UAIMH Newsletter

Utah Association for Infant Mental Health

(Issue 16, Fall 2011)

Editor: Judith Ahrano Kittel
Technical Editor: Mary Ellen Heiner

http://www.uaimh.org

President's Corner

Tribute to Agnes (Agi) M. Plenk

As the 2011-2012 season of professional conferences begins from *Critical Issues Facing Children and Adolescents* to *Bridging the Gap* to our UAIMH spring conference on *Reflective Supervision*, my thoughts turn to Agi Plenk.

In the 1950s, Dr. Plenk had a vision to impact society's blindness or reluctance to see the emotional suffering of young children. While working in academic medicine as senior psychologist in the Department of Psychiatry at the University of Utah and in private practice, she saw greater need in the community. She held fast to her dream of developing an effective treatment model and center to improve the emotional social well-being and behavior of young children. She had trained in the psychoanalytic theory in Vienna and at the Chicago Psychoanalytic Institute and sought other developmental theories and educational models, which could better fit and reach more children and parents. She founded The Children's Center in 1963 and remained the director until 1986. A strong training and supervision model was part of the agency's foundation. She often graciously credits the agency's success to her staff.

Today, we wish to pay tribute to Agi for her vision, which she made a reality: changing the lives of young children and their parents through establishment of Children's Center and consultation in the community. In addition, many of us also wish to thank her for providing the stimulating, learning environment in which training and mentorship occurred and professional foundations were laid.

> *"The therapist often discovers he or she has the same fears and conflicts as the patient..."*

In her book, *Helping Young Children at Risk: A Psycho-Educational Approach,* Dr. Plenk described the philosophy, theories, techniques, and nuts/bolts of The Children's Center. She touches briefly on the procedures for training and supervision and wrote, "Ideally, these were freewheeling discussions and not didactic sessions." I want to expand on her statement and add my perception. My supervision experience with Agi and the other clinical staff was based on support, knowledge, and empathetic reflection while addressing the practical, the search for deeper understanding of the child and parent, as well as the feelings and thoughts of the therapist engaged in the work. Does that supervision process sound familiar? Yes, I think Agi's supervision was what is now described in the literature as *reflective supervision*.

In a recent consultation with Agi, she had these reflections on therapy. "The therapist often discovers he or she has the same fears and conflicts as the patient and if the therapist explores and understands his or her own feelings as human and usable, it turns from theory to practice. The process can be comforting and helpful, yet not easy and maybe painful. The therapist must relate as a human being. Often we put the patient in a box and try to maintain our ideas, which can be academic, dry and intimidating. Often we think theories remain outside ourselves, but they don't. Theories are absorbed into the therapist's thinking and way of living.

Contents

(continued...)

[With this absorption] the therapist becomes more human with the patient. The theory is brought into daily practical life as the therapist speaks to the patient in everyday language as he or she helps the patient solve the difficulties in life…In terms of children, the child needs to be accepted, always accepted and not rejected for a behavior seen as inappropriate or upsetting to the parent [the parent always stays present in the relationship]. The negative behavior is just a happening not a sickness. The adults need to look at what they were doing when the inappropriate or disturbing behavior occurred."

I asked Agi if her unyielding determination to act on behalf of young troubled children and establish The Center, had roots in the WWII atrocities and Henry and her escape from Europe. She answered, "No. It came from my father. He had a capacity to analyze quickly, formulate ideas, write, and act. He was a newspaper reporter…my mother was the practical one. I took in strengths from each parent. I appreciate more and more the strengths and weaknesses of my parents and brother. My sportiness came from my brother…. My parents often had interesting visitors to our dinner table for intellectual, political, and cultural discussions…. I am sure at times I was a challenging child to parent."

When asked about the current world and national situation, Agi responded, "It will be interesting to see what is left in 5 years." This sounds like a call for greater commitment and advocacy in our work. She adds, "A sense of humor is the healthy helper in looking at and accepting fear and conflict in ourselves, our patients, and general involvement in people's lives."

"A sense of humor is the healthy helper in looking at and accepting fear and conflict in ourselves, our patients, and general involvement in people's lives."

Since her husband's death in March of 2011, Agi has even more time to ponder the emotional and social needs of others and has expanded her thinking into the world of older individuals and the kind of living situations and care needed. Hence, she continues to analyze, formulate ideas, and discuss solutions while in her 95th year of living.

We honor you, Agi.

Reference

Plenk, A. M. (1993). *Helping young children at risk: A psycho-educational approach*. Westport, CT: Greenwood.

Readers are referred to The Children's Center's website www.tccslc.org to the Founders Corner and the Agnes Plenk Endowment Fund.

