UAIMH Newsletter

Utah Association for Infant Mental Health

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http://www.uaimh.org

President's Corner

What does Infant Mental Health (IMH) look like in Utah? When people on the street are asked what "mental health" looks like in children, it conjures up images of suffering, disorders, and something being wrong (see this video by the Frameworks Institute). However, when we speak of Infant Mental Health (IMH), what we really mean is **optimal social-emotional development in babies and toddlers** (see www.uaimh.org) that is a foundation for later health and wellbeing. The IMH field works toward promoting this optimal health, preventing problems early, and intervening more intensively if necessary. This issue of the UAIMH Newsletter highlights several professionals in Utah who are passionate about infant mental health

Karen Malm, a clinical psychologist in the Salt Lake Valley, explains what IMH is in understandable words. What does it really mean to support babies' social-emotional health and growth? No, we are not talking about a baby "on Freud's couch"! Although Karen has a wealth of experience as a clinician working with infants and their families (at Summit Community Counseling and previously at The Children's Center), her emphasis in the article is on IMH in everyday life. She makes it very clear that IMH is supported by parents on so many levels *and* that parents and families need support for the optimal growth and development of their babies.

From Southern Utah, Debbie Justice also honored us with an article. Debbie only recently retired from The Learning Center in St. George, which she founded and led for 22 years. Suzanne Leonelli, Board Member of UAIMH, took over as Executive Director last summer. Debbie's story about TLC's early days is fascinating. She describes how they set out to assess children for Early Intervention (EI) eligibility and how some children seemed to be entirely on track in all areas of development that were assessed (like their motor and communication skills) – but they still struggled with challenges in the social-emotional realm. To this day, social-emotional concerns (the area of IMH) is often not adequately addressed. Developmental screening is encouraged and increasingly applied—by Help Me Grow Utah, the State Health Department (and Justin Nuckles, who also wrote an article for this newsletter), and pediatricians across the state. However, time for screenings is typically limited, and not all professionals are trained to screen for social-emotional concerns. Debbie Justice and the TLC were pioneers in Utah in figuring out how to best identify children in need of social-emotional interventions, and how to best intervene. There is still a lot of work to do, but due to the pioneering work of TLC, The Children's Center, and others, awareness of the importance of IMH is growing in Utah and beyond.

Contents

The third example of a professional with a passion for Infant Mental Health in Utah is Justin Nuckles, who only recently began his position at the State Department of Health in Salt Lake City. Justin is coordinating the statewide use of developmental screening and the Strengthening Families program. His article connects his beginnings in Southern Utah, where the fire of his interest in IMH was ignited by a professor at Dixie State. She inspired him to partake in two highly acclaimed programs specializing in infant and early childhood mental health: the Erikson Institute and the Infant-Parent Mental-Health program at the University of Massachusetts in Boston. We are so lucky in Utah to have Justin back now, making a difference for families and young children here!

All kinds of exciting things have been going in in the beehive state in relation to Infant Mental Health. Let me share some highlights with you.

1. Our Past President, Dr. Vonda Jump, just did a TED talk at USU! How exciting! She addressed her talk to her daughter, Bianca, and all other expectant and new

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parents, and titled it *"Dear Bianca: Use Your Heart to Build Your Baby's Brain."* The talk was organized through TEDxUSU, and you can watch it here.

