Secure Attachment Focused Interventions

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Abstract

The intent of this research paper and power point is to provide a foundation to determine the effect secure attachment focused interventions may have on the development of 0-5 year olds of mothers with depression. There is an abundance of data indicating the negative effects maternal depression can have on children, but resources to address the effects are limited. The relationship developed between an infant and the primary caregiver is explored and what happens to attachment when depressive symptoms are present. The data will support strong consideration towards implementing an integrative adult and early intervention model to enhance the relationship between primary caregivers and young children leading to secure attachments and healthy development.
Definitions

**Caregiver:** Primary, usually mothers, but includes fathers, grandparents, relatives, foster or adoptive parents, and all other primary caregivers.

**Interventions:** Professional support services to assist adults, children and families in overcoming barriers interfering with healthy development.

**Secure attachment:** Sensitive and emotionally available parenting helps the child to form a secure attachment style which fosters a child's socio-emotional development and well-being.

**Language development:** The communication process occurring between a primary caregiver and 0-5 year old.

**Emotional regulation:** The ability to respond to stressors within the environment.

**Serious Mental illness (SMI):** Depression, PTSD, anxiety disorders, other general disorders as defined in the DSM-5.

**Serious and Persistent Mental Illness (SPMI):** Major depression, schizophrenia, bipolar disorder, borderline personality disorder as defined in the DSM-5.

**High Risk:** A population exposed to stressors including but not limited to; poverty, single parenting, chronic illness, chemical dependency, violence, educational barriers and lack of support.
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**Rationale for Research**

The moment infants enter this world they begin to experience life through relationships. Initial attachments are usually with mothers although circumstances may warrant another primary caregiver. Throughout this review, mothers with depression will be the focus with a clear understanding that the definition of primary caregiver includes fathers, or may include relatives, foster or adoptive parents and more.

Data will support or detract from the hypothesis that interventions with a focus on secure attachment may impact the development of zero to five year olds of mothers with depression. The majority of the journal articles available focus on depression in mothers, with an acknowledgement that serious mental illness, (SMI) overall, may have an influence on relationships. The development of zero to five year olds is defined primarily in the context of language and self-regulation. Development is most impacted in this age group by language and the abilities to self-soothe and self-regulate in stressful situations. The interactive process between the primary caregiver and the young child is vital to this development. Treatments for adults and children tend to use a silo approach rather than an integrative implementation of support services. The intervention models reviewed will refer to adults and children separately and collaboratively to show the impact integrative efforts may have on enhancing the secure attachment between the mother and child.

This writer identifies a bias based on personal experiences, including being a parent and grandparent with mental illness in the family. Both current employment at a mental health center and past work experience as a family education specialist with an early childhood Head Start program has initiated the above hypothesis and exploration into finding evidence based
practices. Furthermore, current enrollment in the Adler graduate school Marriage and Family program has motivated this writer to examine current practices at a community mental health center with an intent to identify gaps in treating children, our most vital resource.

**Proposal**

This writer intends to demonstrate, through literature and a power point presentation, that investing in children age 0-5 and their families will produce long term cost effectiveness both monetarily and generationally.

Definition of 'Return on Investment - ROI'; a performance measure used to evaluate the efficiency of an investment or to compare the efficiency of a number of different investments. To calculate ROI, the benefit (return) of an investment is divided by the cost of the investment; the result is expressed as a percentage or ratio (www.investopedia.com/terms/r/returnoninvestment.asp).

The programming focus will be on a Minnesota area mental health center, a leader in the community, with an opportunity to create and implement ongoing integrative mental health services for families with young children. As recipients of multiple Minnesota grants targeting families with young children, the educational opportunities and funding are currently available to the mental health center. However, to sustain ongoing programming targeting this vulnerable population, there is a need to implement a strategic plan that will be cost effective to the agency and the families served.

