, cousins, and fathers interact with adolescent mothers in providing care.

How can Head Start programs help adolescent mothers continue to support their children's healthy development in the context of shared caregiving?

## ***Conflict in Shared Caregiving***

Head Start families vary greatly in how much support the kin network provides to the parent(s), but also in how much conflict exists in the shared caregiving relationships. Conflict is distinct from lack of support and exists at various levels. Thus, a grandmother-mother relationship can contain high levels of support and conflict, or abundant support with little conflict, or sometimes high levels of conflict with very little support.

The birth of a child, particularly to a very young mother, can bring a stressful period of adjustment for the entire family. One study of shared caregiving among EHS families in an urban location found that mothers experienced various forms of conflict with their family and the family of the child's father (Sellers 2005):

- Kin network members provided unwanted or conflicting childrearing advice.
- Others' child care undermined the mother's discipline.
- The father's family refused to publicly acknowledge paternity.
- The mother's family isolated the child from the father.

Of particular relevance to Head Start programs is the extent to which various members of the kin network make important childrearing decisions. If a Head Start program aims to improve child outcomes, it should acknowledge the key decision-makers in the kin network, provide support, and address the conflicts if necessary. One strategy is to help the young mother gain confidence and feel good about her maternal role by nurturing and developing her negotiation skills. Sometimes the conflict between the mother and other caregivers is about how to handle important aspects of the child's development, and the consequences may be far-reaching for the child. This was the case for Christine, a young mother enrolled in an EHS program.

Christine, an 18-year-old, was at odds with her mother over how and when to toilet train her 20-month-old son. Every morning, the grandmother would dress the boy in underwear, not a diaper, before dropping him off at EHS, in an effort to have the staff toilet train her grandson. But the boy showed no interest in the process, and Christine and

Christine was a reserved young woman who thus far had deferred to her mother regarding major decisions about her son. To help her gain confidence in negotiating with her mother, the program's family service advocate sat down with Christine. Together, they went over a checklist to see if the child was ready to be toilet trained. She provided Christine with information about toilet training that supported the mother's belief that her son would accept toilet training when he was ready. The family service advocate helped Christine develop negotiation skills by role playing, in which the family advocate acted out the part of Christine's mother, while Christine learned to make her case. The family service advocate asked Christine whether she wanted to speak to her mother at home or at the center with the family service advocate present. Christine chose to speak to her mother at the center, and they set up an appointment for the following week.

### ***The Caregiving Context***

Head Start should consider kin network relationships in designing and implementing service delivery to support the social and emotional well-being of the child and family. Capturing the caregiving context of adolescent mothers requires:

- Determining the kin network
- Talking with the adolescent mother about how roles and responsibilities are defined
- Identifying important relationships in which there is support and/or conflict about caregiving
- Helping the adolescent mother learn ways to manage shared caregiving

It is important to recognize the bond that adolescent mothers have with their children, and that even the youngest mothers want what's best for their child. Identifying the family structure and understanding the caregiving context allows staff to empower the adolescent mother, identify areas needing support (such as working through kin relationships), and customize service delivery (by including key decision-makers in discussions, for example). In doing so, programs will be able to effectively support the mother and her kin network to the benefit of the child.

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## **A Teen Parent's Story of Resilience**

Adolescent mothers face many challenges in raising their children. But when a child is born with disabilities, the challenges are compounded. This is the story of the resilience of one teen mom whose daughter has faced serious medical problems.

Missy Ulmer was 16 years old when her daughter Jade was born with Down Syndrome in 1998. Luckily for Missy, she had a strong support system that included her mother and Early Head Start (EHS).

Missy was pregnant and had just started high school at a traditional school when her mother helped her enroll in Discovery Alternative High School in Port Orchard, Washington. The school had a teen parenting program and was about to open an Early Head Start center. When Jade was born with Down Syndrome that December, the staff at EHS rallied to Missy's side.

Over the years, her mother and EHS would support Missy as her daughter faced medical challenges including reconstructive heart surgery at age 2 and Acute Lymphoblastic Leukemia at age 3, followed by two years of chemotherapy. Jade also regularly battled a respiratory virus that causes pneumonia.

### ***Building Self-Confidence***

From the beginning, EHS was instrumental in building Missy's self-confidence as a young parent. Staff taught her that she could be a good parent regardless of her circumstances.

"They taught us how to deal with being a parent because it's a blow to your psyche to be a teen with a baby. Early Head Start helped me with my self-confidence to raise a baby with disabilities. They pointed out my strengths and helped me see that I was the only one who needed proof of my parenting skills," Missy said.

At her most difficult times, EHS staff offered Missy emotional support as she struggled with her daughter's many hospitalizations. Staff encouraged her to talk about her feelings and provided her with a comfortable setting where she could feel safe to talk.

"They were really good at telling if something was wrong. They would pull me into the office and encourage me to talk about it," Missy said. "They didn't care if I screamed or cried or just sat there. They helped me get through it. They were my counselors, friends, and confidantes."

### ***Parenting Skills and Knowledge***

As a requirement for the EHS program at the high school, adolescent parents were required to take parenting classes daily and to spend a minimum number of hours in the EHS "lab" with their child, where staff could support parent-child interactions. The program helped Missy and the other teen moms (and one teen dad) develop the parenting skills, including the emotional tools, they needed to be good parents.

"They taught us how to put ourselves in time-out because being teens, our emotions were running high anyway," Ulmer said. "They taught us how to calm down. They taught us everything. They taught us how to be parents."

Missy said the parenting skills she learned at EHS were reinforced by her mother at home. She was lucky to have a supportive mother who helped her care for Jade. Not all of the adolescent mothers in the program could rely on their parents for help, and in those cases, EHS provided their only source of support.

### ***Help With Resources***

As soon as Jade was diagnosed with Down Syndrome, EHS provided Missy with information on her daughter's condition. Every time Jade faced a medical challenge, EHS helped her find resources and taught her where to look and how to ask for assistance. When she missed classes to care for her daughter who was hospitalized or too sick to leave their home, staff from EHS or the high school brought Missy's schoolwork to her. Missy believes that one of the most important lessons she learned from EHS was how to be an advocate for her daughter's medical care and education.

When Missy registered Jade for kindergarten in St. Louis, MO, where they now live, school officials suggested she enroll Jade in a special education program. Missy insisted that her daughter attend regular classes while receiving special services. She credits EHS, the Olympic Educational Service District 114 in Washington State, and the Office of Head Start with teaching her the skills and giving her the confidence to demand services for her child. At the invitation of the Office of Head Start, Missy attended Special Quest as the parent representative for three years, was featured in the Family Stories Video, and spoke at a Birth to Three conference.

### ***Resilience***

Today, Jade is thriving in her mainstream classroom and has learned to recognize words. She has been cancer free for 8 years. Missy is also thriving. As a testament to her resilience, she said this about her experience as a teen mother of a child with significant disabilities:

“Apparently, I was meant to do what I'm doing because I've had support all along the way. It's been a long tough road, but I honestly don't feel like I've ever fallen down. Early Head Start and my mother helped me to stay standing.”

Missy's family now includes her husband, Jerret, and their daughter Nova. They are all standing tall and strong.

Missy Ulmer was interviewed by My Linh Nguyen of the Head Start Resource Center.

## **Fathers for Life**

by Kathy LeFebvre, Stacy Owsley, Kathryn L. Fuger, and Marnie Morgan

In Missouri, approximately 10 percent of the nearly 19,000 children enrolled in Head Start and Early Head Start have an incarcerated parent. An even higher percentage of the children have a parent on probation or parole.

Since its launch in 2002, Fathers for Life has brought about unprecedented change in the culture of the Missouri prison system by providing incarcerated fathers with the tools and skills to nurture their children while in prison and after their release. In 2005, the Head Start Bureau funded the second phase of the project in two prisons with an Innovation and Improvement Projects (IIP) grant. In addition to providing services and support to fathers, the project promotes the social and emotional development of young children.

The incarceration of a father has a ripple effect. The children are at increased risk for educational, social, and emotional problems. The families face challenges, such as single parenting, stigma, legal challenges, lack of child care, and poverty. Upon release, fathers encounter obstacles to their successful re-entry and to effective parenting. Head Start staff often lack specialized training and resources to meet the confounding needs of families affected by a parent's involvement in the criminal justice system. Fathers for Life addresses these risks in multiple ways.

### ***Support for Fathers***

Group classes, facilitated by Parents as Teachers educators, teach fathers how to support their child's development and learning. Fathers also may request one-on-one Individual Parent Coaching sessions with Parents as Teachers educators.

"Long-Distance Dads," a 12-session parenting program for incarcerated fathers, explores what it means to be a father and how important fathers are to their children. Participating fathers have changed their attitudes about parenting.

There are a lot of things a father is expected to do that I didn't even realize that it was expected. I mean like nurturing your child. I always thought that was mom's thing. ... I've learned that they need that from you too.

The program allowed me to break down some walls and some barriers I had to deal with—the guilt and shame over the years of how I've not been a good dad. ... It's about me growing to be a better father for my child (Missouri Head Start-State Collaboration Office Video 2003).

Since 2005, more than 120 fathers have successfully completed the parenting program. "Graduates" of the program have learned the skills to become more involved and supportive fathers for their children.

### ***Supporting Children in Head Start***

Fathers for Life supports children's social and emotional development directly by:

- Referring increased numbers of target children to local Head Start and EHS.
- Offering supports to enrolled children and their families, such as structured parent/child activities during the father's probation or parole.

- Encouraging Head Start staff, as part of each child’s enrollment process, to ask whether the family is dealing with the incarceration of a father. With this information, staff are better able to provide appropriate referrals for social, emotional, and other community support services.

And indirectly by:

- Providing training and resources to Head Start and EHS staff and other professionals on the challenges faced by families with incarcerated fathers. Opportunities include: training on how to use special topic books for children, cross-training with other agencies working with the same families, and introducing staff to services such as mediation for parents to resolve child-related issues.
- Providing Head Start and EHS programs with teaching materials, such as children’s books designed to help children cope with an incarcerated parent.

### ***Changes in Prison Life***

Fathers for Life has forged a unique collaboration with government agencies, not-for-profits, and educational and faith-based groups, including the Missouri Departments of Social Services, Corrections, Economic Development; the Head Start Collaboration Office; the Missouri Head Start Association; Office of State Courts Administrator; Parents as Teachers National Center; United Methodist Church; University of Missouri Extension; Children’s Services Commission; and University of Missouri-Kansas City Institute for Human Development.

Together, they have created broad-based forms of support for fathers and their families. They have instituted changes in traditional ways of treating the fathers and their families at the demonstration sites. They have put the children’s needs at the center of their efforts and have formed a support system for fathers who have felt isolated and frustrated in the past.

Family visiting areas are now bright and colorful spaces designed to foster children’s development of motor skills, hand-eye coordination, and problem solving. Indoor spaces include puppet theaters and reading corners. Outdoor spaces include playground equipment and walking trails lined with trees and flowers. These areas invite adult-child interaction and encourage families to explore, create, and learn together.

Unlike many prisons, the Fathers for Life demonstration sites promote physical contact between fathers and children. Children may sit in their fathers’ laps as they share a book. Fathers are encouraged to hug and play with their children. In this way, the father-child bond is strengthened.

To stay connected in between visits, fathers may record children’s books on tape and send these tapes and books to their children. Such activities involve the fathers in their children’s learning and reinforce the joy of literacy.

The message that parenting is important is conveyed in many ways. Parenting, child development, and relationship books are made available in prison libraries. Father/Child Activity Days are funded by the State’s Department of Corrections, which provides craft

supplies and snacks. Weekly Parenting Education Days let inmates take advantage of parenting sessions.

### ***Changes After Prison***

Fathers for Life has inspired social services, workforce development, mental health, and other professionals to work together to help ensure successful re-entry of fathers into the community. As part of their initial intake interviews of men recently released from the Fathers for Life demonstration sites, probation and parole officers ask whether they have young children, what their relationship is with their children and the children's mother, and whether their children are eligible children for Head Start. Referrals are made to Head Start as appropriate.

Once referred to Head Start, fathers are offered individualized fathering plans through a specialized intake and assessment process. The plans may include support groups, parent coaching, and referrals to jobs training and career support.

### ***System-Wide Changes***

The depth of collaboration on this project is stimulating system-wide changes in the way that agencies and organizations work with fathers and families dealing with incarceration. Head Start and Early Head Start staff and other professionals are gaining the knowledge and skills to effectively serve them and offer appropriate referrals and resources. All partners in Fathers for Life, including Head Start programs, see their goals reflected in the project, and therefore, they are committed to its success. It is anticipated that the partnerships will develop into a strong, sustainable, statewide coalition committed to supporting families and children with incarcerated and ex-offender fathers.

One notable systems-wide change has been instituted by the Department of Corrections. As a result of the positive outcomes associated with the Fathers for Life demonstration projects, the department has expanded parenting education to all Missouri prisons. The department now believes that it has a stake in children, especially at-risk children, and supports interventions for children and parents to avoid future incarceration.

Some of the Fathers for Life project materials will be made available on the Early Childhood Learning and Knowledge Center (<http://www.eclkc.ohs.acf.hhs.gov/>) to support Head Start and other early childhood programs that want to learn about working with incarcerated fathers or want to replicate aspects of the project.