2. On October 6, 2015, the Utah Chapter of the American Academy of Pediatrics (UAAP) organized an excellent one-day conference with premier experts from Utah and abroad, entitled *Only 1,000 Days: Our Opportunity to Rescue Threatened Moms and Babies.* The conference informed its attendees about the effects of toxic stress on a baby's development by way of epigenetic and other physiological processes (topics we discussed in earlier newsletters). Most of the attendees were physicians, who were very interested in learning more about how to help little ones and their families who have had traumatic experience.
3. This conference was initiated by Dr. William Cosgrove and his colleagues. Dr. Cosgrove is the President of the Utah Chapter of the AAP. He recently joined the Early Childhood Utah committee, which means that EC Utah now has a representative from the esteemed field of pediatrics! EC Utah consists of major leaders and professionals in the field of early childhood, with the goal of improving early childhood development across Utah. Several UAIMH members are part of EC Utah and we continue to advocate for better social-emotional health for our infants and young children. Early Childhood Utah has a subcommittee on Social-Emotional health that we are a part of. Part of our goals for next year included expanded screening and supporting professionals working with young children and their families.
4. An excellent new initiative in Utah is collaboratively working on educating Utah IMH and early childhood professionals about autism: the Utah Network for Early Autism Response (UNEAR) offers education and support in how to recognize the early signs, how to screen, and how to refer to further assessment and treatment. This collaborative effort consists of researchers and professionals from a range of organizations, including the University of Utah, Brigham Young University, Utah State University, Utah Valley University, Utah BabyWatch, the State Health Dept., Univ. of Utah Pediatrics, Autism Council of Utah, Utah Regional Leadership Education in Neurodevelopmental Disabilities (URLEND), State Office of Education, and Intermountain Healthcare/ Primary Children's Hospital. They have offered trainings throughout the state in the summer of 2015 and are continuing their work in 2016!
5. Help Me Grow Utah has just expanded their services to include the prenatal period! Although HMG has been an important first-line portal for supporting parents of children aged 0 to 8, development begins before birth (as Debbie Justice also mentions). By supporting mothers who are pregnant and connecting them to information and services, HMG hopes to improve outcomes for mothers *and* their babies.
6. Our "sister organization," the Utah Maternal Mental Health Collaborative (UMMHC), led by Amy-Rose White, LCSW, specializes in mothers' mental and emotional health around the time of birth, and is working on expanding support for parents in the time around birth. Amy-Rose is an expert on the topic of maternal mental health during pregnancy and the first year after birth. She began her career in Early Intervention and trained to be a Perinatal Psychotherapist. She discovered that, in order to IMH, we need to support mothers, so that they can support their babies.
7. The U.S. Preventive Services Task force just released new recommendations for screening for depression in pregnant and new moms on January 26, 2016. A major recognition that mothers' mental health, and subsequently the baby's mental health are essential health concerns!

Ilse DeKoeyer-Laros, PhD
President, Utah Association for Infant Mental Health
Assistant Professor (Lecturer), University of Utah Psychology Department
Child Development Specialist, Help Me Grow Utah

Infant Mental Health: You've Got to be Kidding!

I was at a party the other day and brought up infant mental health. The person I was talking to said, "Infant mental health! Are you kidding"? The person went on to rant about "why can't we let kids be kids anymore" and "why do we have to have a label for everything." I listened to his response and thought, it would be nice to not have to label everything and to not have to talk about infant mental health. When life was simpler, children could grow like weeds and could eat healthy food without preservatives, wander the out of doors, and learn problem solving from day to day experiences. Today, with the stressors in our modern life and with technology, children are exposed to risk to their mental health more than ever before. Good mental health starts in infancy. To become healthy adults, children need positive caretaking in infancy. Infant mental health is about

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establishing a safe, predictable, stable home environment where healthy attachments are formed that provide the seeds of self-confidence, self-esteem and the core beliefs that lead an individual to feel that they are capable of achievement.

Infant mental health is about establishing a safe, predictable, stable home environment...

Infant Mental Health Before and After Birth

Good infant mental health starts the moment a child is conceived, beginning with good prenatal care and decreasing the stressors in a pregnant mother's life. We want to work towards supporting the mother to be excited for the birth, be prepared to take care of an infant, and to have the knowledge of how to support the baby's needs. In our community, this means having free or low cost care for pregnant women and to provide information for mothers who are considering giving up their infants for adoption or doubt their ability to take care of their child.

Birthing classes are important to teach the mother what to expect during the birthing process so she is not as overwhelmed with the birthing experience which can affect her ability to be present for her baby. Breastfeeding classes help with decreasing the frustration that can occur when mothers try to breastfeed and do not know how to help the baby with this process. It is key to teach mothers about what to expect in the neonatal period and helping guide her with appropriate and realistic expectations. She needs to know that she will not sleep much, she will feel like it is all about the baby, and that she will have little "me" time. This is an overwhelming time and if we let mothers know that it is okay to feel overwhelmed and to link her with resources, then we can prevent early abuse in the infancy period (i.e., shaken baby syndrome) and prevent bonding and attachment issues.

