

## **Promoting Social and Emotional Development in Young Children: The Role of Mental Health Consultants in Early Childhood Settings**

*In Set for Success: Building a strong foundation for school readiness based on the social-emotional development of young children.* (The Ewing Marion Kauffman Foundation)

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### Summary Points

- Early childhood programs have come to play an increasingly prominent role in many communities, providing extended childcare for working parents and enriching educational opportunities for young children.
- Childcare staff are often the first to observe the effects of trauma and stress in families, yet many feel ill-prepared to cope with this added responsibility.
- The early childhood consultation model provides a more comprehensive approach to children's social and emotional development, allowing teachers, parents and mental health professionals to work together to identify children's needs, plan classroom interventions and support families' coping strategies.
- The effective mental health consultant is flexible and team oriented, is comfortable working autonomously in community based settings, and is adept at handling multiple roles and responsibilities.
- In the classroom, the consultant supports the teachers' role in promoting the children's social and emotional development and shares strategies related to normal developmental issues, including separation, frustration tolerance, and aggression.
- Consultants working in preschool programs have the opportunity to provide brief support and advice to parents related to ongoing concerns with their children and crisis situations in their families, and is available to help mediate strained relationships between parents, teachers and administrators.
- The mental health consultant has the opportunity to provide support and "check-ups" to all the children in the program, and to provide more specific intervention, individually or in groups, to children affected by loss or trauma.

## **Introduction: The Changing Role of Early Childhood Education**

Early childhood programs fill important educational and economic demands in this country, and are no longer viewed as playful and optional additions to family life. With the advances in the study of brain development in infants and toddlers and research on the early acquisition of learning skills, preschool education has taken on a new significance. Early childhood programs also meet the needs of working families needing out-of-home childcare. Most women (nearly 60%) with children younger than age 6 are in the labor force and need child care for at least part of the workweek. Recent changes in welfare and workfare legislation have also increased the demands for childcare, and more young children are now spending extended days in center-based care. It is now widely accepted that early childhood educators play a major role in shaping children's emotional, social and cognitive development, and help to lay the foundation for future academic success. Many early childhood centers have also become cornerstones of their community, offering parenting workshops, recreational programs and health and education classes.

With their increasing prominence, early childhood programs are typically the first to feel the impact of family stresses. In many urban and some rural communities, Head Start centers and childcare programs serve large numbers of disadvantaged families. Many of these children are affected by their parents' struggle to provide for their families' basic needs and to maintain adequate housing and employment, and come to their centers bringing their worries with them. Fewer young children now live in two parent households than at any point in recent times. Across all socioeconomic groups, a large percentage of marriages that have produced children now end in divorce, and 40-50% of children born in this country in the last decade will reside in single-parent homes at some point in their childhood (Dubow, Roecker & D'imperio 1997). With these developments, early childhood education programs are often implicitly or explicitly asked to take a more primary role in child rearing.

The increase in the reported incidence of trauma in families has raised new concerns about the psychological development and educational needs of young children. Violence, both within the home in the form of domestic violence and child abuse, and in the community, has been shown to have a profound impact on children's emotional adjustment and cognitive development (Aber & Allen, 1987 Pynoos & Eth, 1986, Zero to Three, 1994). In families affected by substance abuse, HIV/AIDS, mental illness and other debilitating diseases, children have been forced to deal with the loss or potential loss of parenting figures, often forcing young children to take on care-taking responsibilities. Research has shown that children with many risk factors like those outlined above are far more likely to show signs of emotional maladjustment or behavioral problems (Rutter & Quintin, 1977).

Young children are especially vulnerable to the disruptions caused by traumatic events, as they do not have well-developed physical or psychological resources to defend against them. They depend on adults to help them make sense of the trauma, heighten their resilience and shield them from its ill effects. When their primary caretakers are also affected, they are less available to provide reassurance to their young children and to help them re-establish their sense of safety and security. As a result, the burden of care for these children often shifts, at least in part, to caretakers outside their home. The childcare center often takes on added significance for children impacted by trauma who crave consistency and nurturance and are looking for a safe haven where they can play and learn and focus on more age appropriate tasks of development.