This writer will provide information on the current programming, or lack of, that the mental health center offers to families with mental health needs. A focus on the 0-5 population and secure attachment focused interventions will be emphasized along with the long term benefits to implementing integrative services through the mental health center. Data will be
provided along with the following research review indicating a need to reach our most vulnerable population before the cycle of poverty and mental health challenges are passed on to the next generation. “Between 30 and 50 percent of children with parents who are mentally ill have a psychiatric diagnosis, compared to 20 percent of children in the general population” (Cooper, Masi, & Vick, 2009, p. 4). By intervening during the most critical years of brain development, we can enhance the relationship and promote secure attachments between the primary caregivers and 0-5 year olds. This writer will demonstrate the value of investing in evidence based integrative services that address the immediate and long term effects of poverty and mental illness on child development. Only by delving in and supporting families in meeting goals they have for themselves can we begin to make a difference. A client driven model based on the strengths of the families is the foundation on which we can build our support services. “Life consists only of the present moment, and if we do the right thing at this moment, we move toward improvement. On the other hand, if we do not fulfill the requirements of a given situation or do not know how to deal with it, then the chances for improvement are slim indeed” (Dreikurs & Soltz, 1992, p. 66).

**Interventions Based on Secure Attachment**

This writer will explore different modalities of interventions in order to show a contrast between types of implementation of services. The first model is specifically for adults with serious and persistent mental illness. An Assertive Outreach Team, (AOT), is an adult model with low consumer to staff ratios. “AOT is the term used to describe mobile multi-disciplinary teams that provide intensive care coordination to a relatively small cohort of consumers with complex needs who require ongoing proactive and sustained support and treatment to remain living in the community” (Flannery, Adams, & O’Connor, 2010, p. 50). Flannery et al., explain
that holistic community mental health services need to include acute and emergency response services, community care coordination, assertive community teams and partnerships with other human service entities. This AOT model does not include services with a focus on the parent-child relationship. “Partnerships with other services and agencies including drug and alcohol, social services and housing authorities, the role of specialist programs such as those for family and carers and services for specialist populations such as perinatal have not been addressed in detail” (Flannery et al., 2010, p. 53). When assertive teams were first established, ‘maintenance’ was a common objective. If the team could offer continued support to consumers resulting in their mental health remaining stable with fewer relapses and hospital admissions, there would be a favorable outcome (West & Grainge, 2012, p. 21). Current approaches focus more on a recovery model with movement towards an established goal giving hope to individuals.

The next model does embrace parent participation but is primarily focused on the child. The program does not address mental health issues in the primary caregiver. Early Head Start (EHS), was developed as a relationship-based intervention to “promote parental caregiving and child development among low-income families” (Robinson & Emde, 2004, p. 74). EHS began in 1995 to address the needs of 0-3 year olds in addition to the already existing Head Start program for 3-5 year olds. The program includes parental involvement and promotes socialization opportunities through parent nights. Developing social interest can have a profound effect on the mother’s ability to continue accessing support services. The results of a study focusing on EHS, and the implications relationship have on child development, have revealed promising results. “Intensive services directed toward enhancing the early parenting relationship can have significant benefits for low-income mothers with mental health risks” (Robinson & Emde, 2004,
p. 94). However, this particular study did not show positive impacts on the cognitive development of young children.

Increasing studies point in the direction of collaborative efforts when serving families with mental illness. The mental health division of the department of health in Western Australia reported an increase in susceptibility of children of parents with mental illness. They recommended collaboration between crucial government agencies by developing procedures that increase attentiveness to these children and their families. In addition, the report states current services are fragmented between adult and child providers. As a result, “The collective effort of all involved had an evident positive impact on practice, with the potential to improve outcomes for all family members” (Clark & Smith, 2009, p. 97). Staff reported enhanced services as a result of collaboration. Some positive feedback included the ability to access expertise of other providers, sharing information to avoid duplication, and improved outcomes for families. Observations made from gathering input from providers also gave an understanding of inadequacies of collaborating services. A primary barrier was communication between service providers. “Workload and time pressures conspired against collaboration, and coordinating, organizing, and managing meetings were regarded as problematic” (Clark & Smith, 2009, p. 97)