Susan Dickinson, MS
President of UAIMH
Utah Department of Health/CSHCN
Pediatric Psychology
South East Early Intervention Program
Consultant for Reflective Supervision
Former employee of The Children's Center

Nurturing Communication Development

The development of communication skills begins in infancy, before the emergence of the first word. Any speech or language problem is likely to have a significant effect on the child's social and academic skills and behavior. The earlier a child's speech and language challenges are identified and treated, the less likely it is that problems will persist or worsen. Early speech and language intervention can help children be more successful with reading, writing, schoolwork, and interpersonal relationships.

Early identification of speech and language deficits can alter the course of development by recommending effective interventions. Research indicates that the more talk young children are exposed to early in life, the better off they will be cognitively, socially and emotionally.

(continued...)

There are many aspects of communication to evaluate in determining whether a child is at risk for developing a speech and language disorder. These include means of communication, oral motor coordination, speech production, language, and emergent literacy.

The ability to communicate to meet a variety of needs is a milestone for all communicative development and an indication of prognosis in young children. As early as birth, it is possible to assess the infant's intention to communicate, via vocalizations, eye gaze, physical posture and demeanor, for the purposes of gaining attention, communicating rejection or offering continued affirmation. Increasingly, research has demonstrated a relationship between the early use of communicative means (gaze, gestures, vocalizations, words) and later language skills in children with developmental delays and those with autism spectrum disorders.

"As early as birth, it is possible to assess the infant's intention to communicate...."

Coordinated oral motor patterns are a predictor of positive feeding/swallowing skills and research suggests that it is reasonable that strengthening vocal behavior patterns in nonverbal activities at a young age may be helpful in the development of finer control for speech. Sound production skills not only provide information on the child's current level of function but also can assist in predicting the child's future ability to produce speech and language. By 16 months of age, children should be using a larger percentage of consonants than vowels, and babbling should contain more than one syllable.

Language comprehension skills in the second year of life are a significant predictor of later comprehension in both typical and atypical development. Looking up and or orienting to sounds, to his or her name being spoken, and following simple one step directions are positive indicators of intact comprehension.

Vocabulary growth is an important component of the child's overall development and is critical to both communication development and later academic growth. The child's acquisition of new words is influenced not only by sensory and cognitive systems but also the child's experiences, the input language, and the sociocultural influences that surround the child. A traditional "red flag" for 24-month-old children has been the failure to have an expressive vocabulary of 50 or more words and/or 2-word combinations. The size of the child's vocabulary is important, however, there is a stronger indicator of positive outcome if one takes a collective view of all developmental domains involved in interpersonal communication.

Emergent literacy refers to the behaviors and concepts learned by young children that precede and develop into conventional literacy. Early indicators of emergent literacy include scribbling on paper as if writing, pointing to recognized letters and logos, recognizing words on packages or signs and engaging in shared reading. Young children who demonstrate interest in shared storybook readings and other literacy-related activities are more likely to greater achievements in language and literacy development throughout the early school years compared with children with low interest.

Understanding the young child's behavioral and emotional problems and the relationship to communication is equally important. Current research supports a causal pathway that behavioral and emotional problems identified at age 2 years are attributed to the psychosocial difficulties (e.g., frustration) of not being able to communicate effectively and that these problematic behaviors are ameliorated as language skills improve with age. It is critical for caregivers to try and make sense out of the young child's nonverbal and or verbal communication attempts in order to reduce the risk for behavioral and emotional problems during childhood and adolescence and respond appropriately. A young child with little to no speech will attempt to get an adult to focus on an object or event. These nonverbal attempts may include acts of showing off, pointing or showing objects or pictures for the purpose of establishing joint attention. The response of the caregiver to these communicative attempts will

(continued...)

shape future communication attempts and behavior initiated by the young child. The research continues to state that although these findings support a wait-and-see approach to behavioral and speech and language intervention among late talkers with otherwise normal development, it is important to highlight the considerable evidence linking persisting language impairment and psychiatric difficulties.

Effective communication is fundamental to all aspects of human functioning....

The goal of early identification of communication challenges is to reduce the risk or alleviate the effects on a child's development by preventing future difficulties and to promote the necessary conditions for healthy development. Effective communication is fundamental to all aspects of human functioning, particularly early relationships, learning and social interactions. The social relationship begins at birth with the parent-child interaction. It is the communication behaviors of the infant that shape and enhance the parent-child interaction and foster positive early social and emotional development.