### **Challenges in the Classroom**

Many of the children who have had disruptions in their early development and attachments present with challenging behaviors in the classroom. They may appear to be fearful, disorganized, inattentive and unresponsive to learning (Koplow, 1996). Head Start teachers have reported that their students are displaying more symptoms of emotional distress, including

withdrawal and depression as well as acting out and aggressive behaviors (Yoshikawa and Knitzer, 1996). This trend mirrors findings from epidemiological research suggesting an increased prevalence of psychiatric disorder in children, with onset at younger ages (Cohen, Provet & Jones, 1996). Many of the disturbances that emerge in older children can be traced to risk factors present in infancy and early childhood (Werner, 1989).

Many early childhood programs are struggling to adapt to this added responsibility. Teachers and other preschool staff are often overwhelmed by the extent of their children's disturbance or distress, and do not feel they have received adequate training to respond to their needs (Knitzer, 1996). They fear that opening up discussion of traumatic or stressful events might lead to unpredictable emotional reactions in the children that they cannot control. Teachers also often feel pressured to maintain a formal academic curriculum with an emphasis on the mastery of cognitive concepts, and do not feel it is appropriate to use classroom time to deal with their children's emotional turmoil (Hyson, 1994).

In addition to coping with an increase in family stresses and childhood trauma, many early childhood programs are struggling to maintain developmentally appropriate curriculum in the face of external pressure to focus more directly on early academic tasks. This trend is seen frequently but not exclusively in middle and upper middle class communities where pressure to compete with peers and stay ahead of age expectancies can add undue stress to children and their families. Preschools that emphasize social and emotional development more than teaching pre-academic skills (learning letters, colors and numbers, etc.) often feel at odds with the parents they serve and, not infrequently, with local school districts whose expectations for kindergarten children are often at the far end of a developmental continuum. As one teacher described the situation in Westchester County, "kindergarten is now equivalent to 2<sup>nd</sup> grade just 15 years ago." As a result, some preschools feel they must move forward with learning tasks before many

children have the developmental skills to succeed, including the ability to separate and work independently, to tolerate frustration and persevere, and to remain attentive and delay gratification.

### **A Collaborative Model: Mental Health Consultation**

Given the changes in early childhood education and mental health, the preschool has become, in many ways, the ideal setting for integrating the work of professionals in both disciplines. Forging a partnership between mental health professionals and teachers allows schools to provide a comprehensive approach to the emotional and cognitive development of the children they serve. The preschool is also a logical place for clinicians to reach out and involve parents in their children's development, and to support them in developing their own coping strategies. Unlike the clinic or office, the school provides ample opportunities for more informal and brief interactions between a mental health consultant and parents. In this way, parents and other family members can come to know the clinicians at their own pace in a familiar setting often before any concerns regarding developmental delays or emotional distress in the children have been noted.

Early childhood programs are often mainstays in their neighborhoods, respected and trusted by the local population. Joining together with these programs gives clinicians the imprimatur to practice without the same stigma or skepticism that might be applied in the less familiar office environment. The experienced mental health consultant will also seek to learn more about the ethnic and cultural traditions of the families, the program and the local community. The preschool/mental health partnership presents the opportunity to provide interventions that respond to the needs of all the children in the center, not just those with identifiable symptoms of emotional disturbance or those deemed most at-risk. Clinicians can be available to consult on issues of any magnitude, as their primary role is to foster the behavioral,

emotional and cognitive development of all children. This prevention model includes "check-ups" of all the classrooms through observations and sitting in on team meetings, and "wellness" visits with those children who are responding nicely to the school environment. This allows the clinician to not only respond to crises and dire situations, but in some instances, to anticipate them, and provide early intervention to children at risk. In addition, the consultant has the opportunity to acknowledge and enhance the everyday workings of the teachers and staff in the school that create a welcoming environment and foster the social and emotional competence of all the children.