Infant Mental Health and the Brain

Another important aspect of infant mental health is the development of the brain and making neural connections which will impact the individual throughout the lifespan. When infants are born, they have more neurons than they will ever use. The connections that are used will stay, the others will die off. A key connection established during this early time period is the development of our brain structures related to self-calming and affect regulation. When an infant is stressed and crying, it does not have the ability to calm itself and to decrease the excitement happening in its brain. As a parent, we swaddle the infant tightly and control the developing motor neurons and help the flailing limbs to be in control. Then we carefully hold the baby to our chest.

Our calming heart helps to calm the infant's heart, our calm breathing helps slow the infant's breathing, and our soft voice used to calm the infant, helps them to know that we are there for them. This process directly helps to make the connections that the brain will later use (as an adult) to self-calm. If a mother is herself agitated and upset while trying to calm the baby either because she is frustrated or because she is being traumatized, then the infant is not establishing that connection. They do not learn to self-calm and later in life may show difficulty with maintaining the ability to self-regulate their emotions.

As parents we also teach infants about their internal states and what feelings are. When babies are happy, we smile, we raise our voice tone, and we tell the baby, "you're happy!" When the infant is sad, we make a sad face, our voice tone lowers, and we tell the baby, "You're sad." The baby has neurons that mimic what they see called mirror neurons. When they look at our face, their brain responds as if looking in a mirror and they can mimic what they see. So when we smile at the baby and say "You're happy," the baby registers that facial expression and that word and voice tone and starts to learn that emotion. As the infant grows to a toddler, we add new emotions like frustrated, scared, and nervous. We are directly teaching our babies about what they feel inside and then we teach them how to cope with those feelings and to seek comfort from the adults in their lives. It is these mirror neurons that appear to be defective in children with Autism Spectrum Disorders (ASD).

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Infancy and Beyond

Infancy is such an amazing time period of growth and development, a time for an individual to explore their bodies, their senses, their environment and their mind. We are driven to attach to others for our survival and to learn that adults are helpful and supportive, and that we have a right to be cared for and loved. Babies are born ready to bond and learn, and we need to provide a safe environment to make that happen. The early roots of self-empowerment begin in infancy when a baby learns that "when I cry, someone comes for me and

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comforts me." This early lesson of cause and effect will be important throughout the lifetime and will mean that the child can learn from consequences and the adult can follow societal rules. All of these issues are at the root of infant mental health.

My father once told me, "You take parenting so seriously," and I said "Yes, because I am creating the environment to help develop a healthy child who can then become a productive adult." Infant mental health interventions help mothers who struggle, help prevent problems that will grow into bigger issues, and overall will help us as a society to develop well-rounded, productive adults.

Karen Malm, PhD
Licensed Psychologist
Executive Director of Summit Community Counseling

The Learning Center (TLC): Building Infant-Toddler Mental Health Services from Scratch

"You have to help me!" the frantic mother cried into the phone. "There is something wrong with my son." I received this call in February of 1994. At this time, The Learning Center for Families (TLC) had only been in existence a scant 5 months. We had been contracted by the Utah State Department of Health, Baby Watch Early Intervention Program, to provide services in Washington County, Utah, in September 1993. We had three and a half staff, a very small enrollment and only received a few referrals per month. Now I have Mrs. A, on the line who is continuing to recite all her concerns about her 26-month old as I gathered information for the referral: "He is mean. He bites, pinches, punches and scratches me. He has pulled my hair out in clumps. If I tell him 'no' his tantrums last for hours and he destroys everything. He has tried to strangle the dog. He was so mean to the dog we had to give her away. He doesn't take naps. He is impossible to put to bed at night. He refuses to sleep and cries for hours. I have tried everything to discipline him and nothing works!" Her desperation was heartbreaking. I obtained some additional information over the phone per Mrs. A.: the child was talking, toilet training, walked and ran, played with toys, etc. What could the deficits be--which tools would I use to evaluate this child?

