



*The Newsletter of*  
**The Indiana Association for Infant and Toddler  
Mental Health**

**From The Chair**

**REFLECTIONS**

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The results of a new survey of parents of young children birth to three commissioned by ZERO TO THREE and funded by MetLife were recently published (March 2010). The nationally representative sample was asked about their parenting experiences, influences on their parenting, and knowledge of children's experiences and development. The survey indicates that many parents have incomplete understanding of how early experiences affect young children's development. For example, the majority of parents were unaware of when young children start to experience feelings like sadness or fear or when they begin to have feelings related to self-esteem. The survey also provides details on parents' understanding of self-regulation, the topic of our current issue. See the full report at [www.zerotothree.org/parentsurvey](http://www.zerotothree.org/parentsurvey). Also in this issue, we continue to celebrate IAITMH's 10th anniversary with a perspective from former SPRANS Project Director Barbara Gibson (Alborn), who was instrumental in starting the IAITMH. Many current and former Board members will enjoy Barb's memories. Please join me in thanking Barb for all her efforts to set the stage for our current successes in supporting early childhood mental health efforts in Indiana. **Angela M. Tomlin, Ph.D., HSPP**

**Regulation and Relationship**  
**Elesia Dixon, MA, University of Indianapolis**

*Introduction*

The development of self-regulation in early childhood has become an important area of research in developmental psychology and has implications for clinical practice. *Self-regulation* can be defined as the ability to monitor and manage one's thoughts, emotions and behaviors in order to cope effectively with environmental demands (Calkins & Williford, 2009). These regulatory processes have gained more attention in early intervention programs as researchers have linked self-regulation in infancy and toddlerhood to children's school readiness and social competence during the early school years. The development of self-regulation is not an easy or straightforward progression; rather, it is a gradual and complex process that is influenced by brain development, the child's temperament, and the parent-child relationship.

*Brain Development*

The development of self-regulatory processes is greatly dependent on brain maturation. It is important to note that the areas of the brain involved in self-regulation are immature at birth and are not fully developed until late adolescence (Tarullo, Obradović, & Gunnar, 2009). Therefore, challenging behaviors that parents and providers frequently encounter in young children, including impulsivity, distractibility, and emotional outbursts, can be partially attributed to immature brain development. There are several brain regions that are involved in self-regulation, namely **(Continued on pg. 2)**

## **Regulation, continued from pg 1**

the prefrontal cortex, anterior cingulate, and orbitofrontal cortex. These three areas must be interconnected and work together for effective self-regulation to occur. The *prefrontal cortex* is responsible for more advanced attention and organization skills, including planning, following rules, reasoning, decision-making, and impulse control. The *anterior cingulate* receives signals from other areas of the brain, including the prefrontal cortex, for the purpose of integrating cognitive and emotional processes. It is involved in self-control, motivation, and problem-solving (for example, adjusting behavior when a strategy is not working). The *orbitofrontal cortex* is involved in decision-making, especially when rewards are involved.

### ***Temperament***

Many parents and providers are familiar with the concept of temperament as a way to understand children's behavior and interactions. Research has established that the development of self-regulation traits is influenced by temperament and the fit between the child and the rearing environment (Bates, Goodnight, Fite, and Staples, 2009). Temperament refers to an individual child's disposition and how he or she reacts to and copes with various characteristics in the environment. Researchers have identified several temperamental traits that are believed to be involved in self-regulation (Thompson, 2009). *Fearfulness* as a dimension of temperament refers to behavioral inhibition while in the presence of novel situations or intense stimuli. Fearful temperament has been linked to better self-control, self-regulation of aggressive tendencies, and early moral development. *Effortful control* is an executive dimension of temperament that is involved in the regulation of automatic process such as anger and fear. In addition, effortful control governs a child's capacity to plan, focus attention, and inhibit the tendency to respond inappropriately in a situation and instead respond appropriately. Children who are high in effortful control are more advanced in conscience development, positive emotional adjustment, and social competence. Conversely, deficient levels of effortful control are associated with early externalizing problems (Olson, Sameroff, Lunkenheimer, & Kerr, 2009).