A Home Visitor Program, (HVP), developed in 2001, in Australia, focused on in-home family care for mothers and infants provided by nurses. The nurse and mother together, interpret the relational experiences between mother and infant. The nurse focuses on building on the strengths of the mother and infant, and the mother’s ability to recognize the infant’s cues. A plan is developed to enhance interactions between mothers and infants leading to clearer communication. The HVP also included, “supportive counseling, problem solving, identifying community supports, monitoring mood and anxiety, and supporting the development of parental
knowledge and skills in infant development and behavior” (Rossiter, Fowler, McMahon, & Kowalenko, 2012, p. 90). The HVP findings indicated that staff needs to be skillfully selected to assure certain professional and personal qualities. “In particular, this mode of service delivery requires skills in listening and communication, working in partnership and strength-based approaches, as well as up-to-date and evidence based knowledge of infant development, parent infant relationship processes and attachment” (Rossiter et al., 2012, p. 98). Feedback from the recipients was very positive. There was an increase in overall parenting confidence and relief in knowing support was available. A recipient of the program responded with, “The ability to be able to talk to a professional, non-judgmental person on a regular basis about my child and the feelings and doubts surrounding the new experience I was going through, was very reassuring” (Rossiter et al., 2012, p. 93). Empathy plays an important role when implementing support services. If providers can accept recipients of services where they are at without comparing them to an ideal, they will be open to receiving needed support.

Keeping Families Strong, (KFS) was a pilot, “designed as a strengths-based family-centered intervention following two evidence-based preventive interventions for distressed families and by empirical research on maternal depression” (Valdez, Mills, et al., 2011, p. 7). The mission of the project was to explore the effects interventions have on family functioning, including the child and parent. Acceptance of interventions was also considered. Four areas were identified to have an impact on the family. First, providing needed emotional support for the mother with depressive symptoms. The second area is to establish children’s strengths through effective parenting that included sensitivity and care. Third, promoting social activities as a family and the fourth area was being able to openly discuss the effects of depression on the family. The children, ages 9-16, reported their mothers were more accepting and life was less
stressful after participating. In addition, “the mothers reported increased levels of family activities and cohesion, along with improvements in their own emotional, social and physical functioning across a range of areas” (Valdez et al., 2011, p. 15). Social supports increased with family involvement in outside activities and connections. The mothers’ mental and physical health was also impacted as a result. Alternately, an increase in “school maladjustment” was indicated and may have been a result of children processing what was occurring at home. As family relationships began to improve, painful issues were addressed and the children seemed to respond by acting out at school (Valdez et al., 2011).

**Summary of Findings**

A variety of support services geared towards interventions to alleviate mental health symptoms or enhance development of zero to five year olds can be accessed. However, the services are often implemented separately to adults and children. The first two models demonstrate that separation. The assertive outreach team represents an integrative approach for adults. The findings from the early head start program, while having an impact on the parent-child relationship, does not address adult mental health and did not show any significant improvement in cognitive development of the children. The home visit program provided a direct service for infants and their mothers and received positive feedback from recipients, but did not address high risk families. The keep family’s strong pilot addressed mental health but did not serve children under five. Two identified barriers of a collaborative effort when implementing services are cost effectiveness and time management issues. The cost of allowing time for staff of multiple agencies to collaborate is an obstacle that needs to be explored more.

Outcomes are shown to be positive when providing social supports using an integrative approach
when working with families. The needs of high risk families may warrant integrative services addressing several identified areas, with secure attachments being an important piece.

**Development of Zero to Five Year Olds**

Early intervention programs focused on healthy development of zero to five year olds can address the effects mothers with depressive symptoms have on the development of young children. There is an increase in the need for these programs, for at risk children in particular.