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## Grandparents: Making A Difference

by Jacqueline M. Davis

A woman, who is struggling with mental illness, is unable to provide consistent, ongoing care for her two children. The grandmother steps in to make a difference.

A young mother and father have decided that they can no longer raise their two children at this time. Although the grandmother has a heart condition, the grandparents step in to make a difference.

A daughter with four young children, a husband, and two graduate degrees passes away suddenly. The father of the children decides he cannot care for the children alone and makes arrangements to place them in separate homes. The grandparents step in to make a difference.

Regardless of the circumstances, grandparents today are increasingly assuming the responsibility of partial or primary caregiver for their grandchildren, often to avoid having the children enter foster care. According to the 2000 Census, nearly 2.5 million grandparents in the United States are heads of households with primary caregiving responsibility for more than 4.5 million children under age 18—the children of their children (Simmons & Dye 2003).

Regardless of the situation, children still have the desire to be loved and cared for by a parent. The ability to step in and fill the void is an awesome responsibility. Grandparents may be required to make major lifestyle changes, interact with social services to get services for their grandchildren, and advocate on behalf of their grandchildren.

They may have to defer their needs for the grandchild's needs.

Unlike traditional foster parents, grandparents often receive no training to care for children who may be at risk and receive limited financial assistance to meet the children's needs (U.S. Dept. of Health & Human Services 2007). The result can be emotional strain on the grandparents and the heightening of any mental health issues they already have. A study of grandparents raising grandchildren in Illinois found that one-third (36.8%) of the grandparents reported significant symptoms of depression (Smithgall et al. 2006). It was also found that nearly four-fifths of the grandmothers reported at least one health problem, and many had three or more health problems such as arthritis, high blood pressure, and diabetes.

Grandparents who are caregivers of grandchildren face a number of issues that can impact their own well-being, including:

- Legal issues related to raising their grandchildren. Whether obtaining legal custody, power of attorney, temporary guardianship or adoption, the steps getting there create stress. "My stress came from not being able to get the documentation...the necessary papers."
- Concern for or anger and resentment toward their own child (the parent of the grandchildren). "I know my daughter is not getting all the benefits she should get considering her multiple disabilities...those types of things contribute to [my] mental state."

- Red tape in obtaining necessary resources and services for financial assistance, health care, and a nurturing learning environment for the grandchildren. “We went through a battle to get food stamps. We went through a battle to get Medicaid... It seems like our legal system faults us [grandparents] for how things have transpired.”
- Deterioration of physical health. “I never knew I had a heart problem. I was working two jobs and was a Union Rep... They told me my arteries are blocked. I [now] have tubes in my chest...I lost my job.”

While there are many stressors that might upset the mental wellness of grandparents who are raising grandchildren, many grandparents find joy in seeing their grandchildren happy. Furthermore, if other family members share the responsibilities, some of the stress can be alleviated.

### ***What Can Head Start Do?***

Grandparents often cannot do it alone. Head Start can help them get the services they need for their grandchildren.

“My 4-year-old granddaughter has learning disabilities and some physical disabilities, and they [Head Start] are really working wonders in helping me get her all the programs she needs. My granddaughter wouldn’t talk. Now she talks very fluently and in complete sentences.”

“We knew something was wrong... It took going to a Head Start conference and sharing my story with the lady that I was sharing a room with. She was actually able to get me a grant to pay for my [grandson’s] speech therapy and developmental therapy. The difference is remarkable. It has taken a lot of stress off of me.”

In addition, Head Start can play a vital role by supporting the grandparent generation. Programs can:

- Recognize the issues related to aging, especially the physical and mental health needs of grandparents, and help connect the grandparents with the medical, mental health, and other health services they need.
- Build partnerships with local agencies and service organizations in the public and private sector that serve as advocates for grandparents raising grandchildren. Grandparents can sometimes be ambivalent about initiating contact with these agencies and service organizations but may be more willing to seek help if Head Start can pave the way.
- Enlist the assistance of grandparents in forming grandparent support groups to provide education and information as well as emotional support.
- Consider specialized training for Head Start staff that focuses on grandparent/grandchildren relationships. Staff can help grandparents build communication skills, promote healthy boundaries, and instill values and beliefs.
- Seek out legal organizations, family attorneys, or others who are willing to volunteer time to work with families facing grandparent/grandchildren challenges. Legal issues top the list of challenges faced by grandparents raising grandchildren.
- Tap in to the resources offered by the American Association of Retired Persons (AARP). The Association’s ever-expanding resources provide grandparents with

information on state and Federal guidelines about tax credits, health insurance, and public benefits.

- Take a cross-generational approach to supporting families. When grandparents are the primary caregivers, but the parents are still involved, Head Start programs can encourage open communication lines and support grandparents with regard to issues such as parental visits and discipline.

Grandparents, who embrace the responsibilities as caregivers of grandchildren and who overcome many obstacles along the way, are to be applauded. Molded by the magical hands and the mystical wisdom of their grandparents, the grandchildren do not forget the unconditional love and care bestowed upon them. It goes a long way to brighten the hearts and lives of the grandparents and strengthens their resolve to join with other grandparents and lift their voices to make a difference.

The vignettes and the quotations in this article came from a focus group of grandparents raising grandchildren enrolled in Head Start that was conducted May 16, 2007, by Jacqueline M. Davis.

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## What is Trauma?

As defined by the National Institute of Mental Health, emotional trauma refers to “an experience that is emotionally painful, distressful, or shocking, which often results in lasting mental and physical effects... Psychiatric trauma, or emotional harm, is essentially a normal response to an extreme event” (U.S. Department of Health and Human Services 2001).

The Child Traumatic Stress Network (2007) distinguishes two different types of emotional traumas:

Acute traumatic events occur at a particular time and place and are usually short-lived. They can involve sustaining or witnessing a serious injury or witnessing the death of someone else; facing imminent threats of serious injury or death to yourself or others; or experiencing a violation of personal physical integrity.

Exposure to chronic trauma situations occurs repeatedly over long periods of time and can create intense feelings of fear, loss of trust in others, decreased sense of personal safety, guilt, and shame. These kinds of traumatic situations include:

- physical abuse
- long-standing sexual abuse
- domestic violence
- wars and other forms of political violence

Child traumatic stress occurs when children and adolescents are exposed to traumatic events or traumatic situations and when this exposure overwhelms their ability to cope with what they have experienced.

In this Bulletin, we examine trauma in terms of domestic violence, family disruption and welfare placement, and natural disasters and their impact on the lives of young children, their families, and other caregivers, including Head Start staff.

Editor’s Note: The Improving Head Start for School Readiness Act of 2007 designates funds to support staff training and child counseling and other services to meet the needs of special populations, including children who are exposed to chronic violence. The Act also requires that the Secretary submit a report to Congress with an evaluation of Head Start agencies’ procedures for responding to large-scale emergencies, including procedures for communicating with families, staff training, and recommendations for improvements as related to Head Start and EHS.

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## **Bouncing Back from Katrina**

What does resilience look like for people who have endured a disaster that has made the headlines day after day?

In 2006, one year after Hurricane Katrina struck the Gulf Coast, researchers from the Henry J. Kaiser Family Foundation conducted a door-to-door survey of the residents of New Orleans and the surrounding area. What they found was a strong resolve among the residents to rebuild their lives and their community.

“We found an incredible sense of optimism, hope for the future. And when we asked people ‘Do you plan to stay? or Do you plan to go?’, only a modest number, 11 percent of the people we talked to said, ‘I plan to go.’ So we found an incredible resilience among the people in New Orleans. And that was the good news in the survey because that resilience, that strength, that hope for the future is the foundation to build on.”

Drew Altman, President and CEO of the Henry J. Kaiser Family Foundation, from an interview with Michele Norris, All Things Considered, May 10, 2007. National Public Radio. Available at

<http://www.npr.org/templates/story/story.php?storyId=10119566&sc=emaf>.

To read the full survey report Giving voice to the people of New Orleans: The Kaiser Post-Katrina baseline survey, visit <http://www.kff.org/kaiserpolls/pomr051007pkg.cfm>.

# Understanding Loss and Grief

by Karen McKinney

A 5-year-old girl was on the playground when she noticed a picture of a little boy posted at the entrance. She had seen the picture many times, but today she studied the picture, then asked her teacher why the picture of the little boy was there. The teacher took a deep breath and held back tears, then told her it was the picture of a little boy who used to be in her class. She told the little girl that the boy died several years ago, and his parents wanted to make sure that he was remembered so they built a playground for other children to enjoy. The teacher then took the little girl to see another picture of the boy that was located in the library. She also showed her that the same picture was placed in the library books. Again, she said that his parents wanted other boys and girls and their families to remember the little boy who loved to play outside and wished for more books in the library.

The little girl went home that night and told her mother about the picture of the little boy who died. The mother was surprised to learn that the little boy was the child of a teacher at the school. The next day the parent went to this teacher to ask more about her child's death. The mother expressed that she didn't know how to talk to her daughter about death and that she was hesitant to ask questions herself. The teacher replied that it gave her much joy to talk about her son and to know that others wanted to learn more.

This is just one example of how death or loss can have an impact on children, early childhood educators, and families. Often the subject of death provokes fear and anxiety that prevents us from engaging in open discussions. Furthermore, because there is a certain stigma surrounding death in our society, most individuals are not given the opportunity to view death simply as the final phase of life—an approach that contributes to overall health and wellness. Therefore, it is important to increase our own awareness of death and loss, recognize associated issues, and also consider planning for dealing with death or loss within our early care and education programs.

Most Head Start programs have been forced to address issues of loss and grief with little preparation. A program may be forced to deal with the death of a staff member, a child in the program, or a pet in the classroom. Sometimes, a program encounters multiple losses created by a natural disaster with the accompanying loss of life, property, and community. More often programs address the countless numbers of “deathless deaths,” such as divorce or separation; a change in employment or residence; a change in health that results in a loss or impairment; or learning a child has special needs.

Any type of loss involves the process of grief. Grief is the normal response of sorrow, emotion, and confusion that comes from losing someone or something important. The grieving pattern that people experience may include shock, denial, anger, guilt, depression, and acceptance.

Head Start programs are in a unique position to support children, families, and staff in dealing with loss and grief. While there are no quick answers to dealing with loss and the subsequent grief that typically follows, there are many proactive steps a program can take to provide awareness, understanding, and support.

The following resources may be available to support programs as they address issues of loss and grief.

- A mental health professional who is certified as a death educator or grief counselor may offer classes on death awareness or provide grief counseling.
- A local hospital or funeral home may also offer classes or support groups.
- Web-based grief support groups address specific types of loss, such as loss of a spouse, child, or pet.
- Colleges often offer courses such as death, dying, and human health; psychological impact of death and loss; and stress and the impact of loss on young children. These courses may be offered through the departments of health promotion, psychology, or early childhood education. Many courses include experiential learning opportunities, such as meeting a death educator, visiting a funeral home, or writing an obituary and will.

Head Start programs also can offer the opportunity for staff to explore their own feelings, attitudes, and values about loss. By learning more about ourselves, we will deal more effectively with the loss and grief that each of us will inevitably experience. We also will be better able to support others in their grief.

Head Start programs can help children, staff, and parents begin to explore these issues by launching a dialogue about the events in life that contribute to loss and grief. In this way, the Head Start program can contribute a crucial element to the overall mental health and well-being of those in its community—an approach that contributes to overall health and wellness.

Each day is a reminder of the fragility of life, yet few are prepared for the final phase of life known as death. The author encourages individuals to become involved in learning more about death and playing a role in helping others become aware of death and loss. Useful resources for early childhood educators include:

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Karen McKinney is a former Early Head Start Director at Rosemount Center in Washington, D.C. She has had extensive experience with loss and grief. Her first experience occurred when she learned her son had a significant disability. She then experienced his death at age 5. Her greatest contribution to death awareness and education occurred through teaching a college course on Death, Dying and Human Health. This article was written in memory of Scott McKinney and Tyler Nordgren, the author's son and nephew.

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# Trauma and Domestic Violence

by My Linh Nguyen

The American Psychiatric Association (2005) defines domestic violence as control by one partner over another in a dating, marital, or live-in relationship. The means of control include physical, sexual, emotional, and economic abuse, threats, and isolation. Estimates vary greatly regarding the number of children exposed to domestic violence each year. According to the Child Welfare Information Gateway, 3.3 million to 10 million children a year are estimated to be at risk for witnessing or being exposed to domestic violence (Bragg 2003).

While domestic violence occurs among all social and economic groups, it is more likely to affect low-income families. It is important for Head Start programs to recognize the signs of domestic violence among families and children and to provide proper support to these vulnerable victims.

## ***Effects on Children***

Children experience domestic violence in many ways. In addition to witnessing domestic violence, children can also hear or infer violence, such as when they see cuts, bruises, or broken limbs. The impact of witnessing domestic violence can be just as significant as if the child had been the intended victim. Children who witness domestic violence can suffer severe emotional and developmental difficulties similar to children who are the direct victims of abuse (Schechter & Edleson 1999).

Many adults wrongly assume that very young children are not affected by domestic violence. In reality, they are often too young to talk about the violence or too afraid to bring it up. But even if infants and toddlers do not fully understand violence, they can feel danger and loss. Exposure to violence may be particularly harmful to children when it occurs very close to them, especially in their homes. They may become fearful and distrustful. The process of developing trusting relationships may be delayed or may not take place at all (Cohen & Walthall 2003). However, when a child's primary caregiver is the victim of abuse, the caregiver may still try to maintain a safe, loving, and nurturing environment, even if emotionally unable to offer the child adequate comfort and support (Cooley 2007).