### ***Regulation in context of relationships***

From birth to age three, children largely depend on their parents to help them manage their emotions and behavior (Tarullo, Obradović, & Gunnar, 2009). Parents serve as the external regulators of young children's affective and arousal states while enhancing the development of self-regulation capacities by providing guidance and support. For example, the parent may soothe or actively coach and teach the child during frustrating situations. In other instances the parent may help the child learn to "take a break" and return to a difficult task later, teach the child how to appropriately verbalize negative feelings, or coach the child to hug a stuffed animal when distressed. Parents also model self-regulation skills through their own behaviors. This is accomplished by talking out loud about his or her feelings, modulating his or her own emotions when the child is upset, and utilizing effective coping strategies. Between three and six years, children begin to assume more responsibilities for their self-regulation as their brains mature. However, parents continue to play a role in their children's development by providing a consistent, reliable caregiving environment and choosing other environments (for example, child care or preschool) that will scaffold their children's learning of self-regulatory skills.

### ***Conclusion***

Research findings regarding the development of self-regulation have relevance for early intervention providers. These findings have transferred to the development of early intervention programs that focus on developing self-regulation skills early on to prevent negative socioemotional outcomes from occurring. Future research is needed to further examine the interactions between these skills as well as other neurobiological, genetic, and environmental factors.

## Further Reading on Regulation and Relationships

Bates, J. E., Goodnight, J. A., Fite, J. E., & Staples, A. D. (2009). Behavior regulation as the product of temperament and environment. In S. Olson and A. Sameroff (Eds.), *Biopsychosocial regulatory processes in the development of childhood behavioral problem* (pp. 116-143). New York, NY: Cambridge University Press.

Calkins, S. D. & Williford, A. P. (2009). Taming the terrible twos: Self-regulation and school readiness. In O. Barbarin and B. Wasik (Eds.), *Handbook of child development and early education: Research to practice* (pp. 172-198). New York, NY: The Guilford Press.

Olson, S. L., Sameroff, A. J., Lunkenheimer, E. S., & Kerr, D. C. (2009). Self-regulatory processes in the development of disruptive behavior problems: The preschool-to-school transition. In S. Olson and A. Sameroff (Eds.), *Biopsychosocial regulatory processes in the development of childhood behavioral problem* (pp. 144-185). New York, NY: Cambridge University Press.

Tarullo, A. R., Obradović, J., & Gunnar, M. R. (2009). Self-control and the developing brain. *Zero to Three*, 29(3), 31-37.

Thompson, R. A. (2009). Doing what doesn't come naturally. *Zero to Three*, 30(2), 33-39.

Thompson, R. A. & Goodvin, R. (2007). Taming the tempest in the teapot: Emotion regulation in toddlers. In C. Brownell and C. Kopp (Eds.), *Socioemotional development in the toddler years: transitions and transformations* (pp. 320-341). New York, NY: The Guilford Press.

### SAVE THE DATE IAITMH 12th Annual Conference August 27, 2010

*Supporting Parent-Child Relationships: Treatment, Advocacy, and Research*

Riley Hospital for Children  
Ruth Lilly Auditorium  
Indianapolis, IN

**Keynote** : Tina Dorow and Beth Petinelli  
**Child Parent Psychotherapy**

#### **Break Out Sessions:**

- **Special Needs**
- **Advocacy**
- **Home Visiting**
- **CPP in Foster Care**

### TRAINING CALENDAR

IMH Task Force, May 7, 2010, contact Angie Tomlin (atomlin@iupui.edu)

Mental Health America Indiana, Annual Meeting, Recession Depression, June 4, 2010.

8th Annual Conference on Health, Disability, and the Law—Health Care Reform and children with Disabilities, June 18, 2010, IU School of Law, Indianapolis.

Darlene Kardatzke Early Childhood Mental Health Lectureship, August 18, 2010, Charles Zeanah, MD

Infant Toddler Specialist Initiative Conference, August 25-26, 2010, Ft. Benjamin Harris.

**Indiana Association for Infant and Toddler Mental Health**  
**Barbara Gibson, MS**

The Indiana Association for Infant and Toddler Mental Health (IAITMH) is celebrating its 10 year anniversary! It only seems fitting to step back in time and reflect about its roots. IAITMH grew out of a team of individuals from diverse backgrounds who touched the lives of infants and toddlers throughout the state. Infant/toddler mental health (IMH) has been recognized for decades by early intervention, mental health, and disability providers as a critical component of overall health, but many have neither had the knowledge nor skills to have a positive impact. Further, when parents have had to struggle to access and pay for their child's "medical services," mental health needs have often had to take a backseat.