"You have to help me!" the frantic mother cried into the phone. *"There is something wrong with my son."*

It was 1994, the early years for early intervention. The array of assessment tools to flush out sensory and behavioral health, as well as determine eligibility in Utah, was scant. At that time, TLC staff were using the original *Battelle Developmental Inventory* (BDI), the *Receptive-Expressive Emergent Language Test* (REEL), the *Mullen Scales of Early Learning* (MSEL) and the *Hawaii Early Learning Profile* (HELP). Consider, also, that the Early Intervention training being developed to meet the *Comprehensive Staff and Personnel Development* (CSPD) requirements in Utah had not yet been launched. Early interventionists in the early 90s were often 'winging it' based on their knowledge of typical and atypical early childhood development. Even those who represented the clinical disciplines: speech, occupational therapy (OT) and physical therapy (PT), were nearly all trained in a medical model and/or coming from special education settings working with children 3 – 21 in school settings. And social workers? They weren't providing mental health supports at that time. They were conducting service coordination in most cases. Although our cadre of interventionists could usually suss out the characteristics of autism spectrum disorders (ASD), we at TLC struggled with determining what constituted standard deviations below the norm in social-emotional behavior that was not linked to ASD.

What To Do: Typical Development – or Not?

Which assessments were going to be helpful for evaluating Mrs. A's little boy? I decided I would use the Mullen and the HELP to determine eligibility. However, neither tool was very sensitive to atypical social-emotional behavior unless it fell into the realm of ASD symptomology. According to my assessment report from February 1994, MA was a "moderately active child who engaged easily with this examiner. He chatted using 3- and 4-word phrases throughout the assessment and promptly completed the assessment items with minimal cues." I was able to determine a baseline and ceiling in all areas and, per the MSEL, MA was functioning well above age-appropriately in all developmental domains.

Upon my conclusion of the testing items from the MSEL, I shared MA's scores with Mrs. A. I also outlined additional strengths I observed using the HELP along with my own observations. According to the information at hand, MA did not meet eligibility guidelines as put forth by Utah's

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Baby Watch Early Intervention guidelines. "But you don't understand!" Mrs. A wailed through tears when I delivered this good news, "My boy is not OK! There is something WRONG with him" she insisted while I packed up my tools and prepared to leave. Just then pandemonium broke out. MA, seeing that I was about to leave, screamed "NO!" He wrenched my assessment kit away from me and hurled it at me. He grabbed a lamp and threw it my way as well. He snatched my car keys from the table and would not give them back. MA proceeded to have a screaming tantrum that I could still hear a block away from his house when I finally managed to wrest my keys and get going. My last words to Mrs. A as I struggled to get out the door were "I agree with you. I think something is going on. Let me get the nurse out here so we can finish his assessment."

I was baffled, even though MA was functioning at age-appropriate or above in all the areas assessed with the tools that morning, it was obvious, through my observation, that he did have some differences that would meet eligibility for early intervention per Utah regulations. But just how were we going to measure this as a delay? Our program nurse evaluated MA the next day. She also witnessed his aggressive behaviors and concurred that "There is something going on".

It is not like the TLC team were novices. By this point in my own interventionist career, I had conducted hundreds of assessments and I had certainly seen children acting out aggressively. However, up until this time, I had only seen this in children who already qualified for EI due to one or more delays in other domains. This was my first experience with a purported 'typically developing' child that was so far off the scale in his ability to self-regulate.

Craig admitted that he had little experience in treatment of children birth through 2 years of age; however, he was willing to learn alongside us and our families.

Serendipity and Figuring out how to Intervene

The nurse and I made MA eligible due to 'informed clinical opinion' where we described, in detail, the behaviors we observed in the assessment report. But now how would we help this family? In a moment of supreme serendipity, a newly licensed LCSW, Craig Roberts, who had done an internship with a therapist who had specialized in sand play therapy moved to Southern Utah shortly after MA enrolled. Craig admitted that he had little experience in treatment of children birth through 2 years of age; however, he was willing to learn alongside us and our families. Not that long after Craig joined our team, we began receiving dozens of referrals for little children with unusual behaviors.

There was the 2-year old with trichotillomania. His parents tried shaving his head but he resorted to pulling his eyebrows and eyelashes out. There was also an element of pica in his behavior because he would put the hair in his mouth. When he ran out of strands on his own body, he started picking up hair and pet fur off the floor and putting that in his mouth. Then there was the 2-year-old girl who acted like a puppy. Although she had mastered utensils in the past, she suddenly decided not to use them anymore and would lap her food. She barked and crawled on her hands and knees. This little girl's parents became quite alarmed when she started lapping water out of the gutter. She insisted she was a puppy and refused to talk or eat like a child anymore. We received multiple referrals for children who could not sleep through the night. They presented with no other delays with the exception of their sleeping patterns. We had a whole host of children that I called the 'white' children. They would only eat "white" foods: French fries, chicken nuggets, rice, milk and vanilla ice cream. Some of these referrals coincided with other areas of deficits but many of the children were developing along a normal trajectory, yet they were quirky.