Early intervention (EI) programs, authorized under Part C of the Individuals with Disabilities Educational Act (IDEA), provide services to children from birth to three who are identified as having or being at risk for developmental delay. In 2009, almost 340,000 infants and toddlers received EI services. This number, which represents 2.9% of US children birth to three, has almost doubled in the past 10 years. Despite an increase in the number of children obtaining services and documented effectiveness of early intervention, studies suggest that many young children, particularly Black children, who have or are at risk for developmental delays fail to receive them. (Feinberg, Donahue, Bliss, & Silverstein, 2010, p. 336)

The effect a mother’s depressive symptoms have on the development of zero to five year olds is primarily influenced by their relationship. “As language skills grow they begin to reflect and influence children’s social relationships and capacities. The relation between language and self-regulation develops in the context of adult–child relationships as caregivers guide children’s behavior, moderate their arousal, and help them interpret effective experiences using language” (Ayoub, Vallotton, & Mastergeorge, 2011, p. 584). Children zero to five use language to obtain social goals, negotiate interactions, communicate their needs and express their personal views.
Research indicates the interactions between a mother and child impacts development of pathways in the brain. “The first two to three years of life, during which patterns of attachment to primary caregivers are forming, is considered to be a critical period for the experience dependent maturation of the brain” (Beatson & Taryan, 2003, p. 220). There is growing interest in the effect early relational experiences have on the developing brain including executive functioning abilities. “Research has thus provided compelling support for the idea that individual differences in executive functioning are meaningful for child cognitive and socioemotional functioning” (Bernier, Whipple, & Carlson, 2010, p. 327).

Along with language, self-regulation allows a child to identify and monitor emotional responses. “During Self-regulation, the capacity to control deliberately one’s affect and behavior, accounts for children’s growing capacity to voluntarily uncouple their behavioral response from the immediate emotional impulse” (Koshanska, Philibert, & Barry, 2009, p. 1331). Self-regulation is the direct result of a secure parent-child relationship. The ability to self-soothe is learned by infants observing their mother’s faces, “The results suggest that, more than age, it may be the response of infants to the developing relationship, shown in their distress and the amount that they visually search for their mother during separation, that is related to how infants’ brains process different kinds of faces” (Swingler, Sweet, & Carver, 2010, p. 679). Furthermore, insecure attachment in infancy carries on into the toddler and preschool years, “…those who as infants had been insecurely attached to their mothers developed poor regulatory capacities in toddler and preschool years, but those who had been securely attached developed as good regulatory capacities” (Koshanska et al., 2009, p. 1336). Emphasis on the importance of secure attachment for learning self-regulation is a common theme throughout studies on development in early childhood.
A U.S. study targeting 33 children, ages four and five, and their mothers with a focus on “early self-concept as an important mediator between social experience and social behavior” is an example of the importance of social interest in development. Self-reporting from zero to five year olds is generally difficult to gather and assess. In this particular study, children participated in a questionnaire through a puppet theatre. The children were told, “These puppets are writing a story about children your age, and they want to find out all they can about you” (Goodvin, Meyer, Thompson, & Hayes, 2008, p. 439). The results were organized to include the changes in children’s self-concept and individual differences in consistency of self-perceptions. The findings of the study showed that “Children with a more secure attachment relationship at four years old described themselves at five years old as having more positive self-regard and less negativity, and greater agreeableness” (Goodvin et al., 2008, p. 447). A secure attachment, warm and sensitive, between a parent and child might add to lucidity within a child’s understanding of self by allowing them to incorporate different parts of emerging self-awareness into a united complete self. Children with low self-concepts depicted themselves as more negative when their mothers were experiencing more negative affect including depressive symptoms and parenting stress (Goodvin et al., 2008, p. 448).

Adapted Family Connections (TA-FC) is a “manualized trauma-focused practice rooted in the principles of Family Connections (FC), an evidence supported preventive intervention developed to address the glaring gap in services for this specific, growing, and underserved population” (Collins et al., 2011, p. 29). The program is described as follows, “Participants receive family assessment, emergency assistance, a service plan, advocacy, coordinated referrals to community agencies, and outcome-driven intervention over a period of up to six months” (p. 36). Families at risk often have multi-generational effects from years of emotional instability.
resulting from poverty and trauma. “Treatment strategies that address the child’s experience within the family while incorporating evidence-based interventions show promise for the treatment of youth and families who are traumatized” (p. 30). The effects of trauma put this high risk population at further risk of developmental delays. “Posttraumatic stress phenomena influence a number of developmental processes including a cognitive functioning, initiative, personality style, self-esteem, outlook and impulse control” (Stover, & Berkowitz, 2005, p. 707).

