Mental Health Module 1

Module 1 - Where does Mental Health come from?

Outcomes

As a result of completing this module, participants will be able to:

- Build and support nurturing relationships to promote health social and emotional development;
- Develop strategies to promote resiliency within Head Start children, families, and communities; and
- Define mental health as a positive attribute rather than as the absence of mental illness.

Key Concepts

- Mental health is a positive state, not just the absence of mental illness. Head Start fosters mental health by promoting the healthy social and emotional development of every child, family and staff person.
- Building respectful, responsive, supportive relationships with children, families, staff and co-workers is a critical skill in promoting mental health.
- Some common characteristics of mentally healthy people include: curiosity, optimism, self-confidence, ability to exercise developmentally appropriate self-control, ability to cope with frustration and solve problems, and the ability to form meaningful relationships with others. Some common characteristics of mentally healthy families include: adults are in charge, children feel they belong, it is safe to express feelings and needs, change is expected, and sources of help and support are used when necessary. Head Start works to instill and confirm these qualities.
- Resilience is the ability to succeed despite adversity and challenges. Head Start supports qualities in children, families and communities that encourage resiliency and healthy social and emotional development in every child.

Background Information

A. Where does Mental Health come from?

Each child comes into the world wanting to connect with others, to grow, and to explore. **Social development** (our feelings about and expectations of relationships with others) and **emotional development** (our feelings about and expectations of ourselves) take place in the context of relationships from the very start. Newborn infants enter the world ready to be responsive and active partners with the most important people in their lives: family and other primary caregivers. As infants grow and come to know and trust the small day-to-day interactions that make up those relationships, they learn that they can affect the world and are worthy of love. The child's feelings of security, confidence, and trust blossom.

These early relationships are the foundation of continued mental health and will have a profound affect on how children come to view themselves and what they expect of other people and the world. A child who has had the positive relationships and experiences that allow emotional and social development to flourish will come to Head Start and subsequent new experiences ready to grow and learn.

B. What does mental health look like?

There are individual, family, and cultural variations in how someone who in mentally healthy feels and behaves. While there is no on definition of mental health, and while many roads can lead there, mentally healthy young children display the following characteristics:

- capacity for warm, trusting relationships with other children and adults
- positive self-esteem: a feeling that they can be effective and make things happen in the world
- developmentally appropriate control of impulses and behavior; a progressively developing ability to handle assertiveness, curiosity, and anger according to the norms of society, the peer group, and the particular setting (e.g., Head Start, playground, home)
- progressively increasing ability to express needs, feelings, and ideas with words.
- beginnings of empathy and compassion for others; deals (in a developmentally appropriate way) with loss and limitations.
- acquiring the skills to concentrate, focus, and plan as a basis for learning.

Families, like individuals with them, display characteristics of healthy social and emotional functioning. The mental health and development of a family is more than the sum of the mental health of the individuals within it. **Mentally healthy families display a great deal of diversity, but tend to share the following characteristics:**

- Adults are in charge - adult family members are leaders and models; they make and gently, but firmly, enforce rules. When parents are a couple, they value and protect their relationship in the face of the demands of life and parenting.
- Children feel valued and as though they belong - children have opportunities to participate and contribute to family life and are encouraged to spend time with and share meaningful talk with important adults.
- Communication is clear and negotiation is fair - family members are encouraged to express how they feel and say what they need.
- Change is expected.
- Outside help is used when necessary.

The nature of the relationship a child has may be the single most important factor in her emerging sense of self. Also important, however, are the unique qualities that the child brings to the relationship, for example, physical characteristics, temperament, and individual life experiences that shape expectations. As much as we would like to, we cannot guarantee that a child will have only positive experiences. **All children and families will face stressful circumstances and events.** Fortunately, we can support the development of families, schools, and communities that encourage resiliency in our children to increase the likelihood that they will rebound from stressful experiences.

C. What is resiliency and how does Head Start build it?

Resiliency is the ability to recover readily or "bounce back" from adversity and stressful events. Researchers have found that resilient children and their families share certain qualities which seem to help protect them from the damaging effects of negative life circumstances and events. A resiliency approach to supporting children and families focuses on developing and confirming those protective factors.

Historically, a great deal of research about vulnerable children and families has come from a "risk" approach. Researchers begin by identifying a group of people who share a "problem" - for example, substance abuse or juvenile delinquency - and ask ... *What early experiences does this group of people have in common."* These researchers then consider those common experiences to be "risk factors" that increase the likelihood of a problem occurring. Identified risk factors can be used to help target limited resources and direct support where it is most needed. The limitation of this approach is the focus on what goes wrong, instead of what goes right.

A more positive, strength-base perspective is the resiliency approach. Resiliency researchers have looked at very young children who share

certain vulnerabilities, for example, low birth weight or very low-income families, and studied these children over a period of time. They have discovered (and we know) that **not all children who share the same risk factors end up developing problems later in life**.
Resiliency researchers ask: *"Of this vulnerable group, what do the children who succeed have in common? What are the characteristics or protective factors that have helped these children succeed in spite of their vulnerability and/or negative life events?"*

The answers to these questions point to **"protective factors"** or qualities that resilient children share. These factors can be at the level of the individual child, at the level of the family, and at the level of the school and larger community. Every child, no matter how resilient, can develop problems. The more risk factors and negative life events a child has to deal with, the greater the threat to that child's well-being.