Initially, Craig set up a modified version of play sand therapy to work with the children who were brought to our center. Craig would work with the child in the room and the parents would watch the play from a one-way window. Craig would meet with the parents after the session to discuss what they observed. The sessions would end with the parents engaging their own child in the play room while Craig coached and supported their work. Craig was all about "follow the child's lead" and I heard it from him before I ever heard it from Stanley Greenspan. He would also conduct parent-only sessions where he discussed how play can be therapeutic and helpful in regulating children's behavior.

Around this time we wanted to share what we were doing with Baby Watch and our colleagues. We put together a short video of a 20-month old during a play session. We explained that this child had experienced a great deal of medical trauma. He had been hospitalized numerous times for various medical procedures. In the video, the child repeatedly threw and kicked the toys from the medical kit. He took the daddy figure out of the playhouse and sat on it. He was nonverbal but was demonstrating through his play how "he had been traumatized and felt helpless," Craig narrated. I remember

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less than insightful feedback as some in the group grumbled "All babies throw toys." We definitely had trouble convincing our colleagues we were onto something.

Meanwhile at TLC, the intradisciplinary method really started paying off. As Craig learned more about early childhood development and early intervention TLC staff learned more about infant-toddler mental health. Within 2 years, Craig ditched the center-based set up and started treating children and families in their homes. We went after enhanced funding from private and community-based foundations to support this model. At the root of every child's disordered play, we would find issues with attachment and sensory processing disorder and the therapy became more geared at helping families help their child.

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Reaching Out

Meanwhile, we reached out to The Children's Center to provide training on infant-toddler behavioral health in Southern Utah. We asked that they train our staff as well as our capitated county mental health services staff. At that time, I was trying to get our local mental health department to provide services to young children we identified with mental health issues- especially the children who were being diagnosed with autism. The answer I received was two-fold: (1) children with autism should be served by the Division of Services for People with Disabilities (DSPD), not mental health; and (2) county youth mental health service providers were experienced in using cognitive behavioral therapy (CBT). This method could not be used on preverbal children.

While the training provided by The Children's Center was extremely helpful, and supported our resolve to serve children with atypical social-emotional development, it did not immediately change our mental health partners' scope of practice. It was only in 2003, when county mental health was called out by Medicaid for underserving infants and toddlers, that they hired a pediatric psychologist who had experience working with children newborn and up. Finally we were able to refer families to mental health for additional testing and diagnosis. This helped families tremendously and it also aided us by providing children with a diagnosis that could then be the basis on eligibility for early intervention.

The tools improved as well. We adopted the *Infant-Toddler Symptom Checklist* as soon as it was published in 1995. We were using the *Social-Emotional Assessment* from Stanley Greenspan before it was incorporated into the revised BDI. Craig also started nurturing a theory that pregnant mothers who were experiencing a great deal of stress and adverse trauma were more likely to have babies that struggled with their own self-regulation and social-emotional well-being. This was years before *From Neurons to Neighborhoods* was published, highlighting all the research that has been done in this area.

One ironic consequence was that once county mental health began to serve our infants and toddlers, we no longer had very many hours for Craig. Early intervention is mandated to be the payer of last resort. Therefore, children with Medicaid were referred out to our county mental health services for social-emotional support services. Craig's contract hours with us slowly dried up until one day, he left us and was hired by mental health.

TLC's Expanding Services

TLC started as an early intervention provider but through the years also developed contracts with Early Head Start and the Office of Home Visiting. Additionally, we became contract service providers for families living on the Arizona Strip through two different home-visiting programs: First Things First and Arizona Early Intervention Program. We cross-trained all staff to provide services for any one of our five home visiting programs. In this fashion, we are easily able to support families with a seamless service plan if they were enrolled in more than one program simultaneously. We went back to contracting for Craig's services one day per week to work primarily with pregnant women. We have learned through our two-plus decades of working with infants and toddlers that, for some high risk families, the best intervention starts before the child is even born.