### **Precursors to an Effective Collaboration: Skills and Competencies**

Developing an effective collaboration between mental health providers and preschools requires a good deal of enthusiasm, respect and support from both parties. The mental health consultant must be careful to develop a set of shared assumptions and goals with the school, and not assume a rigid "expert" stance regarding the ways to enhance the children's development. The process of defining goals should result from a mutual examination that draws on the expertise of both teachers and clinical staff. Consultants must also recognize and appreciate the opportunities available in this setting to have an impact on a wide number of children, parents and educators. Although clinicians of diverse backgrounds and experience can function in this role, the effective consultant must be flexible and team-oriented, enjoy community-based settings, and be comfortable working autonomously apart from other clinicians. The consultant must also be adept at handling multiple roles and responsibilities, including crisis intervention, parent workshops, child observations and assessments, teacher training and systems work. Perhaps most importantly, consultants should acknowledge their own limitations as sole agents of change, and must seek to share their knowledge and training with teachers and parents who will have the greatest impact on the young children in their community.

The partnership is enhanced when teachers are willing to consider their educational role in broad terms that encompass the social and emotional development of children. The mental health collaboration will also be strengthened if teachers are open to new ideas and disciplines, and are willing to integrate these in the classroom. Ideally, they are willing to undertake new challenges with the consultant, to focus on children's feelings and social skills, to confront the sometimes difficult realities of their children's lives, and to reflect on and discuss their own feelings and reactions elicited in their work with the children.

### **Collaboration with Teachers**

The mental health consultant working with early childhood teachers will be more effective if she works to develop an open and respectful relationship with them, that encourages a free flow of information back and forth. The degree of warmth and trust in the relationship will further influence the teacher's acceptance of this "outsider's" presence, and will impact on the children's willingness to relate to the consultant and share their feelings and concerns. At some point, the consultant must prove herself to the teacher, by actively helping in the classroom, dealing with difficult children or being available to discuss personal issues. She should also recognize that the teachers are the key agents of change within the program, and that the work in the classroom will have the most far-reaching impact on the children. Gaining an appreciation that early childhood teachers are also often firmly embedded in the communities they serve, and frequently have longstanding relationships with families that they refer to the consultant, will also serve her well.

Interventions in the classroom often emanate from teachers who look to try out or get approval for their ideas from the mental health consultant. A suggestion to use more transitional objects with foreign-born Andre, a 4 year old boy with severe separation anxiety, or to provide more "special time" to a 3 year old Anna, whose father had recently succumbed to a long illness,

are but two examples of strategies proposed and carried out by teachers with the consulting psychologist's encouragement. This team approach can demystify notions of "promoting mental health" and assure teachers the consultant is there to support their work and help the children feel more comfortable. In this process, the teachers often come to realize that their goals in the classroom- helping children feel secure, teaching them to share and work cooperatively, working through frustration, helping children to focus and learn self-control- are in fact the "cornerstones" of social and emotional competence in young children.

Classroom management techniques often require more intensive and joint planning, but generally begin with the teacher's request for help with difficult to manage children:

Andrew, three and a half years old, was a whirling dervish in the classroom. Impulsive and somewhat aggressive, he would frequently run about the room crashing into other children or toys, and disturb free playtime as well as story time. Early attempts to contain his aggression were fairly successful, as Dr. Jones, the consulting psychologist, and his teacher, Ms. Winn, designed a behavioral plan for school and home that his parent gladly adopted. His impulsivity and hyperactivity continued to wreak havoc, however, especially during circle time. Finally Ms. Winn decide to have Andrew sit in an adult-sized cushioned chair by her side at circle, in which no other children were allowed to sit. Andrew readily took to this idea, and though fidgety and often inattentive, he began to sit through most circle times. Few other children complained about Andrew's "special chair" as they seemed to recognize that his sitting there allowed them to enjoy the teacher's stories. In fact many became protective of Andrew's new position, and would mildly scold each other if they usurped his place.