References

American Speech-Language-Hearing Association. (2008). *Roles and responsibilities of speech-language pathologists in early intervention: Technical report.* Available from http://www.asha.org/policy

Gilkerson, J., Montgomery, J., Richards, J., & Xu, D. (2009, November). *Infants around more adult talk become toddlers with better language skills*. Rockville, MD: American Speech Language and Hearing Association Convention. http://www.asha.org/Events/convention/handouts/2009/1262_Gilkerson_Jill.htm

Paul, R. (1987). *A model for the assessment of communication disorders in infants and toddlers.* Rockville, MD: National Student Speech Language Hearing Association. http://www.nsslha.org/uploadedFiles/NSSLHA/publications/cicsd/1987AModelfortheAssessmentofCommDis.pdf

Whitehouse, A., Robinson, M., & Zubrick, S. (2011). Late talking and the risk for psychosocial problems during childhood and adolescence. *Pediatrics*, *128*(2), 324-332. Available from http://pediatrics.aappublications.org/content/128/2/e324.full.pdf+html

Recommended references for further reading:
http://www.asha.org/public/

Jori Harris, M.S. CCC-SLP

Solid Food for the Healthy Infant and Toddler

When to Start Introducing Solids

There are many ideas on when to introduce solids (semisolids) to infants. The most accepted time is between 4-6 months of age. Some practitioners and authors recommend waiting until the latter age with the main reason being a reduction of the risk to develop food allergies. Most still agree on developmental readiness (head control, sitting with support, bringing things to the mouth, interested when others are eating) as being the best time to introduce solids.

What Should Be Introduced First

Iron-fortified rice cereal continues to be the most common answer to this. Reasons include the need for additional iron source after 6 months of age and rice being a low-allergen risk food. The introduction of fruits and vegetables typically follows the introduction of cereal; however, some practitioners and authors feel red meat should be introduced as it is another good source of iron.

I have had some parents question the use of rice cereal.

(continued...)

They have "read" that rice cereal has been linked to obesity in childhood. The research I have looked at suggests that rice cereal introduced before 4 months of age was associated with increased obesity at age 3 *in formula-fed infants* (Huh et al., 2011, *Pediatrics, 127,* e544). Again, most practitioners seem to agree with the 4-6 months recommendation.

Baby Food: Have You Checked Out The Products Lately?

Some parents have told me they want to make their own baby food because commercial foods add too much sugar. I recently went to the websites of Gerber and Beech-Nut and looked at the ingredients listed for all the stage 1, 2 (and 2½), and most of the stage 3 foods. Sugar is not listed in the ingredient label. I think parents are confused by "added sugar" and "natural sugar." When looking at the nutrition facts label, you will see high numbers of sugars in baby food. That is because baby foods are mainly the fruit(s) or vegetable(s) and water. Fruits and vegetables have natural sugar in them. This is just to clarify a common misnomer of commercial baby food. There is nothing wrong with a parent's choice to make their own. I get excited when a parent tells me they want to make their own! One word of caution, however, in foods that can be high in nitrates. It is recommended to buy commercial baby food rather than making it at home (beets, collard greens, spinach, and turnips).

Research...suggests that rice cereal introduced before 4 months of age was associated with increased obesity at age 3 in formula-fed infants.

I was surprised when I looked at these two websites (Gerber, Beech-Nut). The number of products and small differences in products is as staggering as the number and differences in formulas. The first thing I noticed at the Gerber website was different symbols for labels for different types of products. Gerber has foods that are under the categories of Immuniprotect TM or Nutriprotect TM and SmartNourish or NatureSelect (see accompanying tables at the end of this article).

Beech-Nut has added an extra "stage"—2½—for infants "who have teeth now and may be ready for some new flavors and textures in his diet." I have not bought nor tried this stage so I really don't know if there is a true texture difference. However, the 2nd ingredient for most of these foods was water, so I suspect they are still very strained or pureed.

Is there a difference between strained or pureed? Sometimes stage 1 and 2 foods are referred to as strained and stage 3 as pureed. In reality, there is not a difference between the two words, but there is a difference between the early stage baby food and some of the stage 3 foods. Combination dinners in stage 2 are still pureed with no chunks. In stage 3, chunks begin to appear. I personally am not a fan of the stage 3 dinners with the chunks; however, for most healthy infants developing normally they should not be a problem. In some high-risk infants, the combination of a strained texture mixed with chunks increases the risk of choking. Practitioners should be aware, however, that the nutritional value of dinners with rice or pasta often goes down—especially for protein. For that reason alone, parents should be encouraged to stay with the pureed meats or use dinners with fruits or vegetables rather than with starches.