Young children's reactions to domestic violence are similar to their responses to other kinds of trauma. They may display signs of regression, separation anxiety, fear, acting out, and nightmares. The effects of trauma and ways to support trauma victims are discussed in numerous articles in this Bulletin: "Trauma in the Lives of EHS Children," "Post-Traumatic Stress Disorder in Young Children," and "Supporting Children and Families in the Child Welfare System."

## ***Head Start Families***

According to the findings of the FACES 2000 survey of Head Start families and programs, nearly 10 percent of Head Start children were reported by their parents to have witnessed domestic violence during the previous year. Almost 13 percent of the parents reported that they had been victims of domestic violence in the past year. Head Start

parents experiencing domestic violence were significantly more depressed, and they reported their children to be more aggressive, more hyperactive, more withdrawn, and to have more overall problem behavior. Teachers also reported these children to be more withdrawn and have more overall problem behavior than children whose parents were not experiencing domestic violence (U.S. Dept. of Health and Human Services 2003).

Fortunately, for children exposed to domestic violence and other stressors, both formal early childhood programs (e.g., child care centers, Head Start, nursery schools, and pre-kindergarten), as well as care by family child care providers, neighbors, and relatives, can offer a kind of “safe haven” (Cohen & Knitzer 2004). Head Start programs, because of their comprehensive commitment to children and families, are ideally suited to provide that “safe haven.” In some states, the Head Start-State Collaboration Office and the State Domestic Violence Coalition have partnered to train Head Start programs in a domestic violence curriculum using a “train the trainers” approach (Cooley 2007).

Given the effects of domestic violence on families and young children, Head Start programs should be aware of resources to help families at risk and provide appropriate support for young children who are affected by such troubling events. (See the “Webliography” section at the end of this Bulletin.)

Editor’s Note: The Improving Head Start for School Readiness Act of 2007 promotes partnerships between Head Start agencies and other entities to reduce the impact of substance abuse, child abuse, domestic violence, and other high-risk behaviors on healthy child development.

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# Supporting Children and Families in the Child Welfare System

by Elena Cohen

Infants and very young children are the largest group of children to enter, remain, and re-enter the child welfare system. They are more likely to be reported for neglect than for any other reason. And they are at great risk for socio-emotional, behavioral, and psychiatric problems (Dicker, Gordon & Knitzer 2001).

To provide effective support and services, it is critical for Head Start and Early Head Start (EHS) programs to understand the unique emotional needs of these most vulnerable children.

## ***Vulnerabilities***

Typically, children turn to their parents in times of stress or fear. Research indicates that children who have access to a nurturing caregiver are more resilient in response to trauma than are children who do not (Cohen & Knitzer 2003). Unfortunately, children who are neglected or abused by their primary caregiver or who witness domestic violence may not have such emotional refuge. Their primary caregiver may mistreat them or, in the case of domestic violence, the battered parent may be emotionally unavailable because of her own trauma. As a result, maltreated children often have complicated, ambivalent, and overwhelming feelings toward the parent who either perpetrates the violence or neglects them. They may be placed in high-risk environments characterized by poverty, instability, and caregivers who may be well-meaning but are psychologically vulnerable themselves (Macomber, Green, & Clark 2001).

In addition, abused and neglected children suffer cumulative losses when they must leave their home. Often the psychological effects of neglect and witnessing violence in the community and within the family are less visible than the effects of physical abuse.

All Head Start staff—but especially teachers—can help maltreated children cope with their feelings through daily routines, developmentally appropriate learning experiences, and play and creative activities that may reduce the impact of trauma and help children work through their fear and anxieties. Working together, program staff, child welfare workers, and families can achieve the best possible outcomes for the child.

Josue was the youngest child of a single mother who was unable to care for him along with his three older siblings. He was placed with a foster family in the same neighborhood and was referred to an EHS program.

The family service worker, child welfare worker, mental health consultant, and EHS teacher met with Josue's birth mother and foster family to teach them about the program and help them enroll Josue. Before the first day of school, they developed a plan to provide a structure of predictability, nurturance, and support for Josue. In addition, and in cooperation with the child welfare worker, the parent coordinator began to work with both birth and foster families to help them get connected to needed services in the neighborhood. The goal is to maintain the child's contact with his birth family and to reunite them as soon as possible.

## ***Support for Children***

By providing a stable, supportive environment, EHS and Head Start staff can help children develop secure attachments, acquire self-regulation skills, and maintain continuity.

### **Secure Attachments**

Separation from caregivers and other traumatic events during early childhood can have long-term consequences. Even children with conflicted and negative attachments—a characteristic of children who have been abused or neglected—have strong emotional reactions when relationships to caregivers are disrupted.

Head Start staff can facilitate the formation of new attachments and lessen the impact of potentially traumatic events by supporting children throughout the grieving process that may accompany changes in placement and by providing the continuity of a stable caregiver and a nurturing environment.

### **Self-regulation Skills**

Many abused or neglected children have an impaired capacity to self-regulate, to manage new stressors, and to make use of relational forms of soothing and comfort. As a result, they may exhibit challenging behaviors including colic, excessive fussiness, and sleep or feeding disturbances. Head Start staff can screen and refer for assessment and intervention those children who are hard to console, have sleeping or feeding problems, or those who are not demonstrating appropriate milestones in any area of social, emotional, cognitive, or physical development.

### **Continuity**

Head Start staff can support children by sharing their knowledge of the child's needs, wants, comforts, beliefs, likes, and dislikes with extended family, foster families, caseworkers making decisions about placement, and other professionals. This sharing of information can help overcome the many discontinuities that children can experience in the child welfare system. Besides the disrupted attachment that occurs when a child is placed in foster care, the child may endure multiple changes in child welfare workers and mental health providers, among others. This lack of continuity is disruptive to the child. It also results in a fragmented or total lack of knowledge about the child's internal experience and reality.

### ***Support for Families***

Designing a support system for young children must include a carefully considered and appropriate involvement of the child's caregivers (biological, substitute, and adoptive parents). When safety can be ensured, it is in the best interest of the child that biological and substitute caregivers maintain an ongoing relationship with the child and other caregivers. Head Start staff can provide caregivers with guidance about the child's needs for consistent and reassuring daily routines, the child's complex feelings toward parents or foster parents, and appropriate (non-aggressive) techniques for managing the child's behavior.

When caregivers feel that their emotional needs are met, they are more capable of doing the same for their children. By listening non-judgmentally and sensitively to the stresses, stories, and family histories, teachers and family service staff can identify the special strengths and needs of each caregiver and how each of them feels about what is happening.

### **Conclusion**

EHS and Head Start staff are in an optimal position to meet the specific developmental challenges faced by young children involved in the child welfare system. By providing a stable, secure environment, programs can have a positive impact on a child whose life has been disrupted by abuse or neglect.

Editor's Note: The Improving Head Start for School Readiness Act of 2007 designates funds to support staff training and child counseling and other services to meet the needs of special populations, including children in the child welfare system. It also calls on programs to enhance collaboration and coordination of services with other entities providing services for children referred to Head Start programs by child welfare agencies.

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## **My Life in Foster Care**

by Julie Palmer-Blackwell

In 1947, when I was just 9 months old, my dad, an immigrant from India, brought me to live with Clara McBride Hale, known as Mother Hale. She was the nice lady who lived upstairs in a five-room apartment in Harlem's Sugar Hill neighborhood. The famous Hale House, now a sanctuary for young children whose parents cannot care for them, did not exist yet.

Back then, my dad had a heart condition and had to work. My mother was not in the picture at the time. I can only imagine my dad's sense of urgency. He had been my caregiver and was the parent with whom I had bonded. He had to find a place where I could be safe and cared for. Mother Hale's home was the answer.

Mother Hale had been taking care of other peoples' babies and children since her own husband had died years before, leaving her with two young children. She knew first-hand the desperate circumstances that parents experienced in their quest for safe and reliable child care.

Today, we know that when we leave our babies, we say, "Good-bye. I love you, and I'll be back." It is not likely that my dad knew that. So, absent of some coaching from the very wise Mother Hale, he left me, alone and afraid of being in a strange place with people I did not know. I was told that at first I would just sit and stare off into space. Gradually, with sensitive and loving care and attention from Mother Hale, I formed a bond with her. Under her care, I passed all the developmental milestones in the early years, such as walking, talking, and learning to feed myself. In later years, two of my sisters joined me at Mother Hale's home and helped make this family unit complete with loving adults (including Mother Hale's adult children) and other foster children.

### ***Research on Foster Care***

A study of "alumni" of foster care was conducted in 2003 to determine how youth formerly in foster care have fared as adults and what changes in foster care services could improve their lives (Casey Family Programs 2005). The study reviewed 659 case records and interviewed 479 alumni.

Here are some of the findings:

- More than half entered foster care at age 12 or older, but 14.9% were placed at age 5 or younger.
- The average number of years spent in foster care was 6.1 years.
- On average, they experienced 1.4 placement changes a year.
- A disproportionate number of alumni had mental health problems compared to the general population.
- As adults, more than half had one or more mental problems, and one-quarter suffered from post-traumatic stress disorder.
- Their high school completion rate was comparable to the general population, although the former foster children were more than six times likely to use GED programs to

get their diplomas. Many had experienced seven or more school changes during their foster care years.

- As adults, their employment rate was lower than the general population, and they lacked health insurance at twice the rate of the general population.
- More than one in five alumni experienced homelessness for one day or more within a year of leaving foster care.

Although public attention often focuses on the negative side of foster care and extreme cases of maltreatment, the benefits of foster care should not be ignored. The study concluded that “the majority of alumni reported positive experiences with their foster parents. More than four in five said they felt loved while in care” (Casey Family Programs 2005). According to Misty Stenslie, deputy director of the Foster Care Alumni of America, there are an estimated 12 million adult alumni of foster care in the United States. “Most of us alumni will report that being in foster care was an overall positive part of our lives,” said Ms. Stenslie.

### ***Some Protective Factors***

It is clear from the alumni survey that growing up in foster care can have long-term consequences. Thankfully, my experience in Mother Hale’s home provided enough protective factors to promote my positive development. These protective factors included:

**Family Life.** Our family included Mother Hale; her children, Nathan, Lorraine, and Kenneth; and my sisters, Carol and Robin. We ate dinner together on a nightly basis, and during this time, we talked about our day, laughed, and sometimes argued. In this very “normal” setting, we were acquiring the tools for a successful life.

**Spiritual Anchor.** As a family, we attended church regularly. I sang in the church choir and was active in the youth group.

**Lasting Relationships.** Because we bonded together and formed a family, my sisters and I were able to have lifelong relationships with the Hales, our birth parents, and one another. This made it possible to have a healthy, developmentally appropriate childhood and gave us a foundation for forming healthy relationships as adults.

**Stability.** I was fortunate to have only one placement. I left Mother Hale’s home when it was time for me to go to college.

**Relationship with Birth Family.** It is better to have a relationship with one’s family than not, as long as the child is physically and emotionally safe. In my case, I grew up with two of my three sisters and had ongoing relationships with my birth mother (very difficult at first, but later on, a wonderful relationship shortly before she died) and with my dad (always wonderful). I also formed a lasting bond with my baby sister, Mary, who was reared by our mother.

**High-Quality Early Care and Education.** As early childhood educators, we know that high-quality early childhood education, including continuity of care, can be an effective intervention for distressed and/or disorganized families and children by providing respite, regularity, and structure; modeling appropriate practice; and offering opportunities for

positive relationships. Because Mother Hale was essentially a stay-at-home mother and her daughter Lorraine was a teacher, my early childhood education took place at home. Mother and Lorraine were voracious readers who taught us to value education and encouraged us to read and talk. We were all great talkers! When I entered school in the first grade, I was already reading.

Few School Changes. I attended three elementary schools and attended just one junior high school and one high school. My school environment was fairly stable, especially as I got older.

Education. Good grades and higher education were non-negotiable. All but one of us completed college. Many of us earned advanced degrees.

Resources When Leaving Care. Although I made the transition to college and adult life, I continued to be part of the family. When I brought my children to visit their grandmothers, Mother Hale was one of them. I still receive a lot of support from the Hales who were truly my other family.

## ***A Happy Ending***

I am happy to say that today I am a motivational speaker, jazz singer, and a dedicated educator and advocate for children and families. I owe all of my accomplishments and successes to my wonderful foster mother, Mommy Hale, and her family who gave me the tools for living, as well as to my parents, Carolyn Truesdale and Tony Alli, who gave me life.

Perhaps the most important lesson I gained from my life with Mother Hale was the power of family. I am the proud mother of four adult children, three adult step-children, and grandmother to 14 grandchildren. All four of my children have benefited from the values passed onto them through me from Mother Hale and have become high achievers in their careers. When people call Mother Hale and myself a success story of foster care, I like to point out that my children are part of that story as well.

Editor's Note: The Improving Head Start for School Readiness Act of 2007 designates funds to support staff training and child counseling and other services to meet the needs of special populations, including children in foster care. It also emphasizes community assessment to identify children in foster care who are eligible for Head Start.