The resiliency approach is a hopeful and empowering one because it sets forth a road map for promoting positive results. If we, as parents and Head Start staff, expect to prevent all our children's negative life circumstances and experiences, we will often feel as though we have failed. We can not always control these things. **If we focus on how we can build and support protective factors for the individual child, for families, and for our schools and communities, we are focusing on giving children tools to successfully cope with difficulties.**

"As long as the balance between stressful life events and protective factors is favorable, successful adaptation is possible. However, when stressful life events outweigh the protective factors, even the most resilient child can develop problems. Intervention may thus be conceived as an attempt to shift the balance from vulnerability to resilience, either by decreasing exposure to risk factors and stressful life events, or by increasing the number of available protective factor (e.g., competencies and sources of support in the lives of vulnerable children)."

Throughout this guide, we will explore how Head Start can reduce risk and encourage resiliency by supporting protective factors in individual children, in families, and in the institutions that make up the larger community.

Test Questions:

1. **Social development is defined as**
   a. *how other people relate to you.*
   b. *feeling and expectations of ourselves.*
   c. *feelings and expectations of relationships with other.*
   d. *learning good manners and respect.*
2. **Displaying the capacity for trusting other children and adults, positive self-esteem, increasing ability to express needs, and skills to focus or concentrate would describe**
   a. *characteristics of mentally healthy young children.*
   b. *any young child.*
   c. *what we should expect of all children at all times.*
   d. *the ideal but unrealistic characteristics of a young child.*
3. **The unique qualities that a child brings to a relationship would include**
   a. *only those behaviors that are unacceptable and inappropriate.*
   b. *physical characteristics, temperament and individual life experiences.*
   c. *a different ethnic background from the other children.*
   d. *more efforts on the staff's part to get the child to behave like the other children.*
4. **Resiliency means**
   a. *protecting the child from any harmful events.*
   b. *that the child learns to live with a tragic event.*
   c. *completely forgetting about past events.*
   d. *to recover or "bounce back" from stressful events.*
5. **When we focus on protective factors for a child we are focusing on**
   a. *how to keep the child from any stressful event.*
   b. *giving the child tools to cope with difficulites.*
   c. *what went wrong in the child's life so we will know how to fix it.*
   d. *all the safety factors that are important in the center.*

Background Information

In the first part of this module we discovered that mental health is something that is positive and having living skills and support are a necessity for everyone. Unfortunately, many people, when you say the words "mental health" will still think in terms of mental illness. Some parents get real anxious if you talk to them about a Mental Health Professional talking or evaluating their child.

This is an attitude or a perception that we must help our parents overcome, as well as possibly making adjustments in our own perceptions. It is a necessity that our communications match the concept we are promoting - namely: mental health is positive.

We can do this by communicating to all of our parents that **mental health is as much a part of Head Start's daily activities as nutrition, health, education or any other content area.** A lot of how we do this will be through our use of words that we associate with the term "mental health". At Head Start we are not into "finding problems", we are into growth and development. Examples:

- We do not deal with "depression" in a child. We develop "self esteem".
- We do not talk about a "needy" family. We foster "family strengths".
- We do not talk about a "problem" of a child. We discuss building "resilience".

If our orientation to our children and families becomes focused on solutions rather than problems this will be communicated to parents in our everyday language. When we are consistent in this manner of perception and communications, at this point if we make a referral of a child to a Mental Health Professional, the parent will know that the real issue is not - what is wrong with my child, but what can we all do make things better.

When talking to a parent about a referral for their child to a Mental Health Professional, it may be easier to get the parent involved and cooperative in the process by communicating that we are looking for better ways to enhance the child's progress than to communicate to the parent that their child has serious problems and we are looking for a way to "fix 'em".

When we take the problem approach to a mental health referral at best we will have an anxious parent throughout the process - at worst a resistant parent or a parent who feels threatened and insulted and will refuse to cooperate. **For many parents, their self esteem is directly related to the view others have of their children.**

By taking a positive, growth oriented approach to a mental health referral we create a situation from the very beginning of our communications that involves the parent within the process that all of us at Head Start who work with their child are involved. *It may be beneficial to talk in terms of "our" child, and in terms of what "we" will do.*

Test Questions:

6. What is the error in a Teacher telling a parent, "Your child is having a problem with another child in the room."?

a. ☐ *Only a Special Services/Mental Health staff person should say this to a parent.*

b. ☐ *The Teacher will hurt the parent's feelings.*

c. ☐ *The Teacher is focusing on the problem, not the solution.*

d. ☐ *There is no error. This must be said if the Teacher sees a problem.*

7. What is the least likely reaction of a parent if we talk to the parent about a child's "problem"?

a. ☐ *The parent will be helpful and understanding.*

b. ☐ *The parent will be anxious.*

c. ☐ *The parent will be resistant.*

d. ☐ *The parent will be threatened.*

8. The Mental Health or positive approach to communications with families emphasizes

a. ☐ *how we are all part of the solution.*

b. ☐ *a clear understanding of the problem.*

c. ☐ *what will be necessary to "fix" the child.*

d. ☐ *that only the Special Services/Mental Health staff can handle the child.*

1-c, 2-a, 3-b, 4-d, 5-b, 6-c, 7-a, 8-a