In this case, the consultant helped to design a behavior rewards system, but played a more critical role in supporting the teacher's ideas for how to contain and manage her student.

Together they charted his progress, looking for changes in the frequency, intensity and duration of the targeted behaviors. This process is often critical with more active or impulsive preschoolers, as it highlights that attention, impulse control and inhibition are *developmental processes*, not fixed entities. Seeing progress towards more self-control and focus is often the key to teachers' being more receptive to these children and less likely to want to label them or, in more severe cases, to ask that they be medicated or removed from their classrooms.

In a well functioning partnership, even the most traumatic events can be jointly addressed by teacher and consultant:

Ms Marano, an experienced head teacher, and Ms. Andrews, a consulting social worker, had been working closely together at St. Joseph's Head Start for two years. Though initially quite anxious when discussing her children's emotional concerns, Ms. Marano had gained considerable confidence in this area, and knew she could call on Ms. Andrews for support as needed. On one Monday morning, four-year-old Charles announced to the class that his mother had been stabbed over the weekend. Ms. Andrews was immediately called into the classroom, spoke with Charles and his teacher, and led a brief circle time in which she clarified what had happened, elicited the children's concerns regarding their own and Charles' safety, and offered them the opportunity to discuss things further with her or Ms. Marano whenever they desired. Ms. Marano did not shy away from this event, and continued to report on Charles' and the other children's progress in team meetings, and to call Ms. Andrews back for check-ups with the class over the next several weeks.

This young boy would have no doubt benefited in any event from having an insightful, experienced and psychologically minded teacher. Yet her ability to call upon the consultant to share the burden of processing this trauma and to follow the mental health professional's lead added a further dimension to her classroom repertoire, and allowed her to explore new emotional territory without major trepidation.

### **Engaging Parents**

Coming to know parents in early childhood centers is far different than in traditional mental health settings. As mentioned, there are many opportunities for informal contact, at drop-off and pick-up times where parents often gather to have coffee or chat with neighbors, in the classroom with parent volunteers and at parent gatherings or workshops. The consultants may be expected to join in local debates and share some details of their own family and personal life with staff members and parents. Like in therapy, each consultant needs to come to his or her own limits of disclosure, and to assess how these limits impact on the relationship with the center. Yet for many mental health professionals, this less confined role can be a welcome break

from the more formal structure of traditional psychotherapy, and gives them to the opportunity to support social and emotional development in a more normative context.

Often interventions with parents involve brief targeted interventions aimed at remediating specific fears or anxieties of children in the preschool. In some cases, the consultant may maintain a relationship with a parent and the intervention may focus on helping the child indirectly, through parent contact and “checking in” with the teacher:

The Rosens, whose daughter Nancy attended preschool in their suburban town, had watched their home burn to the ground after some faulty wiring ignited a massive fire. The consultant at the preschool, Dr. Douglas, had heard about the fire, but the teacher and school director reported that Nancy, who was a friendly and confident four-year-old, was doing well, and did not appear to need the consultant’s help at school. The family had found a suitable house to rent while their home was being rebuilt, and they all seemed to be coping well. About one month after the fire, Mrs. Rosen called the consultant, and relayed that while Nancy “seemed fine” during the daytime, she was having a terrible time falling asleep, insisted on sleeping in her parent’s bed, and woke up many times during the night. Everyone was exhausted, and Mrs. Rosen felt a mixture of sympathy and anger toward her young daughter.

Mrs. Rosen did not want the consultant to see Nancy directly, but was extremely eager to talk about how to handle the sleep problem at home. They spoke extensively for the next two weeks, and during these conversations the consultant primarily provided a listening ear for Mrs. Rosen, as well as making some concrete recommendations. These included having Mrs. Rosen and Nancy “play about the fire” using dollhouse figures and puppets, using relaxation techniques at bedtime, and having one of Nancy’s parents sit in her bedroom as she fell asleep. Mrs. Rosen used some of the recommendations and chose not to try others, and she remained in phone contact with the consultant over the next several weeks. Nancy’s sleep disturbance gradually improved, and she was also able to talk about the experience of the fire with more ease. The consultant did not hear from Mrs. Rosen again until later in the spring, when she called to let him know how much better things were going at home.