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Mother Hale passed away in 1992. To learn about her legacy and the work carried on by the Hale House, visit <http://www.halehouse.org>

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# **Supporting the Mental Health of Homeless Children**

by Karin Elliott and Sarah Fujiwara

Every year 600,000 families with 1.35 million children experience homelessness in the United States, making up about 50 percent of the homeless population over the course of the year (National Alliance to End Homelessness 2007).

Key factors contributing to the increased number of homeless families are extreme poverty and a lack of affordable housing in many parts of the country. Many families become homeless because they earn low wages and cannot keep up with expenses. Many families lack a network or support system upon which they can rely in a crisis. Families also become homeless as a result of domestic violence, physical and mental health issues, or substance abuse. Often, families who become homeless live with friends or relatives before moving into a shelter.

## ***The Impact of Homelessness on Young Children***

Research shows that children experiencing homelessness face mental health challenges. Homeless children have higher levels of anxiety, withdrawal, and depression than their counterparts who are not homeless. Homeless children are also more likely to have increased health problems, increased behavioral issues, developmental delays, and lower educational achievement (The Better Homes Fund 1999). Some homeless children have either witnessed or experienced violence.

More than 20 percent of homeless children between the ages of 3 and 6 have emotional problems serious enough to require professional care (The Better Homes Fund 1999). Behaviors commonly displayed by children who have experienced homelessness include anxiety and withdrawal, depression, aggression, hoarding, eating and sleeping disruptions, and acting overly friendly or mature beyond a child's years. Children experiencing homelessness need strong supports, resources, and nurturing relationships from consistent caregivers to help alleviate these impacts.

## ***How Head Start Can Help***

Head Start can offer a supportive environment to homeless children and their families. Head Start programs can help alleviate the impact of homelessness on young children. Head Start providers can offer a safe and stable environment, activities in the classroom geared towards social and emotional support, and referrals for children and families to appropriate community services.

There are also specific strategies that Head Start staff can use when they see signs of strain in a homeless child's social and emotional health. Examples of typical behaviors seen in homeless children and ways to address them are described below.

**Hoarding.** Children who may not have had "enough" may hoard markers, food, or other items to help them feel better.

- Have enough supplies for children to play with, including multiples of popular items. It is best to have fewer toys but to have several of each type. Sharing will come later.

- Reassure children that the play dough or other toys will be there tomorrow and that they will be able to play with them again.

Acting Mature Beyond Years. Many children will have experienced a need to “take on” responsibility for younger children or even occasionally for parents.

- Explain to children that the adults are there to keep them safe. Let them know that there are adults who can help their parents (if they are sad or need support). It doesn’t have to be the child’s job.
- Head Start teachers can help children by “teaching them to play” and by removing the burden of responsibility from them.
- Be sure to have parent discussions and conferences away from the children so that they are not re-traumatized by hearing the family story again and again.

Lack of Boundaries. Very often children who have experienced the trauma of homelessness lack appropriate boundaries.

- It is critical to always introduce yourself and classroom visitors to a child.
- Reinforce safety by creating clear expectations and limits.

However, no single program can provide the full array of support services that homeless families need. Head Start programs need to seek out and establish active partnerships with relevant service providers in their communities to ensure that homeless children and families receive effective, comprehensive services.

### ***Horizons for Homeless Children***

Horizons for Homeless Children (HHC), a nonprofit organization based in Massachusetts, operates three child care centers that provide a nurturing environment for homeless children, while offering their families support and services to help them achieve personal and economic self-sufficiency. HHC has 34 slots for Head Start children.

The program is funded with a combination of private dollars (60%) and public funding (40%) that includes Head Start, child care vouchers, community partnerships, homeless child care vouchers, and teen parenting program funding.

HHC is committed to providing a child care environment and experience that promotes positive mental health for children. An aspect of its unique programming is the presence of an extra teacher in each classroom for additional attention.

Quality, nurturing relationships can help to alleviate some of the stress that homeless children experience. Additional opportunities for individual attention can contribute to children’s positive social and emotional development.

CHART:

Massachusetts law requires child care centers have:

-2 teachers for 7 infant

-2 teachers for 9 infants/toddlers

At Horizon for Homeless Children, each classroom has:

-3 teachers for 7 infants

-3 teachers for 9 infants/toddlers

End of Chart

## **Conclusion**

Serving the homeless presents unique challenges to local Head Start programs. It is possible to reduce the negative impact of homelessness on the health and well-being of infants, toddlers, and preschoolers. Creating supportive environments, promoting stable and nurturing relationships, providing quality interactions, and dealing effectively with challenging behaviors in the classroom are just some of the ways that you can make a difference.

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## **A Historical Look: Serving Homeless Children and Families in Head Start**

Perhaps no children speak more directly to the mission of Head Start than those who are homeless. Recognizing both the essential need to serve this population and the need programs might have for guidance in this area, the Head Start Bureau launched several initiatives aimed at enhancing services to homeless children and families.

- A 1992 policy brief on Homeless Children and the Head Start Program encouraged local Head Start programs to target for enrollment those families with preschool-aged children experiencing homelessness. This guidance is still relevant today (ACF-IM-92-12, issued 06/05/92).
- In October 1993, the Head Start Bureau funded 16 Head Start grantees to implement three-year demonstration projects for homeless children and their families. The objectives of this initiative were to: (1) enhance access of homeless families to Head Start services; (2) provide services responsive to the special needs of homeless children and families; (3) identify effective methods of addressing the needs of homeless families; and (4) implement and document replicable strategies for collaboration between Head Start programs and community agencies on behalf of homeless families.

Findings from the demonstration projects are summarized in the report, *Head Start Demonstration Projects Serving Homeless Families: Descriptions, Effective Practices, and Lessons Learned*. The document details effective approaches and challenges as well as recommendations from Project Directors. The report (attachment to ACYF-IM-HS-99-02, issued 03/12/1999) is available at the Early Childhood Learning and Knowledge Center at <http://eclkc.ohs.acf.hhs.gov/>.

One former demonstration project that has continued to support homeless children and families is Parents in Community Action, Inc. (PICA) Head Start in Minneapolis. The program's "Project Secure" provides transportation and other support services for eligible children living in homeless shelters to attend full-day Head Start and Early Head Start. Support for parents includes a life skills and housing subsidy support program to help families move from shelters into permanent housing. For more information, visit <http://www.picaheadstart.org/hs/projectsecure.html>.

Another former demonstration project that has continued its efforts is Action for Boston Community Development, Inc. (ABCD), which now partners with Horizons for Homeless Children (see article "Supporting the Mental Health of Homeless Children" in this Bulletin).

- In 1995, Congress passed legislation requiring Head Start programs to coordinate with efforts to implement subtitle VII-B of the McKinney-Vento Homeless Assistance Act regarding education for homeless children, pre-k through grade 12, and ensure that homeless children are identified and prioritized for enrollment. The legislation also allows homeless families to apply, enroll in, and attend Head Start programs while required documents are obtained within a reasonable timeframe.

Editor's Note: The Improving Head Start for School Readiness Act of 2007 prioritizes homeless children for enrollment in Head Start. The Act also calls on programs to better meet the needs of homeless children, including transportation needs, and to improve the outreach and quality of services to homeless children and families.

## Learning to Live in the U.S.

by Judy David

Imagine fleeing your home and all that is familiar. Imagine huddling in a refugee camp with thousands of other people, sleeping under a tent in the boiling sun or the freezing cold. Imagine surviving that way, in limbo, for weeks, months, or even years while you wait for another country to accept you as a resident. And then imagine landing in your new country, where everyone speaks and acts differently than what you are used to. This is the reality for many refugees from all parts of the world.

Over 41,000 refugees arrived in the U.S. in 2006, and many of the families and young children were eligible for Head Start. The mental health issues they may face include (Birman 2007):

- Migration stress—Many families have endured great difficulty on their journeys to the U.S. and have been separated from family members and their community.
- Acculturation stress or culture shock—There may be vast differences between the new culture and the native culture; there may be a generation gap as the children adapt and learn English faster than their parents.
- Traumatic stress—Many families have experienced war, violence, and multiple traumas. Refugees may suffer post-traumatic stress.

Many Head Start programs have found culturally appropriate ways to address the mental health needs of refugee families and children. Designated a refugee resettlement city, Boise, Idaho, has become home to many African, Asian, and Eastern European refugees. With an active outreach and recruitment effort, Friends of Children and Families, Inc. Head Start/Early Head Start, enrolls a diverse population. Providing mental health support requires understanding the culture and respecting its traditions. Elizabeth Dilley, Executive Director, explains:

Many families are used to living in one small community or village in their homeland. They often move into the same apartment complex here. They typically turn to each other to discuss important matters. We're working on ways to bring the mental health services to them where they live and feel comfortable. We also are learning how to communicate effectively with the families given the different roles that men and women have.

The staff at Friends of Children and Families also recognize how important it is to prevent challenging behaviors and to build resilience in all children. Anticipating that some refugee children initially will want to hold onto their toys or play things because they have experienced extreme deprivation, the educational staff make sure that there are enough classroom materials so that all children can participate in activities.

Some Head Start programs partner with community agencies whose staff are bilingual and bicultural mental health professionals. In Falls Church, VA, the Center for Multicultural Human Services offers a wide range of services in 30 languages; its staff include trained professionals, 80% of whom are immigrants or refugees. The Center has partnered with Higher Horizons Head Start and Early Head Start to serve its diverse population of families and children from all over the world. The program turns to Center

staff to make classroom observations when there are mental health concerns about children; to consult with teachers and parents; and to provide individual therapy and parenting education and support groups, including a program for Survivors of Torture and Severe Trauma. Most of these services are delivered at the Head Start site which makes them readily accessible to families.

What makes this partnership work? Mary Ann Cornish, Director of Higher Horizons, credits the sensitivity and diversity of the Center's staff. But she also describes the very special role that Head Start plays:

Once families come into our program, they quickly see that we have their best interests at heart. They trust us. If we have to make mental health referrals, families know that we wouldn't send them to a place where people didn't speak their language or who couldn't connect with their experiences as immigrants or refugees. Because they trust us, they trust the Center too.

Given the stress or trauma that refugees often experience in their homelands or during their escape and the challenge of adjusting to a new country and culture, it is important that Head Start programs be alert to their mental health needs. Head Start programs and its community partners are in an optimal position to promote the resilience and mental well-being of this vulnerable population.

Editor's Note: The Improving Head Start for School Readiness Act of 2007 designates funds to support staff training and child counseling and other services to meet the needs of special populations, including refugee children.

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## **SIDEBAR:**

The Refugee Mental Health Program (RMHP), located in the Substance Abuse and Mental Health Services Administration (SAMHSA), provides refugee mental health consultation and technical assistance to Federal, state, or local agencies at no cost. Specific RMHP services and activities include: on-site and distance consultation; community assessments, program development, dissemination of technical assistance documents; and development and provision of workshops and training programs for resettlement staff, mental health personnel, or other providers. Priority is given to

programs funded by the Office of Refugee Resettlement (ORR, ACF, HHS). For more information, as well as products and other resources, visit <http://mentalhealth.samhsa.gov/cmhs/SpecialPopulations/refugmhnew.asp>.

The Head Start Connection Web page has been specifically designated to connect the Office of Refugee Resettlement (ORR), service providers, and Head Start programs. A list of ORR partners and resources is included.

<http://www.acf.hhs.gov/programs/orr/whatsnew/headstartconnection.htm>

## **The Early Promotion and Intervention Research Consortium**

Did you know that Early Head Start (EHS) programs are involved in research on mental health in early childhood?

The Early Head Start Infant Mental Health Initiative, begun in 2001, consisted of both programmatic and research components. At the program level, the Pathways to Prevention training experience provided a specialized infant mental health consultant for 25 EHS and Migrant and Seasonal Head Start programs to help them work toward their goals in mental health.

The Early Promotion and Intervention Research Consortium (E-PIRC) is the research component of the Initiative. In 2002, the Head Start Bureau and the Office of Planning, Research, and Evaluation (OPRE) funded four-year grants to support five partnerships between academic institutions and EHS programs.

The purpose of the research was to develop and test approaches to supporting the mental health of infants, toddlers, and their families in EHS. The five projects incorporated diverse ethnic and linguistic groups, teen mothers, urban and rural populations, and homeless families.

As described in the next section, the approaches fit into two broad categories:

- providing training and assistance to EHS staff
- providing direct intervention and support to EHS families

### ***Training and Assistance to Program Staff***

Project HAPPI: Healthy Attachment Promotion for Parents and Infants (An Early Head Start Infant Mental Health Initiative), led by Brenda Jones Harden at the University of Maryland, provided training on infant mental health and ongoing support to home visiting staff and center-based caregivers/teachers.

Early Head Start-University Partnerships: Improving Mental Health in Children Served by Early Head Start, led by Jane Squires at the University of Oregon, implemented and evaluated a preventative intervention program aimed at enhancing developmental growth and social and emotional competence in children through enhancing home visitors' knowledge and skills regarding mental health.

### ***Interventions with Families***

High-Risk Adolescent Mothers and Their Children: Comparing Two Preventive Interventions, led by Neil Boris and Sherry Heller at Tulane University, compared two interventions that use a relationship focus—Circle of Security and the Nurturing Program—to increase attachment organization between high-risk adolescent mothers and their children.