Soft-Meltable Food and Finger Feeding

In recent years, new terminology has appeared on finger food(s) and a new line of product has appeared focusing on finger food. I refer to these foods as "soft-meltables" and I feel they are great choices when a baby has a pincer and is ready to do some finger-feeding. These food(s) melt easily when munched on. This is different from other traditional finger foods (such as cheerios) that require chewing in the molar region of the mouth to really break down or mush up the item and reduce the risk of choking. I encourage parents to

In some high-risk infants, the combination of a strained texture mixed with chunks increases the risk of choking.

(continued...)

begin with the soft meltables and to watch their infant eating these. They should start to see their infant move the food item from one side of the mouth to the other and chewing more with the food in the molar region. Once this starts to happen, the baby is ready to move on to fork-mashed and/or soft table food.

The Independent Toddler

My oldest son is now 19 years old and I can still remember him as a ~15 month old feeding himself some pasta and stopping after about 2-3 bites and letting me know he was all done. My first thought "you can't survive on 2-3 bites of pasta!" Well, yes and no. If your child truly eats only that amount and does not drink a "milk" based product of some sort...chance are your child will have some growth issues. However, for the healthy and normally developing toddler, those 2-3 bites are okay!

A toddler should not be in charge of what is being offered.... Most do not know a healthy food versus junk food.

My favorite book on dealing with problem eaters has been Ellyn Satter's "How to get your kid to eat... but not too much." I recently bought the AAP ebook, "Nutrition—What Every Parent Needs to Know" and was very pleased with the quick read-through I gave it. Both of these books talk about the importance of splitting some of the mealtime responsibilities. A toddler should not be in charge of what is being offered. Although there are many smart toddlers out there, most do not know a healthy food versus junk food. They know one may taste better (IE sweeter) than the other and will most always choose the tastier one. Adults should be aware of what healthy foods are. Therefore, the adult is responsible for what is offered at the mealtime. Whether the child eats it or not is the child's decision, but it is important that the adult does not cave in and then fix something else. That puts the child in overall control and not the adult. I tend to tell parents, "The adult is responsible for what, when, and where; the child is responsible for how much to eat from what is offered—if they choose to eat at all." When a parent tries to take over one of the child's responsibilities—"eat just 2 more bites," or when a child tries to take over one of the adult's responsibilities—refusing meals but coming back 30-60 minutes later and wanting a cookie—the stage becomes set for mealtime battles. Battles only lead to stressed parents and temper tantrums from the child. Separation of the responsibilities provides the child with some independence while keeping the parent in overall control.

The Bottom Line

Normally developing healthy infants and toddlers will typically receive all the nutrients they need if they are offered a well-balanced diet. Keep in mind the former RDAs—now known as DRI (Daily Recommended Intakes) are based on intakes over time and averaged to daily intakes. If a toddler eats poorly for a few days, chances are s/he will not develop vitamin deficiency diseases or conditions. For these children, vitamin/mineral supplements are probably not necessary. Also, if a parent is supplementing a toddler with a pediatric formula or instant breakfast they are already giving extra vitamins/minerals. However, there is a growing subgroup that might benefit from supplements. These are the children that I do not place in the "normally developing healthy" group. These children typically have sensory issues of which picky eating habits are only one. Some of the ASD children truly do cut out all foods but 5-6 from their diets. In situations like this, vitamin/mineral supplements may be warranted (as might a visit to a practitioner who specializes in not only treating ASD but also to a dietitian with experience in treating these children). Parents should also consult their primary care provider if they think their child is not receiving appropriate nutrition.

Normally developing healthy infants and toddlers will typically receive all the nutrients they need if they are offered a well-balanced diet.

Maggie Chaney, MS, RD, CD
Child Health Nutrition Specialist
Neonatal Follow-up Program
Utah Department of Health
mchaney@utah.gov

(continued...)

How Two Companies Separate/Designate Their Baby Food

Company	Single ingredient food (typically in 2½ oz. containers)	Combined ingredients (typically in 3.5 to 4 oz. containers)	Some change in texture; combined texture found in dinners (typically in 6 oz. containers); soft-meltable finger foods	Soft table food items in convenient portions for toddlers (typically microwavable meals)
Gerber	1st foods (supported sitter)	2nd foods (sitter)	3rd foods (crawler)--many of the graduate food falls here	Gerber Graduate meals and entree dishes
Beech-Nut	Stage 1 (for beginners and older	Stage 2 (from about 6 months) Stage 2½ (from 8 months)	Stage 3 (from about 8 months)	Stage 4 (from about 12 months) includes convenient microwavable meals.