In this example, the parents made use of the consultant in a spontaneous, circumscribed manner, but such brief interventions often carry meaning that goes beyond the immediate situation.

Many parents have reported to us a sense of reassurance and relief in knowing that a mental health professional is on-hand “just in case,” to answer questions, listen, and provide an informed opinion when necessary. Just as teachers test the waters with the consultant during the entry period, parents also may try out the consultant to see if this is a person who can be trusted,

is approachable and helpful. Even when their encounters are brief, parents' positive experiences with a consultant are likely to encourage them to support the notion of on-site mental health services, to feel more comfortable with mental health professionals in general, and to spread the word to other parents.

Even when they have become a familiar presence, the consultants need to be aware of boundary issues in presenting educational or treatment recommendations to parents, as they may not always be eager to participate and may be confused by the on-site presence of a mental health specialist. Children who display signs of behavioral or emotional problems in early childhood centers have usually not been previously identified as needing services. Parents who enroll their children in nursery schools or childcare are not necessarily seeking support or advice with these issues, as they would, for instance, if they voluntarily came to a mental health provider on their own. Often the need for more parental input will arise when a child's functioning is compromised in the classroom, or when his or her behavior is disruptive and impacts on other children. In these instances, the centers typically ask parents come in and discuss the situation. Parents are more likely to comply with this request and react less defensively if they have a previous relationship with the center, and if the staff and the consultant assume a non-threatening stance in presenting the areas of concern. If there is a healthy rapport, calling parents in for a discussion can be a relatively simple process, and the consultant may well be welcomed as another potential problem-solver:

When Ms. Boudreau was asked to come in to the Little Tots Center to discuss her son's separation difficulty, she was not surprised. Ben, a three-year-old boy who had recently immigrated with his family from Europe, was tearful and clingy throughout much of the morning, and seemed to be reacting in part to his mother's inconsistency during drop-off times. She would sometimes stay briefly and reassure him, but at other times would stay for extended periods as he began to cry or show other signs of distress. In her meeting with the consultant, he suggested that Ben might bring classroom books home that she could translate into French, her native language, to help him feel more comfortable and more connected with his peers. The consulting psychologist advised her to stick to a more consistent pattern in the morning, staying for 10-15 minutes to help him settle and

then leaving him in the care of his teachers. Within two weeks, this combination of a fixed routine and using books as transitional objects greatly eased Ben's partings with his mother, and he began to more actively join in classroom activities.

The mother in the example was already well disposed towards the school, acknowledged her son's problems, and was not threatened or alarmed by the notion of psychological intervention. The consultant and teacher also had time to discuss the issues in advance, and were hopeful that they could work together with the child and his mother. At times, children's classroom difficulties are presented in a less coordinated and timely manner, to parents who are less prepared to hear about them. The consultant may be asked to intervene when there are strains in the relationship between the parents and the preschool. The goal in these cases is often to improve communication and foster a mutual understanding between parents and staff as well as respond to the current problem:

Ms. Gonzalez worked as an administrator at a public school pre-kindergarten, and her four-year old son Manny was enrolled in the program. Manny was an active and rambunctious boy, who was prone to accidents at home and in school. Previous incidents at the school in which he had sustained minor cuts and bruises had left his parents angry and suspicious, and they believed that Manny's teachers were not providing adequate supervision and did not particularly care for him. In classroom visits, the consultant, Dr. Monroe, did not find that supervision per se was a problem, but he did observe that the teachers were not comfortable with Manny and the three or four other active boys in the class. They ranged from being tentative to sometimes being harsh and overbearing with them. To help the situation, Dr. Monroe had been encouraging the teachers to have more active outdoor playtime, and had himself been trying to organize ball games for these boys. During one of these, Manny was tackled by two other boys and received a fairly serious gash above his lip. He was brought to the nurse who administered first aid, and then contacted Manny's mother, Ms. Gonzalez, whose office was just down the hall. Ms. Gonzalez was furious that she had not been contacted directly by the teachers and by what she again perceived to be a lack of supervision, as nobody could tell her exactly what had happened.