Infusing Infant Mental Health Services in Early Head Start Through a Research-Based Collaborative Partnership, led by Neena M. Malik at the University of Miami, conducted screenings, including observations of parent-child interactions, and provided intensive

parent-infant psychotherapy to families observed to be at risk for relationship difficulties and developmental delays.

EHS Latina Mothers: Reducing Depression and Improving Infant/Toddler Mental Health, led by Linda S. Beeber at the University of North Carolina, tested a five-month home-based, manual-guided intervention for depressive symptoms with Latina mothers. For more information on the Pathways Training provided by the Early Head Start National Resource Center, see <http://www.ehsnrc.org/highlights/mentalhealth.htm>. For more information on these E-PIRC studies, see <http://www.acf.hhs.gov/programs/opre/ehs/epirc/index.html>.

## **Free to Grow: Partnerships to Strengthen Families**

From 1994 to 2005, Free To Grow (FTG), a national demonstration program, worked with 15 local Head Start programs and their community partners to test an innovative approach to substance abuse and child abuse—two closely related public health problems. FTG focused on reducing risk factors and increasing protective factors by strengthening the family and neighborhood environment of small children. FTG fostered partnerships among local Head Starts and schools, law enforcement agencies, county governments, the public housing authority, homeless shelters, and substance abuse and mental health treatment organizations. The initiative was funded partly by the national Head Start Bureau (now Office of Head Start), the Robert Wood Johnson and Doris Duke Charitable Foundations, and local programs.

From 2001 to 2006, Wake Forest University School of Medicine conducted a process and impact evaluation of FTG. The process evaluation included an assessment of technical assistance to local sites and the perceptions of stakeholders such as Head Start. The impact evaluation assessed the effects of FTG interventions in reducing the risk and increasing resilience of targeted families and neighborhoods, as well as strengthening community partnerships. Results of the evaluation were presented at various conferences.

# **Unlikely Partners in Rural America**

by Julie Adrian

At Head Start, we are all champions for children, and as champions we cannot stop until we see that each Head Start family is on the way to reaching their full potential. When we know that we have impacted a Head Start family, then we know that we have touched the life of a child. (Almeta Keys, Executive Head Start Director)

Sorrel, Four Corners, Glencoe, and Ashton are four low-income communities in St. Mary Parish, LA, served by St. Mary-Vermilion Community Action Agency (CAA-Head Start). These neighborhoods were vulnerable and ridden with substance abuse, drug dealing, and crime. Some parents, themselves jobless, were reluctant to report their child's money-making drug dealing. That was the status quo until the inception of Free To Grow (FTG) 2000, when CAA-Head Start and its partners made innovative and foundational change and inspired members of the community to help themselves. But changing the minds and hearts of people who had become accustomed to their environment was not easy.

## ***Holistic Approach***

To increase family support and to better serve the children, CAA-Head Start/FTG integrated an encounter form into its initial intake interview which would make it easier to track support services for families during their child's enrollment. The form was designed to share special concerns and needs and to better address the family's and child's needs. In this way, a more holistic approach was undertaken to better serve families and children.

## ***Drug Awareness***

The CAA-Head Start/FTG collaboration led a series of classes for parents within the community. In one class, a state trooper displayed drugs and drug paraphernalia to the parents. Parents learned about what each drug did to the body and the consequences for selling drugs. District Attorney Phil Haney described his office's open-door policy.

## ***Leadership Development***

Leadership Development classes, a 9-12 week series led by Denise Teno, Neighborhood Family Advocate, also were offered to parents and community residents. After successful completion of the course, parents in the community graduated with caps and gowns, a first for many who had not graduated from high school. Some of the graduates have taken leadership roles, such as Ray Manuel, a Head Start parent, who was motivated to run for public office and was appointed Justice of the Peace in Glencoe.

## ***Neighborhood Watch***

The local police departments were one of the FTG partners, and they took new steps to support the communities. For example, a police car was designated by the St. Mary Parish Sheriff, David Naquin, to patrol the area. This was very significant to the community. The closest police station was 20 minutes away, and even after many in the community had complained, there was a reluctance to assign a patrol car specifically to

the area. On the heels of FTG, the Sheriff himself stood with the community to put up the neighborhood watch sign which, to the community, symbolized his commitment and support.

### ***Role of Faith-Based Organizations***

Faith-based organizations had an ongoing major role in strengthening the community and supporting the efforts initiated by FTG. They made announcements about events held by CAA-Head Start/FTG. In turn, they were inspired by the energy and support they received from FTG. St. Moses Baptist Church organized the March for Jesus, which rallied about 200 people on a 7-mile walk to a park. Once overgrown with weeds and a drug-dealers' domain, the park had been cleaned up thanks to FTG. It became the site for a Resource Fair. Community residents visited booths set up by local organizations, businesses, and educational institutions. The community now can plan events in the park, such as an Easter egg hunt and baseball games.

### ***Recreation Center***

Although plans were underway to build a recreation center in the Four Corners area, the facility was not fully funded because neighbors complained that it would draw noisy, disruptive groups. To complete the project, Rev. Brian K. Stevens, a key player in the FTG project, led target area residents to move beyond complaints to petition the Parish Council. Eventually the new multi-use recreation center was built under the oversight of Rev. Craig Mathew to include a kitchen, basketball court, and much-needed community space. The dream of the residents for over 30 years became a reality thanks to the major efforts of family-strengthening and partnership-building by the agency and FTG.

### ***Replication***

To inform other programs of the knowledge and successes they found, Almetra Franklin, CEO, and Almeta Keys, Executive Head Start Director, St. Mary-Vermilion CAA-Head Start, shared information about community engagement and partnership-building with other FTG grantees, such as Head Start of Greater Dallas. They also spoke at national conferences, trainings, and hearings, including testifying at Congress and presenting at the National Head Start Association Academy in Albuquerque, NM.

### ***Lessons Learned***

In this impoverished and vulnerable Head Start community, FTG left a legacy of greater coordination among the stakeholders—the residents, the police, the District Attorney's office, and the churches, to name a few.

What lessons can be passed on to other Head Start programs committed to making community-wide changes?

- Hire a consultant who can play the role of a coordinator to facilitate non-conventional community partnerships. Select a person who is a community resident, “a familiar face” and is deeply rooted in the community.
- Employ community leaders to take active roles; never underestimate any available resources including faith-based groups.

- Employ other staff who are members of the community or encourage staff to have a presence in the community.
- Be optimistic even if members of the community do not think positive change is likely and may resist the unknown. Use your community's available resources, such as churches, to convince members of the community that change is possible.
- Present a holistic program approach that integrates the family and community, and thus, ensures the child and family are on the way to self-sufficiency.
- Reach out to local funding resources.

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by Terry Lock

From 2000-2005, Maui Economic Opportunity (MEO) Head Start/Free To Grow (FTG) project targeted the community of Wailuku that included two low-income housing complexes, a large elementary school, a prison, and a homeless shelter. Wailuku had the highest reported rates of child abuse, domestic abuse, and alcohol and methamphetamine abuse in Maui County.

### ***Tackling Community Violence***

The MEO Head Start/FTG collaboration worked to decrease the violence in communities. To help Head Start families and residents of a low-income housing complex who were frustrated with drug dealing and violence in their neighborhood, staff assisted them in taking action by initiating a partnership with police. With the guidance of the community police and the local housing authority, families and resident volunteers were trained as patrol members.

### ***Supporting Incarcerated Mothers***

FTG also worked closely to bring inmate mothers and their children together through a project called “Ohana Strengthening.” At the Maui Community Correctional Center, inmate mothers participated in supervised parent-child interaction and parenting classes. Temporary caregivers in the community were given the chance to utilize the assistance of case managers and attend regular support group meetings.

As the incarcerated women spent time with their children, the guards learned to see them in a different role. Instead of viewing the women only as inmates, the guards learned to view them as mothers whose children depended on them. Seeing the women in this new light helped the warden and guards change their attitudes, thoughts, and feelings toward the female inmates and led to better treatment for the women. When FTG ended, the activities of Ohana Strengthening were continued with funding from the Hawaii Children’s Trust.

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## Videotaping Builds Parent-Child Relationships

by Milly Burrows

The Early Head Start (EHS) program at Associates for Human Services, Inc. in Taunton, MA, serves 42 infants, toddlers, and expectant families. It is a delegate of Triumph, Inc., Head Start and is fully funded through Triumph. The EHS program employs nine staff, including four parent-child advocates who deliver home-based services. The on-staff mental health services manager is a licensed social worker who provides regular observations of parents and children, clinical guidance to staff, and consultation to parents.

Staff use a variety of tools and techniques to strengthen relationships with parents and to support them in meeting their children's social and emotional needs. One technique is to videotape parent-child interaction and make it into a "Watch Me Grow" videotape for the family. This is a way for parents and staff to learn about the parent-child relationship and is also a souvenir of the child's development. The technique is based on the University of Minnesota's Center for Early Education and Development's "Seeing is Believing" videotape strategy, which helps program staff partner with parents to document the parents' successes, see the child's development, and learn about the parent-child relationship.

All EHS families are offered a chance to make a "Watch Me Grow" videotape twice a year (or more if parents wish). Ideally, the videotaping is conducted by the parent-child advocate during a routine home visit because she has already established a trusting relationship with the family and is better able to make the parent feel at ease in front of the camera. With the parent-child advocate behind the camera, it is up to the parent to direct the play activity with the child.

The videos, which last 10-20 minutes, do not capture the entire home visit. Rather the focus is on the play activities between parent and child that occur during the visit. After the taping, the parent-child advocate and mental health services manager review the video together. The mental health manager writes a summary that highlights the parent's strengths and skills and includes guidance to help the parent enhance her skills and strengthen her relationship with her baby.

Shortly after the taping, the parent sits down with the parent-child advocate and the mental health services manager for a guided viewing of the video. They ask reflective, open-ended questions such as, "Did you notice what happened there?" or "How do you think your child felt when that happened?" These questions help lead the parent to make discoveries on their own.

Here is an example of how this approach benefited one family:

Maria, an EHS parent-child advocate, met with 32-year-old Olivia and her children on a weekly basis. Olivia's devotion to her children was obvious. She had very high expectations, particularly of her oldest child, 2½ -year-old Natasha, who had just rejoined the family after living temporarily with her grandmother. Olivia expected Natasha to sit obediently while her infant twin sisters played, relinquish toys to them, and take on other more mature responsibilities. Maria was concerned that Olivia was frequently harsh in disciplining Natasha. Although Maria worked diligently to help Olivia see the differences

in her children's temperaments and understand their developmental levels, Olivia maintained her unrealistic view. As a result, Natasha could never seem to meet her mother's expectations.

After discussions with the program's mental health manager, Maria offered to videotape her next visit as the first of several "souvenirs" of the children's development and as a tool to "see what the children can teach us." Olivia welcomed the observation, but agreed to the videotaping only after being reassured that it was her choice and that she would be the only person with a copy of the tape.

The following week, Olivia, Maria, and the mental health manager watched the videotape together. As they reflected on what they were seeing, the mental health manager affirmed Olivia's efforts to encourage her children's skills. She then asked Olivia, "Did you notice what happened there?," drawing attention to the chain of responses occurring between mother and children. Olivia commented: "I'm hard on her [Natasha]. I never noticed how really good she is with her sisters!"

This was a turning point for Olivia. She recognized that Natasha was trying to engage her sisters in play and conversation. Natasha was sometimes, but not always, able to control her own impulses while they explored the toys together. Olivia was finally able to see Natasha's interactions as age-appropriate. During the months that followed, Maria and Olivia had many other discussions about Natasha's development. Olivia was able to understand Natasha's strengths and challenges. Eventually, Natasha was enrolled in a preschool program where she made a very easy adjustment.

## ***Conclusion***

Olivia's story demonstrates the effectiveness of a reflective videotaping technique together with a diligent, caring parent-child advocate and an on-staff mental health services manager who provides regular observations of parents and children, clinical guidance to staff, and consultation to parents. In Olivia's case, videotaping was effective because the home visitor had developed a trusting and positive relationship with the family and used every opportunity she had to reinforce Olivia's positive interactions with her children.

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## **A Change of Focus with Positive Behavior Support**

This article is based on an interview with Linda Broyles and is partially adapted from the report Program-wide positive behavior support: Supporting young children's social-emotional development and addressing challenging behavior, by Lise Fox, Susan Jack, and Linda Broyles.

Southeast Kansas Community Action Program (SEK-CAP) Head Start serves more than 800 children and families in 12 rural counties across 7,200 square miles in what is considered the most depressed area of the State. For many years, it seemed that SEK-CAP staff spent the majority of their day "putting out fires" and addressing challenging behaviors. Supervisors and program managers were constantly engaged in crisis management.

"In the past, we would call in the mental health provider or special educator," said Linda Broyles, Director of Early Childhood Programs at SEK-CAP. "They were our SWAT Team, but they couldn't fix a problem permanently."

So in 2001, Broyles contacted Susan Jack, an early childhood behavioral consultant in Kansas to see if there was a workshop that would help her teachers and program staff. Susan told Linda that a one-shot workshop was not what was needed. She advised SEK-CAP to adopt a program-wide model called Positive Behavior Support (PBS) to promote children's social competence and address challenging behavior. Staff training would be an essential piece of the effort, but much more would be needed for sustained change to occur.

The SEK-CAP model represents one of the first program-wide applications of PBS within a Head Start program. Implementing the model involved change on all levels including policy, administrative practices, allocation of resources, relationships with community partners, staff training, professional development, technical assistance, staff support, classroom practices, and partnerships with families.