Although studies on this age group consistently show the effects attachment or lack of can have on development, there is still a shortage of interventions for children under five and their mothers. The need to provide services for this age group in the context of building secure attachment is merited. “As growing evidence shows, parent–child interactions especially during this early period have a strong impact on the development of children’s resilience and psychiatric vulnerability” (Van Doesum, Hosman, & Riksen-Walraven, 2005, p. 159).

Summary of Findings

The information on the effect of mothers with depression on the development in zero to five year olds indicates a need for early intervention services. Evidence towards the impact of secure attachment on language development and self-regulation in zero to five year olds is strong. Brain research demonstrates a direct correlation between secure attachment and developing pathways. Services focusing on secure attachment between infants and their primary caregivers are lacking. Interventions that could interrupt patterns of insecure attachment may prevent future developmental problems. Many at risk children have multiple factors, including the effects of trauma, contributing to developmental delays, and those areas also need to be addressed.

Mothers with Depression
According to the CDC, Center for Disease Control and Prevention, one in ten US adults report depression as of April, 2012. Approximately 14.8 million US adults (6.7%) experience major depression in a given year, and women are 1.7 times as likely to experience depression as men. Current depression (symptoms for at least the previous two weeks) was determined based on responses to the Patient Health Questionnaire 8 (PHQ-8) (4), which covers eight of the nine criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) for diagnosis of major depressive disorder (CDC, 2012). Identifying depressive symptoms in this population is not always an easy task. Stigmas attached to mothers with mental illness may limit their willingness to participate with needed support services. Also, the idea that all mothers will benefit from early interventions is not an accurate statement. This writer hopes to clarify assumptions and identify barriers mothers with depressive symptoms face.

Many factors contribute to maternal depression and parenting styles. A clear path to show cognitive and language development in zero to five year olds is affected by these factors is not available. “Quite possibly genetic factors, mothers’ education, children’s gender, families’ economic status, and the involvement of other adults affect the association between mothers’ depressed mood and children’s cognitive growth” (Sohr-Preston & Scaramella, 2006, p. 74). Predisposition to depression, current environmental stressors, past stressors, and hormonal factors can all contribute to ongoing depression. In addition, lack of supports, poverty, substance abuse, single parenting and violence may also impact a depressive episode. “Depression arises as the outcome or final common pathway of multiple interacting risk factors coming together at a particular time, or over a particular period, in a person’s life” (Beatson & Taryan, 2003, p. 219).

Factors such as cognitive ability and social competency can affect accessing support services. Mothers with depressive symptoms may feel overwhelmed with the responsibility of parenting and too ashamed to ask for help. Mothers may experience guilt due to inability to
complete daily tasks which can accentuate depressive symptoms, “…when a mother is depressed, the family may experience diminished communication, a lack of parental warmth, inconsistent discipline, decreased pleasant activities, heightened family stress and maternal withdrawal, among others” (Valdez, Mills, Barrueco, Leis, & Riley, 2011, p. 4). In addition a rebound effect can develop in mothers with depressive symptoms increasing hostility towards their children. “Irritable and taxing behaviors displayed by infants of depressed mothers may serve to intensify or maintain maternal depressed mood and parent-infant interaction” (Sohr-Preston & Scaramella, 2006, p. 69). Children who exhibit deficits in language and self-regulation skills may deliver more stress for their mothers who are already taxed due to depressive symptoms (Ayoub et al., 2011, p. 597).