When informed by the director of Ms. Gonzalez's upset, Dr. Monroe stopped in her office at lunch. He explained that he had in fact been supervising Manny, and that the teachers had not been remiss in their duty. He also talked at length with Ms. Gonzalez about Manny's high activity level, and shared ideas about how to help him channel some of his energy and organize himself both at home and in school. He also encouraged Ms. Gonzalez to sit down with Manny's teachers and raise her concerns directly with them. She scheduled a meeting for the following week and seemed to feel that the teachers heard her concerns. The remainder of the school year passed without any major incident, and the consultant observed that the teachers seemed more attentive and comfortable with Manny.

In the above example, a moment of crisis turned into an opportunity for the parents and staff to take stock of their relationship and openly air their disagreements. Rather than contribute to a lingering resentment by both parties, it forced open the issues between them, helped along by some coaxing by the consultant. The fact that he was involved in the incident placed him squarely in the center of the dispute for a brief time. Though in an awkward position, he worked hard to not be defensive with this mother, nor to shy away from her anger. Being in this position also allowed him to share some of the "blame" with the teachers, and to further empathize with their dilemmas in dealing with active preschool boys.

### **Interventions with Children**

The mental health consultant enters the classroom wearing many hats. At times, she observes or intervenes with a particular child small group of children. After becoming a more familiar presence in the classroom, the consultant may work with the children as a group to support their emotional development or address specific psychological concerns. The consultant and teacher can address these issues during free play and other unplanned interactions, as well as in planned activities such as circle time discussion, story telling, puppet and dramatic play.

Mealtimes present an excellent opportunity for such informal exchanges.

Ms. Hardy, a head teacher at a nursery school, found that meals were most efficient when the children were encouraged to share the preparation, serving and clean-up, keeping conversation to a minimum. The center's director, however, had recently suggested that informal conversing during meals was an excellent opportunity to support language development. The consultant, Ms. Saunders, felt that such group discussions could also support emotional growth. She felt that the group focus during meals was a natural time to help children express themselves verbally, articulating their own feelings while responding appropriately to the expression of others. Ms. Saunders therefore offered to join the class for meals. The eager and animated young children lost no time in volunteering to participate in group discussions. Teachers and consultant typically followed the lead of the children with discussions emerging that ranged from the smells, sight, taste and feel of the food they were eating, to events that occurred at home, to reflections on classroom activities. At times, the consultant did initiate discussion about a topic of some particular relevance to the classroom, such as feelings about a teacher's unplanned absence or an impending holiday or vacation. Sometimes the children would

begin talks about bad dreams or monsters, or trouble with younger siblings at home. Despite Ms. Hardy's initial reticence, she soon found that these little chats were not only enjoyable to all, but that they improved the atmosphere in the class without causing breakdown in the carefully cultivated structure of the room.

Some teachers express the understandable concern that the unstructured nature of more free flowing conversation will contribute to disorder in the classroom and indeed, depending on the content, this can occur. While verbal expression of more negative feelings can, at times, lead to a more expressive, less controlled atmosphere, this short term consequence is usually outweighed by the gains in understanding and support that occur when such themes are opened for discussion. Children are, in fact, more likely to become unruly and disruptive when their feelings remain unspoken but continue to lurk beneath the surface, and are often notably calmed when given the opportunity to express themselves to adults who listens to them. These group discussions are not meant to be biased towards more difficult or painful emotional content--the children are free to express both negative and positive thoughts and feelings. The open sharing of joy, excitement and other warm feelings is an equally important part of establishing an emotionally supportive environment in the classroom, especially for children who live in more difficult or deprived home environments.