### ***What is Positive Behavior Support?***

Positive Behavior Support (PBS) is an evidenced-based intervention approach that is based on an understanding of the cause or purpose of children's challenging behavior and a focus on teaching them new skills to replace the behavior.

PBS is based on research and humanistic values. It offers a method for identifying the environmental events, circumstances, and interactions that trigger problem behavior, the purpose of the problem behavior, and the development of support strategies for preventing problem behavior and teaching new skills (Fox, Dunlap, & Cushing 2002). The focus of PBS is to help the child develop new social and communication skills, enhance relationships with peers and adults, and experience an improved quality of life (Fox et al. 2003).

### ***The Teaching Pyramid***

To implement PBS, SEK-CAP adopted The Teaching Pyramid, a process for promoting children's social and emotional development and addressing their challenging behavior

(Fox et al. 2003). The framework involves four levels of classroom practices that represent prevention, promotion, and intervention.

At the foundation of the pyramid is the development of positive relationships with children, families, and staff. The second level is the use of classroom practices that prevent problem behavior, support the engagement of all children, and support the development of social skills. For many children, the first two levels may be enough to support their healthy development.

However, some children may need intentional instruction in social skills, social problem solving, emotional literacy, friendship development, and anger management. The next level of the pyramid, social and emotional teaching strategies, addresses the needs of these children.

The top level of the pyramid includes the use of individualized positive behavior support interventions for children who have the most persistent challenging behavior. Even when all other levels of the pyramid are in place, some children will need an individualized behavior support plan that includes prevention strategies, the instruction of replacement skills, and guidance on how to respond to problem behavior so that it is not maintained.

### ***Comprehensive Professional Development***

“Teachers are teaching socio-emotional strategies for life, but we discovered that adults, including educators, didn’t always have those skills. So we had to teach the adults first,” said Broyles.

To implement this model, SEK-CAP reconfigured its professional training. A PBS leadership team has been established to identify the training needs of staff and to plan in-service time across the program year. Initially, classroom teaching staff were trained in the core components of the teaching pyramid and how to implement these strategies in their classrooms. Refresher trainings were provided at regular intervals to address any challenges they faced or to update information. Over time, training has been extended to include:

- all center-based staff
- home visitors
- PBS facilitators trained to support teams

### ***IMAGE: The Teaching Pyramid Model***

From: Fox, L., G. Dunlap, M.L. Hemmeter, G.E. Joseph, & P.S. Strain. 2003. The teaching pyramid: A model for supporting social competence and preventing challenging behavior in young children. *Young Children*, 58 (4):48-52.

There are four tiers.

Tier 1: Intensive Individualized Interventions

Tier 2: Social and Emotional Teaching Strategies

Tier 3: Classroom Preventive Practices

Tier 4: Positive Relationship with Children, Families, and Colleagues

## IMAGE COMPLETE

In the SEK-CAP program, all classroom staff are focused on teaching children the emotional and social skills they need to express their feelings, solve conflicts with peers, and develop friendships. In each of the classrooms, teachers carefully plan activities (sharing books, discussions, art projects, songs, etc.) that help children learn these concepts. Most importantly, all of the classroom staff look for moments throughout the day when they can guide children to use these skills in their interactions with adults and peers.

### ***Key Partnerships***

“It is also very important to share successes with community partners,” said Broyles. “If we happen to find a system of supporting children and families that works, we should be good neighbors and share the news with the rest of our early learning community.” SEK-CAP has relied on meaningful partnerships with families, child care providers, mental health teams, and special services staff to extend this work beyond the classrooms. This has been accomplished through joint training opportunities, planning/problem solving, and team-based support for individual children. Families have been asked to participate in family-focused training programs as well as be members of the collaborative team that will develop support plans for their children.

SEK-CAP has 19 center partners who serve 51 Early Head Start children alongside nearly 300 non-EHS infants and toddlers, all of whom have benefited from the PBS approach.

Both state and Federal funds support SEK-CAP’s mental health component. SEK-CAP has formed collaborative partnerships with community mental health agencies to provide services. In Kansas, where there were few early childhood mental health professionals, SEK-CAP developed that capacity in its communities through joint training opportunities with the community mental health agencies.

### ***A Change of Focus***

The role of mental health consultants with SEK-CAP has drastically changed over the course of this initiative. Prior to PBS, most of the money the program spent on mental health services was devoted to intervention. Now, mental health dollars have shifted to prevention with just a small portion dedicated toward intervention. Mental health providers are actively engaged in supporting the social and emotional development of Head Start children through skill development and ongoing instruction.

### ***Continuous Improvement***

Since the introduction of PBS in 2001, SEK-CAP has met its initial goals of building program expertise, decreasing episodes of child challenging behaviors, reducing referrals to outside experts, and improving staff satisfaction. SEK-CAP is committed to continuous improvement and innovation. In the future, the program plans to offer PBS training to every enrolled family; offer a class on PBS for college credit at a local community college; conduct community-wide PBS strategy sessions; and become a training site for other early childhood programs.

For more on the Teaching Pyramid, see the article referenced below: “The teaching model: A model for supporting social competence and preventing challenging behavior in young children” in *Young Children*, 58(4): 48-52.

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## Promoting Positive Behavior in MSHS

The Oregon Child Development Coalition (OCDC) is a Migrant and Seasonal Head Start (MSHS) serving 2,500 children in 29 centers throughout the State of Oregon and an additional 250 children in state-funded pre-kindergarten. Three years ago, OCDC began implementing a system-wide approach to addressing children's challenging behaviors.

After receiving training from the Center on the Social and Emotional Foundations of Early Learning (CSEFEL), OCDC central office staff developed a system-wide model called the OCDC Positive Guidance Program Directive. OCDC's model is based on the Teaching Pyramid and adapted to meet the needs of migrant children and families (see the article "A Change of Focus: Positive Behavior Support" in this Bulletin).

Now in the second year of a 3- to 4-year implementation plan, the initial focus has been on the first two levels of the Teaching Pyramid — development of positive relationships with children, families, and staff and classroom preventive practices. The current phase involves the implementation of a defined process for response to challenging behaviors, which incorporates teaching social skills to the children and providing positive behavior support.

At the outset, OCDC's biggest challenge was finding qualified mental health consultants who were bilingual or bicultural, experienced in early childhood, and available to work in rural communities. Finding qualified mental health providers, like recruiting families, is a continuous process of outreach to every community partner, such as other Head Start programs, education agencies, health organizations, the existing network of consultants, and local colleges and universities. Thanks to these efforts, competent mental health consultants have been identified.

OCDC's mental health services are funded with MSHS dollars, with a few exceptions. In one county, the program partnered with community agencies to pay for mental health services through a State Improvement Grant. In other parts of the State, some consultants bill Oregon's healthcare program for low-income children and families. And several community mental health programs provide discounted or matching services.

The program is currently developing additional trainings and information for its family service teams and parents. Eventually, OCDC would like to provide additional supports for staff around developing and implementing positive behavior support plans.

Staff from OCDC were interviewed by My Linh Nguyen of the Head Start Resource Center.

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## Early Intervention at Oneida Head Start

by John Pavek

The Oneida Tribe of Indians of Wisconsin Head Start program had been in need of support services to address the social and emotional needs of the children. When a new director, John Pavek, took over a few years ago, he forged a new collaborative approach, drawing on the expertise of the Tribe's Early Intervention and Behavioral Health programs. Now the children, families, and staff are benefiting from these partnerships.

The Early Intervention program includes a nurse, two occupational therapists, three speech pathologists, and an exceptional educational needs (behavioral) specialist. Mental health consultation is provided through a specialist from the Tribal Behavioral Health program. The Early Intervention program is funded by the Bureau of Indian Education. Head Start pays a discounted rate for the mental health specialist from the Tribal Behavioral Health program, which also offers a range of services to the Tribe's families.

The Early Intervention program and the mental health specialist work in tandem with the Head Start program to provide preventative training for Head Start teachers to help them deal with challenging classroom behaviors. For example, specialists train teachers on techniques to teach basic social skills to children that in turn help the children avoid frustration and conflicts. The specialists work with staff in the classroom, provide observations, and make recommendations for classroom management. They also provide skills training to parents.

In addition to the preventative approach, a multi-tiered intervention approach ensures that children's mental health needs are identified and addressed or treated as early as possible. The approach includes:

- Monthly child staffing meetings. Staff, including teachers, family service workers, educational supervisors, health specialists, the mental health specialist, and the Early Intervention behavioral specialist, meet monthly to discuss the development and behavior of every child. When there are concerns about the child, the team develops techniques that teachers can use in the classroom to address the specific challenging behavior.
- In-house referral system. When changes in the classroom are not enough, the mental health specialist is asked to observe the child and work with the teaching staff and family to develop appropriate interventions.
- External referrals. When the Head Start staff and mental health specialist recognize that a child needs more mental health expertise than they can offer, the program may refer the child to its community partners, such as the school districts, the counties, the state of Wisconsin, and the Great Lakes Tribal Council.

Since the comprehensive mental health approach has been in place, teachers have become more confident in their classroom interactions. Teachers know that they are not working in isolation to address the mental health needs of children. And all Head Start staff know that the surrounding community is a partner in providing mental health services in the best interest of the children.

The Oneida Tribe's Head Start program has a center on the Oneida reservation and another in the city of Green Bay. The program serves 108 Federally-funded Head Start children and 15 state-funded children.

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## **Nurturing the Nurturer**

by Dale H. Saul and Brenda Jones Harden

Dropping her keys and heavy toy bag on her desk, Alissa heads toward her supervisor's open door. Sticking her head in, she asks, "Got a minute? I was just at Keisha's—"

"How's she doing?"

"Never got off the couch, just like our last three visits. Jason came over with a book, and she pulled a pillow over her head!"

"And you've been trying so many things. Is the mental health specialist still here? Would you want to see if he can join us?"

Maria has worked in the Panda classroom only five months. As the staff meeting begins to wrap up, she hesitates, then raises her hand. "I know I talked about this last time, but it's Julia's bottles again—sour, twice this week. Her mom was so apologetic when I talked to her, but nothing's changed. ..."

"Maria," another teacher says, "Why don't you call me next time her mom comes in? Her son's in my classroom. Maybe we could talk with mom together."

Scenarios such as these underscore the challenges Head Start and Early Head Start (EHS) staff face, as well as ways they can receive informal and formal support in their work.

When staff reach out to families, they count on relationships to open the door to conversation. Ideally, families see staff as informed, helpful professionals. For staff to build and maintain these relationships, their own needs must also be met. This is especially true when addressing parents' mental health needs and crises.

How do we nurture caregivers who support high-risk families with young children? The first step is to identify staff's general and individual needs. The second step is building a strong organization, not only to ensure that program missions are achieved, but to provide a healthy environment for staff. The last step is implementing strategies that provide ongoing nurturing experiences for staff.

### ***Needs of Caregivers***

**Stress management.** Serving high-risk families can be hard work. In this high-stress environment, some staff may experience stress-related health problems, such as bad backs, migraines, and high blood pressure. For some staff, securing time in a busy schedule to address work stress, time management, and accountability can improve their productivity and availability to families.

**Setting Boundaries.** Passionate about the well-being of children, staff often have years of experience in community child care agencies. Some EHS and Head Start staff had their children in the program; most are women. Head Start emphasizes having staff who are representative of the community. While this emphasis facilitates participant engagement, it may also contribute to the difficulty staff encounter in maintaining appropriate boundaries with the families they serve. Issues can arise when staff, who have strong

feelings about what worked and what did not in their own lives, encounter families with similar issues.

**Professional Development.** Many caregivers have not had mental health or family studies training. They may require specialized training and consultation to understand how a child's overall development and social and emotional health are impacted by a parent's mental health.

One home educator said after a training on depression: I appreciate the mental health stuff 'cause I see so much of it with my families—it looks normal, but it's not. Now I see it's not just poverty, it's what's keeping them where they are—or what got them there in the first place (EHS focus group, University of Maryland 2004).

### ***Supportive Environment***

How can organizations provide a supportive environment? In the relationship-based organization, relationships among staff and between staff and families are based on trust, empathy, and responsiveness.

**Organizational Structure.** Regular staff meetings and supervision enhance staff's connection to the agency and their internalization of the organization's service mission. Clearly defined agency expectations (mission, goals, job description) are essential for staff to know their jobs and improve their skills. The pay-off for revising organizational structure, practices, and goals to support staff is in the parallel process. Experiencing support from peers and supervisors enables staff to support families more effectively. Parents, in turn, can then support their children through trust, empathy, and responsiveness.

**Reflective Practice.** A key element in parallel process is reflective practice, which can be achieved through reflective supervision at all levels of the organization. Reflective supervision moves beyond staff accountability and case management. It provides the opportunity to slow down and review events and dynamics in a non-crisis mode. It can be "a bubble of peace in a crazy work week" (EHS focus group, University of Maryland 2005).