Note. Gerber has also introduced a line of "preschooler" products (meals/snacks).

Gerber/Good Start Terminology

NatureSelect	SmartNourish (organic)	Immuniprotect TM	Nutriprotect TM
Made with 100% natural fruit/vegetable	Made with organic fruit/vegetable	Found in infant formulas; combination of vitamins, minerals, and the probiotic culture BIFIDUS BL	Blend for infant formulas; combination of vitamins, minerals, and the prebiotic galacto-oligosaccharide
Excellent source of vitamin C	Vitamins C and E (antioxidants)		
No added sugar or salt; no artificial flavors or colors	No added sugar or salt; no artificial flavors or colors		

Common Feeding Difficulties

Feeding difficulties are reported by at least 40% of all parents of children with developmental delays. The underlying cause of feeding problems can include many things, but sensory-based feeding problems are the most commonly reported feeding problem in children with autism. These children are sensitive to taste, texture, appearance, and smell—leading to resistance to trying new food, thus limiting foods they like to only a handful.

...Sensory-based feeding problems are the most commonly reported feeding problem in children with autism.

Many children between the ages of 2 and 3 go through a stage of development where they fear new foods. A child with sensory-based problems is likely to show even more distress and anxiety when presented with new foods leading to gagging and tantrums. Often parents will then remove the novel food and return to foods the child has accepted in the past in an effort to get them to eat more.

There are many approaches to treating extreme eating phobias. Below are tips that may help children before the problem becomes severe.

- Understand that food rejections are based on fear of the new food. However, children can and will exhibit control over what they put in their mouths. Try to avoid power struggles over eating.
- Establish meal and snack time routines where food is only offered at the table. If a child is allowed to "graze" all day on juice and cereal he will not be hungry for meals.
- Avoid using food for reinforcement of behavior or for calming and diversion. They will recognize these foods as "comfort foods" and reject other foods.
- Offer a wide variety of foods. The child who is fearful of new foods will need to see this food over and over again before he determines it is "safe." He will need to see other people eating and enjoying this food.
- If possible avoid using the same brand of foods over and over. These will taste exactly the same and the child may come to accept only one brand of a product. This is especially true when a baby moves from the breast or bottle to table foods.
- Avoid commercial products and use pureed, then ground, and then move to chopped table foods as the child's skills increase. This will expose the child to a much wider variety of taste and textures.
- In young children playing with foods and eating with hands and fingers is a great way to learn that a food is safe. This stage may last longer in children with developmental delays. Do not rush to use utensils. Enjoying and exploring foods is more important in preschoolers.

Many children between the ages of 2 and 3 go through a stage of development where they fear new foods.

- Talking while eating should also be encouraged. This again emphasizes that foods can be fun.
- Do not force a child to eat a food.
- Offer small portions of several foods with each meal. Some times offering very tiny portions of a food can lead the child to ask for more which can be a positive experience for a parent of a picky eater.

While many children are very picky eaters only a small percentage of children with autism or sensory challenges have nutritional deficits. Parents need to be reassured, encouraged to keep trying, but remain low key as they work through this difficult time.

A useful reference is *Just Take a Bite* by Ernsperger and Stegen Hanson

Lois Boomer, OTR/L
Bureau of Children w/Special Healthcare Needs
Utah Dept. of Health/Division of Family Health & Preparedness

Announcements/Upcoming Events

October 3-4, 2011

Critical Issues Facing Children and Adolescents Coference, Hilton Salt Lake City Center (75% of the conference time is applicable to mental health of young children and their families

October 13, 2011

UAIMH Board Meeting. Send comments, ideas, or interest in being more involved to Susan Dickinson at sdickins@utah.gov.

April 17-21, 2012

WAIMH--World Association for Infant Mental Health. Capetown, South Africa. Program highlights can be found on the WAIMH website (http://www.waimh.org/i4a/pages/index.cfm?pageid=3298)

Time and Place To Be Announced

UAIMH Conference on "Reflective Supervision" with Rebecca Shamoon Shanok, LCSW, Ph.D. (Reference *Journal of ZERO TO THREE*, November 2010, Vol. 13, No. 2.)

Your Continued Patience is Appreciated!

The UAIMH website has been moved to a new host. Information will continue to be updated. Access continues to be via http://www.uaimh.org.

You may join UAIMH or continue to renew your membership by:

1. Printing and completing or updating the *Membership Form* from the UAIMH website, and

2. Mailing your membership form with your check for $10 made payable to UAIMH to the address below:

Janet Wade, Treasurer
c/o The Children's Center
350 S. 400 E.
Salt Lake City, UT 84111