This writer explored predisposition to depression in addition to environmental and temperamental risk factors and reviewed the following related journal article. Focus is on the hyperphysical-pituitary-adrenal, HPA axis, which controls responses to stress and activates many body responses. The 2003 report states, “Adverse early relational experiences can result in activation of the HPA axis, causing sensitization of depression pathways in the brain” (Beatson & Taryan, 2003, p. 219). Previous studies have shown adverse life events have a significant impact on emerging depression. Individual susceptibility varies greatly and depends on other factors such as genetics and sensitization of pathways created by previous episodes of depression and/or stress. Secure attachments can act as a protectant barrier preventing HPA activation. Infants who are lacking secure attachment do not have the protection and may be prone to depression and other mental health disorders when exposed to psychosocial stressors. “In these cases, the neurobiology of attachment offers a means of integrating findings concerning sensitization of the HPA axis in infancy, the effects of early life experience on brain
development, and predisposition to depression and other psychiatric disorders” (Beatson & Taryan, 2003, p. 219).

Language, both spoken and unspoken is how infants begin to communicate. Communication is the beginning of developing a secure attachment with their mother. Infants watch and imitate their mother’s facial expressions. “One of the most striking features of the interactions between depressed mothers and their infants is the mothers’ silence. Depressed mothers speak less to their children, and when they do; they usually talk in a quiet voice” (Van Doesum et al., 2005, p. 161). A mother’s awareness of symptoms can make a difference in how they respond to their infant. Mothers with severe mental illness self-reported a lack of competency due to their symptoms when parenting. They viewed themselves as not capable of being a good parent. Mothers were observed for five minutes while sitting opposite of their child who was in a bouncy chair. Median scores show mothers with mental illness were observed to be considerably less sensitive, and their infants were regarded as considerably less cooperative (Steadman et al., 2007, p. 262). Lack of maternal confidence can lead to feelings of despair and inadequacy in young children. By four or five children are learning how they should be to fit into the world. Self-regulation and communication have direct implications on a child’s ability to engage in social interactions. The foundation of secure attachment affects whether or not the outcome is positive.

An important factor of early intervention programs is parent participation. A study focusing on the follow through of mothers with depression in early intervention programs found it, “encouraging that children of mothers with clinically significant depressive symptoms participated in early intervention programs given the increased risk conferred by such symptoms on children with existing developmental risk” (Feinberg et al., 2010, p. 344). These children
usually qualify for early intervention services based on delays in language and impaired communication and social interplay. More mothers reporting depressive symptoms participated in early intervention programs than non-depressed mothers. Encouraging mothers to participate in support programs would lead to a feeling of belonging, allowing them to safely engage outside of themselves. By addressing the areas of love, community and occupation, movement towards an integrative approach to serve families is promising. Individuals naturally look towards improving their lives. When mental illness hinders this drive, interventions can assist in safeguarding and protecting against the effects and promote forward movement within families.

“Beginning in 2004, all states were required to report on activities related to supporting family capacities in their performance report, expanding the program’s sole focus from child outcomes to broader family functioning” (Feinberg et al., 2010, p. 343).

A change in the implementation of services is occurring. Intervention models that allow for support of the entire family with a focus on establishing secure attachments to assure healthy development in young children are being considered. Programs that assist in enhancing the quality of life for families with mental illness can provide a “developmentally supportive environment” (Feinberg et al., 2010, p. 343). To address the struggles of primary caregivers with depression separate from the children they care for does not promote family wellness. Young children receiving services for developmental delays, due to living with a primary caregiver with mental illness, will not benefit fully until an integrative approach focused on secure attachment is included. Community programs have the ability to develop an integrative approach to support these families.