Through reflective supervision, staff can become more attuned to child and parent psychological functioning, address their own boundary issues, and think about how they can best promote positive child and family development. Staff can explore the impact families and children have on them and the impact they, in turn, may have on families and children. Working reflectively helps to address the recurring challenges families present and "face the unthinkable," such as suspected child abuse, neglect, and domestic violence. (For more information on reflective supervision see the Steps to Success Unit 3: Reflective Practice Mentor-Coach Manual available at the Early Childhood Learning and Knowledge Center at <http://eclkc.ohs.acf.hhs.gov/>)

**Resources.** Successful intervention with high-risk children and families requires the collaboration of many service providers. Head Start staff should always have an up-to-date referral list, screened by the supervisor, in order to feel confident in making referrals. Consultation from a variety of disciplines (e.g., disability, employment) is important to appropriately address family and child development. In particular, staff need

ready access to a welcoming mental health professional who can provide guidance to staff on young children's behavioral and emotional issues and on parental mental health.

**Staff Training.** Training should focus on specific competencies for a particular job as well as specialized areas, such as maternal depression. Training is enhanced if it is experiential and concrete, occurs in a small group, and utilizes multimedia formats (such as videotapes of staff working). Information and skills acquired through training can be sustained only through ongoing mentoring, supervision, and professional development. Importantly, opportunities should be created to enhance and share professional knowledge through informal and formal peer interaction.

### ***Strategies for Nurturing***

What are specific ways that management can nurture the nurturer?

- Incorporating workshops on stress management and self-care, physical exercise and psychological healing into staff development, promotes general well-being. Mental health consultants should be available for addressing staff concerns and experiences that could affect their work.
- Adhering to safety protocols shows acknowledgment of the risks staff face and their importance to the agency. For home visitors, there should be a system for knowing where staff are, accompanying home visitors to new families, and assigning teams, rather than individuals, to work in more dangerous communities and with more difficult families.
- Providing “mental health days” as part of leave acknowledges the difficulty of dealing with job stress and simultaneously encourages more appropriate use of sick leave.
- Acknowledging staff effort and sharing examples of expertise in supervision during staff meetings, in newsletters, and to funders, demonstrates to staff that what they do is valued. Having a journal or box where staff accomplishments are recorded and shared encourages managers, supervisors, and peers to document staff's positive interactions and interventions with program participants.
- Conducting periodic “retreats” away from the agency provides an opportunity for staff to reflect on their work, get recharged, and reconnect with the overarching mission of the agency.

### ***Summary***

Enhancing Head Start's capacity to address the mental health of participant children and families is rooted in the support of their caregivers, the front-line staff. Understanding and addressing their needs promote the parallel process that facilitates their responsive intervention with families and children. An emphasis on staff nurturing within ongoing professional development and organizational activities improves staff morale and staff capacity to deliver effective interventions. Applying these principles enables Head Start programs to move closer to their mission to enhance the overall development of children and families.

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# Creating a Supportive Work Environment

by Jean Simpson

A nurturing work environment values and supports its child care staff.

How do we assure a nurturing environment that is supportive and shows child care staff they are valued and appreciated? Towards that end, an informal survey of preschool (including Head Start) staff was conducted in 1999 by the Head Start Bureau. Comment sheets were distributed to 125 teachers, child care coordinators, and program specialists, representing African American, European American, Native American, Hispanic, and Asian origins. Eighty of the 100 who responded indicated that feeling valued as an employee is very important to them. The results were presented at the National Head Start Conference in 1999. The findings still hold true today.

The respondents specified numerous circumstances when they feel valued:

- Supervisor listens to an idea, gives feedback.
- Valuable work is assigned.
- Competence, skill, and a job well done are recognized and acknowledged.
- Colleagues request assistance.
- Difficult task is accomplished by collaboration with co-workers.
- Children learn or express positive feelings, such as letting child care worker know they like/miss her.

Circumstances in which staff felt valued helped to influence and affect their performance. Staff reported they were:

- Energized, enthusiastic; investing more time and effort into their work
- Motivated; more willing and able to help others
- Happier; more confident, better able to perform their job
- Comfortable; experiencing less stress
- Seeking challenges and wanting to experience growth
- Feeling loyal, dependable; supportive and interested in organization's success
- Deriving a sense of value from within themselves, not from others

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## **Being an Effective Mentor-coach**

by JoAn Knight Herren

A Mentor-Coach is a journey guide—someone who walks beside another on her journey. Mentor-Coaches support professional development and work to build excellence in the daily practice of teaching staff. Teachers benefit from the support they receive from a more experienced professional who helps them reach their goals and share their challenges. How do Mentor-Coaches do their work?

### ***Getting Started***

In the beginning, they build trust and develop a positive, non-judgmental relationship with their protégé. They must set aside time for learning about the protégé. As an introduction and to set the tone, the Mentor-Coach could share her own story about a past learning experience that was meaningful. Or she could ask open-ended questions that encourage dialogue, such as, “What is one thing that you like to do or care about that most people don’t know?” or “What is an environment that made you feel really comfortable and happy when you were a young child?”

The answers help Mentor-Coaches better understand the protégé as a person, give insight to what she was like as a child and what her beliefs and goals might be about the children and families in the Head Start program. Open communication lays a strong foundation for the Mentor-Coach/protégé relationship.

### ***Working as a Mentor-Coach***

Similar to how early childhood teachers individualize the curriculum to meet each child’s needs, Mentor-Coaches individualize their support to fit the protégé’s unique strengths, needs, and learning style. Individualizing support is a collaborative process, which includes planning, discussing, trying out, and reflecting together. Approaching the relationship with openness and sensitivity regardless of age, sex, racial/ethnic background, language, or origin enhances a Mentor-Coach’s ability to offer support and adds richness to the relationship.

The role of a Mentor-Coach is to be a catalyst for individual growth by engaging the protégé in dialogue and problem solving that challenges the protégé to stretch herself. The Mentor-Coach helps the protégé come to her own conclusions through reflective inquiry. It is not necessary for the Mentor-Coach to have all the answers; sometimes it is best just to listen carefully and pose helpful questions.

It is normal for protégés and Mentor-Coaches to grapple with challenges as they experiment with what learning processes work best. Protégés will face challenges, such as a fear of failure, feelings of inadequacy, or sensitivity to criticism, which may hinder them as they work to achieve their goals and experiment with new practices. These challenges are “growing pains” that are a natural part of learning and experimentation.

One successful approach to these challenges is appreciative inquiry. The Mentor-Coach starts by showing appreciation for what she notices the protégé is doing well and then uses inquiry — in a non-threatening way — to query how things might be done differently. For example, the Mentor-Coach and protégé discuss a teaching strategy the

protégé is using and then consider how it may be improved. This is a positive, non-judgmental approach which enriches and helps secure a trusting relationship. At the same time, the Mentor-Coach learns more about the reasons behind the teacher's behavior and has a greater understanding of the teacher's thinking which helps inform the mentoring process. For appreciative inquiry to be successful, Mentor-Coaches and protégés must share a common goal—to help the teacher be as effective as possible.

### ***Engaging the Protégé***

Effectively engaging the protégé may come in the form of a wide variety of mentor-coaching activities, such as written exercises, shared reading, videotaping of classroom teaching followed by discussion, and role-playing. Presenting a scenario—perhaps based on one of the protégé's concerns—and asking her to identify a solution can effectively build upon the protégé's ability to reflect and make decisions.

Another activity is to ask protégés to write a poem, song, or short creative-writing piece about their vision of effective teaching and then work together to strategize how to effectively apply their vision in the classroom.

### ***Supporting the Mentor-Coach***

It takes a lot of energy, dedication, and hard work to engage the protégé. To do so, the Mentor-Coach must tap into a deep well of creativity and emotion, which must be refilled daily. It helps to find nourishment in a personal way, such as by meditating, reading, singing, or exercising. Also, setting aside time to reflect on mentor-coaching and to plan new approaches keeps the process fresh, interesting, productive, and satisfying.

Early on, establish clear expectations for your relationships with protégés. (Many protégé and Mentor-Coach pairs find it helpful to write these expectations down.)

- Give a brief overview of the mentor-coaching process.
- Ask your protégé if she'd like to start keeping a shared journal. Doing so will give her the chance to reflect on her teaching and respond to your questions in writing, if that is her preference. Discuss possible topics and frequency of entries.
- Make a plan to meet regularly whether on the phone or in person. Encourage your protégé to help you set an agenda for your next meeting.
- Reinforce that your conversations are confidential.

Throughout, ask questions and encourage your protégé's active involvement in the process:

- Discuss ways to develop a reciprocal relationship and treat her as an equal partner who brings unique strengths.
- Support and encourage your protégé to make positive changes by sharing relevant knowledge and resources.
- Encourage your protégé to talk about how he or she learns best and try to adapt your approach to meet the needs of the protégé.
- Invite your protégé to share her professional goals and relevant ideas about teaching early childhood education.

- Encourage her to identify any issues and interpersonal professional needs that she is facing.
- Set aside time on a regular basis to make classroom and home visits with your protégé.  
Lastly, remember that building a learning relationship is a process:
- Reflect on how you talk with your protégé on an ongoing basis and make changes as needed. For example, do you ask open-ended questions that encourage her to share?
- Experiment with different approaches and make changes to improve the relationship to build upon her strengths and interests.
- Ask a colleague to do a role-play with you and pretend to be the protégé. Then, ask your colleague to give you feedback on your communication style.
- There will always be room for improvement, but remember to pat yourself on the back for any progress that you have made.

## ***References***

U.S. Department of Health and Human Services, Office of Head Start. STEP-Notes 2. Washington, D.C.

U.S. Department of Health and Human Services, Office of Head Start. STEP-Notes 3. Washington, D.C.

U.S. Department of Health and Human Services, Office of Head Start. STEP-Notes 4. Washington, D.C.

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## Employee Assistance Programs

What happens when staff face personal problems so great that the problems begin to adversely affect how they do their jobs? Many Head Start programs turn to an Employee Assistance Program (EAP) for help. EAPs provide confidential assessment and short-term counseling to employees and their families to help them cope with issues, such as marriage and family problems, stress-related problems, financial and legal difficulties, and psychological and workplace conflict.

At one urban Head Start program, teachers became concerned, and even alarmed, when a beloved teacher who had been with the program for more than 10 years began to lose her temper with children, families, and staff. The teacher was known for her sweet, easy-going demeanor and near-perfect attendance, and it was a surprise to everyone when she began to miss many days of work.

Her fellow teachers were so concerned for her well-being that they brought the situation to the attention of a Head Start manager. The manager sat down with the teacher and listened as the teacher talked about the problems that had been plaguing her. Her adult son was struggling with mental illness and was displaying inappropriate behavior. Under the weight of this stress, the teacher had recently suffered a mild heart attack. And it was this stress that was causing her to miss work and to lose her temper so easily.

When the manager learned that the teacher was trying to cope with these problems on her own, the manager suggested that she turn to the program's EAP for counseling. The teacher was initially reluctant to go to counseling, fearing that she might be labeled "crazy." But after being assured that it was common for people to seek confidential counseling during difficult times, the teacher agreed to talk to an EAP counselor on a regular basis. Over time, she learned to manage her stress and to perform effectively on the job. The EAP program served her well and helped the Head Start program retain a valuable employee.

For more information on how a Head Start program can benefit from an EAP, please see the article "The Best for Your Employees: What an EAP Can Do" in the Head Start Bulletin on Adult Health, Issue 75, published in 2003, available at the Early Childhood Learning and Knowledge Center at <http://www.eclkc.ohs.acf.hhs.gov/>.

## WEBliography

The following is a sample of Federal agencies and national organizations that have information about early childhood mental health, professional development, and general mental health topics.

<http://www.aap.org/mentalhealth>

AMERICAN ACADEMY OF PEDIATRICS' mental health Web site has resources on mental health, including state and local programs and links to Federal resources and children's mental health organizations.

<http://www.childrensdefense.org>

CHILDREN'S DEFENSE FUND MENTAL HEALTH RESOURCE KIT is designed to help promote access to state mental health screens and assessments for children. The Kit contains fact sheets, action strategies, and resource guide. Go to the Web site and search for "Mental Health Resource."

<http://www.connectforkids.org/node/3003>

THE CONNECT FOR KIDS EARLY CHILDHOOD (0-5) MENTAL HEALTH AND DEVELOPMENT TOOLKIT includes links to fact sheets, trainings, and Web sites covering topics such as child development, intervention, and prevention.

<http://www.nctsnet.org>

THE NATIONAL CHILD TRAUMATIC STRESS NETWORK provides resources for parents, caregivers, and educators including informational guides, statistics, and breaking information aimed at raising the standard of care and increasing access to services for traumatized children and their families.

<http://www.nimh.nih.gov/healthinformation/childmenu.cfm>

NATIONAL INSTITUTE OF MENTAL HEALTH: CHILD AND ADOLESCENT MENTAL HEALTH. This comprehensive site covers mental disorders, treatments, materials, research, and news topics on child and adolescent mental health.

[http://gucchd.georgetown.edu/programs/ta\\_center/index.html](http://gucchd.georgetown.edu/programs/ta_center/index.html)

THE NATIONAL TECHNICAL ASSISTANCE CENTER FOR CHILDREN'S MENTAL HEALTH provides publications, training, and technical assistance to promote service delivery systems for children with mental health needs and their families.

***The resources listed below are directly related to articles in this Bulletin.***

### **Mental health resources to help children deal with violence and trauma**

<http://www.naeyc.org/ece/critical/violence.asp>

THE NATIONAL ASSOCIATION FOR THE EDUCATION OF YOUNG CHILDREN has created a resource page with reports and guidance on preventing violence and helping young children cope with violence.