In some cases, mental health consultants are also available to provide brief assessment and treatment services for the children. Some centers are set up to allow the consultants to provide on-site treatment or to work 1:1 with a child in the classroom. Early childhood teachers often identify children who could benefit from brief, preventive intervention. The most frequent referrals are for children with behavior problems or those with symptoms of depression or anxiety. Parents are always contacted and consulted prior to any individual meeting with a child, and always need to be part of planning any ongoing interventions. Ideally, both parent and child get support that strengthens their resilience and improves their relationship with each other:

Four-year-old Philip was referred for brief treatment after his teachers became more aware of his isolation, and self-deprecating remarks and behaviors. Philip's mother was depressed and overburdened, and at that time, she was unable to offer much support to him. She frequently referred to him as "bad" and compared him negatively to his younger brother, and openly expressed a wish to be rid of him. In the early phase of treatment, Philip would repeatedly depict a mother rejecting and killing her son, and then running off with her younger child.

Philip's therapist openly discussed his mother's difficulties, but also emphasized and attempted to engage his strengths and skills, particularly his keen intelligence. She supported and facilitated Philip's creative use of materials and his dramatic and symbolic play. She also helped his teachers to likewise identify and support his strengths and need for nurturance. They readily accepted these suggestions and began to apply them to other children in the class as well, focusing on how each was a "special person."

Work with Philip's mother was initially difficult, as her depression had left her detached from his feelings as well as her own. She did however, support his treatment and the classroom interventions, and gradually began to identify with the positive view of Philip communicated to her by his therapist and teachers. After leaving his nursery school, Philip was granted a scholarship to a local parochial school. Proud of his achievement, Philip's mother was an enthusiastic participant at his "graduation," and became more actively involved with his schooling the following year.

Some consultants may have opportunities to work with children in small groups.

Preschool groups can serve a variety of purposes: socialization, development of empathy, and growth of interpersonal skills through play and group discussions. Groups provide another way to reach young children whose development may be negatively affected by stressful life events, reflected in maladaptive behaviors such as withdrawal, aggression, or hyperactivity. By observing and working with children's issues in the small group setting, the therapist can observe and further assess social and emotional problems identified in the classroom, interpret and address problems in peer relationships and intervene to improve adjustments to transitions, listening and turn-taking. Often children are identified for a group based on similar experiences or behavior:

In one group of boys attending an urban day care center, the children often played about "fathers." The consultant was aware that in reality many of the boys' fathers were absent from their lives. They continually pretended to be truck drivers, construction workers, and dads going shopping. They used the telephones to make "calls" to their fathers, and often assumed self-consciously "macho" roles, which at times included aggressive or provocative behaviors. The therapist attempted to bring the feelings and thoughts represented by this play into the verbal arena, making simple comments such as, "You

boys really think a lot about your dads,” or “I wonder if George misses his dad.” These play sequences and narrative comments eventually stimulated a more direct discussion of the children’s feelings of disappointment and their longing to connect to adult male figures.

Sometimes children respond to the consultant's words, elaborating the play or making a revelation about their lives. At other times, words seem to fall on deaf ears, and the children do not necessarily respond to what is said. However, even when children are not yet able to make use of interpretations or even simple invitations to talk about their lives, they benefit from the opportunity to play out their feelings and issues in the supportive group milieu.

### **Conclusion**

A strong preschool/mental health partnership can lead to decisive change and can leave programs with more effective tools to meet their children's needs (Donahue, 1996; Donahue, Falk & Provet, 2000; Goldman et al, 1997). The shared vision of professionals can give staff new hope that they can confront difficult behaviors and emotionally charged material in the classroom. Children and families also benefit from the combined focus on children’s social and emotional development and early intervention efforts aimed at preventing more serious problems from developing later on in childhood. In addition, an effective mental health collaboration can enhance a program's resilience, and reduce the stress of staff as they join together to face the day to day challenges of meeting the educational and emotional needs of the young children they serve.

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