Furthermore, the 2009 Institute of Medicine (IOM) landmark report Depression in Parents, Parenting, and Children called for the development of innovative, community-
based initiatives to reduce barriers to care for parents experiencing depressive symptoms. The IOM specifically called for interventions that take place in venues capable of integrating services for parents and children. Early intervention programs represent such a setting. (Feinberg et al., 2010, p. 343)

A 2013 study comprised of interviews of seventeen parents being served on ACT, Assertive Community Treatment teams, demonstrated a need to focus on parent-related treatment services and support. “ACT teams are not consistently addressing the mental health and community support needs of all parent consumers, especially parents of young, dependent children” (White, McGrew, & Salyers, 2013, p. 22). Findings also demonstrated the interconnectedness of mental health concerns and parenting needs. Consumers, who have unmet parenting needs, may benefit from additional services such as, “custody, communications/bonding with children, parenting skills, resources for children, and peer support” (White et al., 2013, p. 27). By incorporating parenting focused skill building into the treatment plans, enhancing attachment, and increasing supports, outcomes for parents with severe mental illness and their children will hopefully improve.

**Summary of Findings**

Severe mental illness, specifically depression, can affect anyone throughout their lifetime. High risk individuals are more prone to depression due to added stressors that need to be addressed in addition to parenting issues. These stressors intensify for parents and even more for a single parent. Mothers in particular may struggle with playing an active, positive role model, when struggling with depressive symptoms. The inability of depressed mothers to initiate healthy communication and pick up on cues from their infants puts zero to five year olds at risk developmentally. Establishing secure attachment early on is vital to ongoing healthy
development. Depressed mothers may lack the confidence and sensitivity needed for their children to thrive. Interventions that can encourage and support mothers with mental illness are needed to promote competency in parenting young children.

**Summary of Major Findings**

Overall, the findings of this report are promising. Interventions focused on secure attachment may impact the development of zero to five year olds of mothers with mental illness. Data identifies developmental delays as a result of insecure attachments. Early intervention programs targeted at the under-five population can support healthy development; however an integrative approach is indicated. Social supports for the primary caregivers and child are crucial for follow through of programming. The importance of acceptance and encouragement by service providers is an important element in the delivery of services. By focusing on a recovery model for the entire family, hope is given. Family and individual autonomy is crucial in each family’s ability to identify their own specific needs and the service delivery model best suited to them.

Common themes were developed throughout the research reviewed. The interplay between genetic factors, social environment and relationship between primary caregivers and their children all contribute to the complexities of secure attachment development affected by depressive symptoms. When the basic needs of families are not met, stress increases leading to an increased probability of mental health symptoms. High risk families are particularly susceptible. Poverty, single parenting, lack of social supports, violence, chronic illness, chemical dependency and education levels are among the many aspects contributing to being vulnerable. Until these basic issues are addressed the mental health symptoms of primary caregivers will most likely continue and the negative effects on the development of young children will increase.
There are several limitations to establishing the most efficient way to implement secure attachment focused integrative interventions. The issues of mothers with severe mental illness, particularly depression, are complex. Depression does not stay consistent, but fluctuates throughout a lifetime. The effects on the development of young children are difficult to assess due to these fluctuations. Limited self-reporting by children zero to five narrows the ability to assess outcomes of targeted interventions. Barriers such as funding and time management interfere with the ability for community collaboration among service providers. A traditional model of serving adults and children separately does not allow for a focus on the parent-child interaction. Models developed based on the latest research available for brain development in infants and young children are needed.

This writer is hopeful that as the area of brain development in relation to secure attachment advances, integrated service models geared towards enhancing mother-child interactions through a holistic family approach will increase. Interventions with the ability to address several identified issues for families tailored to meet individual needs without duplication would be ideal. Providers need to gather as much information as possible and then focus on the strengths of families encouraging them to thrive. Providers can instill hope by allowing families to create their own way of healthy living within a natural support network. As new knowledge points towards the possibility of preventing developmental delays in language and self-regulation, the promise of breaking the patterns of mental illness within families can become a reality.

‘A misbehaving child is a discouraged child. Each child needs continuous encouragement just as a plant needs water” (Dreikurs & Soltz, 1992, p. 36). A systems change can set a strong foundation to provide encouragement for families to flourish. Rather than a
cycle of poverty, mental illness, trauma and hopelessness, we can create a cycle of change, with secure attachments leading to a hopeful future.
References