<http://www.connectforkids.org/node/392>

CONNECT FOR KIDS created Help with the Healing on the Web after high-profile

school shootings and the 9/11 attacks. The Web site provides resources for parents and caregivers to help children cope with trauma, violence, and loss.

[http://www.aboutourkids.org/articles/talking\\_kids\\_about\\_school\\_violence](http://www.aboutourkids.org/articles/talking_kids_about_school_violence)  
THE NEW YORK UNIVERSITY CHILD STUDY CENTER'S Talking to Kids about School Violence resource page provides links to articles and guidelines to help parents, teachers, child care workers, and others support children exposed to violence and trauma.

### **Resources to support loss and grief**

<http://www.adec.org>  
ASSOCIATION FOR DEATH EDUCATION AND COUNSELING is an interdisciplinary organization that offers educational opportunities in the field of dying, death, and bereavement.

<http://www.compassionatefriends.org>  
COMPASSIONATE FRIENDS is a national support organization for bereaved parents, grandparents, and siblings.

<http://www.hospicefoundation.org>  
HOSPICE FOUNDATION OF AMERICA offers professional development for health care professionals who assist those coping with terminal illness, death, and grief.

### **Resources for grandparents raising grandchildren**

<http://www.aoa.gov>  
THE ADMINISTRATION ON AGING Web site provides links to Federal benefit and foundation programs, information resource sites, state and cooperative extension programs, reports, and research articles.

<http://www.aarp.org/grandparents>  
AARP offers links to state resources and fact sheets, resources for job seekers, and a benefits tool to help grandparents determine if they are eligible for public and private benefits.

<http://www.gu.org/Defin8191322.asp>  
GENERATIONS UNITED/GRANDFAMILIES offers an online program directory search tool that allows users to search for local services, including child care and after-school programs.

<http://www.nassembly.org/fspc/documents/Brief20.pdf>  
THE STRENGTHENING GRANDFAMILIES THROUGH RESPITE CARE policy brief describes ways to nurture grandfamilies to allow children to flourish. It offers a listing of Federal and national organizations dedicated to supporting grandparents raising grandchildren.

### **Resources to support refugees**

<http://www.acf.hhs.gov/programs/orr/>  
OFFICE OF REFUGEE RESETTLEMENT (ORR), in the Administration for Children and Families, U.S. Department of Health and Human Services, provides resources to assist refugees in becoming integrated members of American society.

<http://www.refugeewellbeing.samhsa.gov/>

THE REFUGEE MENTAL HEALTH PROGRAM within the Substance Abuse and Mental Health Services Administration (SAMHSA) provides information on mental health consultation and technical assistance about community assessments, program development, and workshops and training programs for resettlement staff, mental health personnel, or other providers.

### **Resources on domestic violence**

<http://www.dvalianza.org/resor/brochures.htm>

NATIONAL LATINO ALLIANCE FOR THE ELIMINATION OF DOMESTIC VIOLENCE has a series of brochures available in English and Spanish to assist victims of domestic violence, including teens and immigrants/refugees.

<http://pathwayscourses.samhsa.gov/vawc/>

[vawc\\_intro\\_pg1.htm](http://pathwayscourses.samhsa.gov/vawc/vawc_intro_pg1.htm)

“IT WON’T HAPPEN TO ME: ALCOHOL ABUSE AND VIOLENCE AGAINST WOMEN” is a free online course sponsored by SAMSHA’s Center for Substance Abuse Prevention.

<http://www.ndvh.org>

NATIONAL DOMESTIC VIOLENCE HOTLINE provides assistance in English and Spanish with access to more than 140 languages. Help is available for victims and witnesses 24 hours a day, 365 days a year. 1-800-799-SAFE (7233) or TTY 1-800-787-3224.

<http://www.nnedv.org/resources/coalitions.html>

NATIONAL NETWORK TO END DOMESTIC VIOLENCE represents state domestic violence coalitions in all 50 states and the District of Columbia, as well as Puerto Rico and the Virgin Islands. The coalitions connect local domestic violence services throughout each state.

<http://www.nationalcenterdvtraumamh.org/home.php/>

NATIONAL TRAINING AND TECHNICAL ASSISTANCE CENTER ON DOMESTIC VIOLENCE, TRAUMA AND MENTAL HEALTH is designed to cultivate a deeper understanding about the mental health and advocacy needs of survivors of domestic violence and their children.

### **Resources on homelessness**

<http://www.serve.org/nche/>

THE NATIONAL CENTER FOR HOMELESS EDUCATION has links to state resources on homelessness and homeless education, including links to each state’s State Coordinator for Homeless Education.

<http://www.familyhomelessness.org>

THE NATIONAL CENTER ON FAMILY HOMELESSNESS has fact sheets and links to inform policy makers, service providers, and the public about the issues facing homeless children and families, such as housing, mental health, substance abuse, trauma, and violence.

<http://www.pathprogram.samhsa.gov>

PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS in SAMSHA supports service delivery to people with serious mental illnesses or co-occurring substance use disorders who are homeless or at risk of becoming homeless.

Substance Abuse and Mental Health Services Administration (SAMHSA) is a Federal agency tasked with building resilience and facilitating recovery for people with or at risk for mental or substance use disorders. The following are descriptions of some of SAMHSA's services and resources useful to the early childhood field:

<http://mentalhealth.samhsa.gov/>

THE CENTER FOR MENTAL HEALTH SERVICES Web site offers a mental health services locator by state, links to mental health resources, and fact sheets and reports on strengthening parenting and enhancing resilience for children.

PROMOTION OF MENTAL HEALTH AND PREVENTION OF MENTAL AND BEHAVIORAL DISORDERS SERIES offers two free training guides aimed at early childhood mental health consultation:

<http://mentalhealth.samhsa.gov/publications/allpubs/svp05-0151/>

Volume 1, Early Childhood Mental Health Consultation provides a blueprint for child care providers to use when hiring a mental health consultant.

<http://mentalhealth.samhsa.gov/publications/allpubs/svp05-0151B/>

Volume 2, A Training Guide for the Early Childhood Services Community offers a guide for trainers to use when teaching the early childhood community how to use the blueprint described in Volume 1.

<http://mentalhealth.samhsa.gov/15plus/>

15+ MAKE TIME TO LISTEN...TAKE TIME TO TALK campaign provides practical guidance for parents and caregivers on ways to strengthen their relationship with their children by spending at least 15 minutes of daily, undivided time with them.

<http://bblocks.samhsa.gov/>

BUILDING BLOCKS FOR A HEALTHY FUTURE is an early prevention program for parents and caregivers of 3-6 year olds designed to educate about the basics of prevention in order to promote a healthy lifestyle.

<http://mentalhealth.samhsa.gov/child/default.asp>

CARING FOR EVERY CHILD'S MENTAL HEALTH CAMPAIGN helps to increase awareness about protecting and nurturing the mental health of young people; foster recognition of childhood mental health problems; and encourage caregivers to seek early, appropriate treatment and services.

<http://www.fascenter.samhsa.gov/index.cfm>

FETAL ALCOHOL SPECTRUM DISORDERS (FASD) CENTER provides information and resources about FASD and also materials to raise awareness about FASD.

<http://www.ncsacw.samhsa.gov>

NATIONAL CENTER ON SUBSTANCE ABUSE AND CHILD WELFARE'S mission

is to improve systems and practice for families with substance use disorders who are involved in the child welfare and family judicial systems.

Editor's Note: The URL addresses listed in the Webliography are current as of this Bulletin's publication. Because Web sites are often updated, pages may be moved or no longer available at a later date. If a Web site that you are trying to access is no longer available, please contact the organization directly for assistance.

## **A HEADSTART BULLETIN PULL OUT: Promoting Resilience in Young Children**

Head Start children often encounter many adversities in their first five years. Some face stresses such as divorce or illness or moving, while others confront catastrophe, maybe a natural disaster or war in their homeland. Whether these experiences in their families and communities overwhelm or strengthen a child depends, in part, on his or her resilience. Researchers define resilience as a “universal capacity which allows a person, group, or community to prevent, minimize, or overcome the damaging effects of adversity” (Grotberg 1995). With resilience, children can triumph over trauma.

How do you know when children are developing resilience? What are the features of resilient children? What strengths can you identify and nurture in Head Start children?

You can use this checklist to provide a general sense of resilience in a child (Grotberg 1995). First, check the statements that describe the child. Many apply to children of all ages—all children need love and trust, and all children need to try new things. Some statements need to be interpreted differently depending on the child’s developmental level. For example, how a toddler focuses on a task or makes a plan differs from a preschooler’s approach.

After you complete the checklist, think about how you, as Head Start staff or parent, can continue to promote resilience in this young child.

Child’s Name: \_\_\_\_\_

Age: \_\_\_\_\_

### **I. Features of Resilience**

1. \_\_\_\_\_ The child has someone who loves him/her unconditionally.
2. \_\_\_\_\_ The child has an older person outside the home she/he can tell about problems or feelings.
3. \_\_\_\_\_ The child is praised for doing things on his/her own.
4. \_\_\_\_\_ The child can count on her/his family being there when needed.
5. \_\_\_\_\_ The child knows someone he/she wants to be like.
6. \_\_\_\_\_ The child believes things will turn out all right.
7. \_\_\_\_\_ The child does endearing things that make people like her/him.
8. \_\_\_\_\_ The child believes in a power greater than seen.
9. \_\_\_\_\_ The child is willing to try new things.
10. \_\_\_\_\_ The child likes to achieve in what he/she does.
11. \_\_\_\_\_ The child feels that what she/he does makes a difference in how things come out.
12. \_\_\_\_\_ The child likes himself/herself.
13. \_\_\_\_\_ The child can focus on a task and stay with it.

14. \_\_\_\_\_ The child has a sense of humor.
15. \_\_\_\_\_ The child makes plans to do things.

II. What can I do to help this child develop resilience?

Grotberg, E. 1995. A guide to promoting resilience in children: Strengthening the human spirit. The Hague: Bernard van Leer Foundation.

## HOJA DESPRENDIBLE DE BOLETIN DE HEAD START: PROMOVIENDO LA RESILIENCIA EN NIÑOS PEQUEÑOS

Los niños de Head Start con frecuencia se enfrentan a muchas adversidades durante los primeros cinco años de vida. Algunos enfrentan situaciones estresantes tales como divorcio, enfermedades, mudanzas mientras otros enfrentan catástrofes— desastres naturales o guerra en su país de origen. Sea que estas experiencias en sus familias y sus comunidades oprima o fortalezca al niño depende, en parte de su resiliencia. Los investigadores definen la resiliencia como “la capacidad universal que le permite a la persona, grupo o comunidad el prevenir, minimizar, o sobreponerse a los efectos nocivos de la adversidad” (Grotberg 1995). Con resiliencia, los niños pueden triunfar sobre el trauma.

¿Cómo sabe usted cuando los niños están desarrollando resiliencia? ¿Cuáles son las características del niño resiliente? ¿Cuáles son las fortalezas que puede usted identificar y fomentar en los niños de Head Start?

Usted puede utilizar esta lista de referencia para proveer el sentido general de la resiliencia en el niño (Grotberg 1995). Primero repase los enunciados que describen al niño. Muchos aplican a niños de todas las edades—todos los niños necesitan amor y confianza, y necesitan probar nuevas cosas. Algunos enunciados necesitan ser interpretados de forma diferente dependiendo del nivel de desarrollo del niño, tales como un niño pequeño o en edad preescolar se enfoca en las tareas o hace que un plan sea diferente.

Después de completar la lista de referencia, piense como usted, como personal de Head Start o padre, puede continuar promoviendo la resiliencia en estos niños pequeños.

Nombre del Niño: \_\_\_\_\_

Edad: \_\_\_\_\_

### I. Características de la Resiliencia

\_\_\_\_\_ El niño/niña tiene alguien que lo ama incondicionalmente.

\_\_\_\_\_ El niño tiene una persona mayor fuera de la casa a la cual le puede contar sus problemas o sentimientos.

1. \_\_\_\_\_ El niño es reconocido por hacer cosas por sí solo.
2. \_\_\_\_\_ El niño/niña puede contar con que su familia este ahí cuando la necesite.
3. \_\_\_\_\_ El niño sabe como quien el/ella quiere ser cuando sea grande.
4. \_\_\_\_\_ El niño confía en que las cosas saldrán bien.
5. \_\_\_\_\_ El niño realiza cosas con cariño que hacen que el/ella les agrade a las personas.
6. \_\_\_\_\_ El niño cree en un poder más grande de lo que se puede percibir.
7. \_\_\_\_\_ El niño esta dispuesto a tratar cosas nuevas.
8. \_\_\_\_\_ El niño le gusta tener éxito en las cosas que el/ella realizan.

9. \_\_\_\_\_ El niño siente que lo que el/ella realiza hace la diferencia en como las cosas resultan al final.
10. \_\_\_\_\_ El niño esta contento con el/ella mismo/a.
11. \_\_\_\_\_ El niño se puede enfocar en una tarea hasta terminarla.
12. \_\_\_\_\_ El niño tiene sentido de humor.
13. \_\_\_\_\_ El niño planifica para hacer cosas.

II. ¿Qué puedo hacer para ayudar a este niño a desarrollar la resiliencia?

Grotberg, E. 1995. A guide to promoting resilience in children: Strengthening the human spirit. The Hague: Bernard van Leer Foundation.