What support could Indiana provide to families and caregivers? What support could Indiana provide to early intervention and disability providers having limited understanding or skills to address IMH? A collaborative effort was launched between the Indiana State Department of Health and Family Social Services Administration to increase access to coordinated community-based services for families of young children, birth to age 3 with special health care needs. Federal funding was garnered for a four year period to increase access and better coordination of medical and diagnostic services along with vital IMH training to decrease the barriers and improve the quality of care and support to infants and their families. Establishing realistic goals and creating an infrastructure were critical to assure a path that would prove to be sustainable.

Several assumptions and decisions were made in this effort to support families, caregivers, and providers.

- Supporting the target groups required not only cooperation but most importantly, collaboration of a broad representation of individuals willing to invest significant time over a couple of years. **Decision:** An Infant Mental Health Development Team (IMHDT) was formed with individuals having a vested interest.
- Maintaining active participation of members, especially large groups, for a sustained period of time would be difficult to achieve. **Decision:** Individuals were selected who had demonstrated or expressed an interest in IMH and knew, from the start the time required and the overarching goal. Members were given the flexibility to be as active as they chose and participated in the specific task group from which they would derive both the greatest personal benefit and be able to offer the most based upon their knowledge and expertise.
- Many providers working within the early intervention field had little or no experience with handling IMH issues particularly in relationship to their specific field of practice. **Decision:** The knowledge and expertise of the IMHDT members was utilized to provide guiding principles for the myriad of professionals and to design trainings to support them.
- Instituting legislative changes that might also include lobbying was not a process in which state employees could participate. **Decision:** Sustaining the efforts of the IMHDT required the establishment of an agency or organization outside of state government.

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- Projects often dissolve when funding ends. **Decision:** An infrastructure, IAITMH, was created to ensure that any processes, documents, or trainings were sustained beyond the funding period.
- Organizations in their infancy often flounder and fail within the first few years. **Decision:** Once the decision was made to establish the IAITMH, the IMHDT worked collaboratively with the Mental Health Association in Indiana (MHAI) to become a subsidiary. This alliance created a win-win situation for each organization. MHAI had now become an organization offering support not only for children and adults but also for families and their infants/toddlers. The newly formed IAITMH had the years of experience, talent, and stability of a well-respected state organization from which to draw critical leadership and support.

Much was achieved with nearly 80% active participation by the 43 IMHDT members and support from the Unified Training System. Task groups were formed, consisting of a blending of parents and early intervention professionals including a psychiatrist, developmental pediatrician, occupational and physical therapists, psychologists, social workers, professionals from higher education institutions, child care organizations, state and local agency representatives, and hospital-based early interventionists. The group diversity provided many lively discussions during which there was never a lack of opinion or perspectives. There was always a creative flow of ideas when goals were being set and programs being designed. In the end, within three short years of the IMHDT's life, team members lived a sense of urgency to leave their mark. This can, most assuredly, be seen by the team's many accomplishments:

1. An IMH Parent/ Provider Survey was conducted and results published and presented with IMH competencies on a state, national, and international level.
2. IMH provider competencies were developed and embedded within the First Steps Early Intervention System.
  1. The IAITMH was created with an initial membership of 55 people.
  2. IMH state level provider trainings were conducted and continue through the IAITMH.
3. The *Mentorship Connection* program was developed and piloted for regionalized access to a support system for a multi-disciplinary group of professionals working with infants/toddlers and their families.
4. Awareness education was provided about IMH and social emotional development in early childhood through Channels 20 (Comcast), 19 (Time Warner), and 11 (Indianapolis Public Schools).
5. Eight IMH Workshops were offered to early childhood educators, parents, foster parents, legal workers including judges and CPS, child and adolescent providers, and medical faculty.

Many of the former members of the IMHDT remain integrally involved with the Indiana Association for Infant and Toddler Mental Health. It is the founders of the IAITMH who continue to be the backbone of this organization. The future of the association will only continue to be bright with new members and new ideas and most importantly will help to make the future of our Indiana families and those professionals serving them better prepared, confident, and competent.