I have recently retired from TLC. One of the primary lessons I have learned in the field of infant-toddler mental health is that to achieve 'goodness of fit' you have to work with those who are best able to adapt, the parents. Families need to understand and be responsive to their child's needs so that they can anticipate challenges in the child/family environment and be proactive in shaping their child's sound social-emotional development.

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Often times this requires pre-pregnancy couples' therapy--the earliest of early interventions.

On a happy note, I heard from Mrs. A. just a few years ago. She remains grateful to TLC for listening to her and helping her raise her child. Her son went on to become a Junior Olympian and was admitted to the Naval Academy. Mrs. A. credits early intervention with helping her child achieve success by helping her learn to parent him in a way that reduced the stress in her home environment. Seeing as we were so green in our initial efforts to provide infant-toddler mental health, I can't help wonder if there is not a little bit of the Jiminy-Cricket-Pink-Feather effect. It truly speaks to the importance of early interventionists supporting families so that they, in turn, can support and nurture their child's positive growth and development.

For more information on The Learning Center and its history, see:

- A wonderful video with Debbie Justice: https://www.youtube.com/watch?v=es50HNCy6YA
- A Prezi presentation recently made by Debbie Justice: https://prezi.com/vcqxkvpsjkw8/through-the-years-with-the-learning-center-for-families/
- The Spectrum (June 27, 2015). Southern Utah Families find Justice at TLC. http://www.thespectrum.com/story/news/local/2015/06/27/local-families-find-justice-tlc/29408773/
- The TLC website: https://www.tlc4families.org/

Debbie Justice, MA
Founder and Executive Director (retired)
The Learning Center, St. George

Lighting the Fire: Education in Infant Mental Health, and Beyond

I consider myself incredibly fortunate to have fallen into the world of Infant Mental Health at an exceptionally early point in my career. I started out my undergraduate work as an Accounting major, but quickly came to the realization that my heart just wasn't in it. Over the next several years I narrowed down my field of interest to Psychology, then Developmental Psychology, and finally to the field of Infant Mental Health as the result of a close association with my mentor at Dixie State University (Dixie State College of Utah, at the time), Dannelle Larsen-Rife.

Immediately after transferring to Dixie State, I had some questions about a few transfer credits and was directed to Prof. Larsen-Rife as the instructor for the equivalent courses. That first meeting with her, we spoke only briefly about course credits before the conversation quickly expanded to my passions and interests. I told her of my interests at the time, and she provided, at my request, a list of books outside the scope of any required course texts for me to ingest. Based on my interests, she also recommended a fairly new course she was offering, titled "*Child and Family Mental Health." For our text, we utilized Lillas' and Turnbull's "Infant/Child Mental Health, Early Intervention, and Relationship-Based Therapies: A Neurorelational Framework for Interdisciplinary Practice.*" From the very first class, I was hooked. I had always been the type of student who dutifully read my texts--this one I devoured. The intersection of mental and physical health, social context and relationships, neuroscience, and interdisciplinary collaboration stoked a fire I hadn't realized had been burning. Recognizing my interest and passion, my mentor told me of her experience in the University of Massachusetts Boston's Infant-Parent Mental Health Postgraduate Certificate Program (now Napa Infant-Parent Mental Health Fellowship Program), on which her course was loosely based. As she listed to me the presenting faculty who participated in this small-group education setting, my mouth watered in intellectual appetite. Included were individuals such as Bruce D. Perry, T. Berry Brazelton, Peter Fonagy, and Ed Tronick, many of whose works she had previously recommended to me. With her encouragement and assistance, I applied to and was accepted into this incredible Fellowship Program, the first participant to do so as an undergraduate student.

Prof. Larsen-Rife also made the suggestion to me of attending the Erikson Institute in Chicago, Illinois, the nation's gold standard program in child development. Once again, I applied to and was accepted into this one-of-a-kind program; I have been incredibly fortunate in my education. That span of 3 years were some of the most rigorous, gratifying, and mind-expanding of my life, as I concurrently first finished my undergrad and began the Fellowship, then began my Master's studies while finishing the Certificate Program. The Institute taught me the intricacies and complexity of typical child development through culture, relationships, and social connection. The Fellowship taught me that even when gross

...Even when gross insult or injury to mental health was present, repair is still necessary and possible....

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insult or injury to mental health was present, repair is still necessary and possible through those very same channels. I'm an idealist by nature, and my experiences have given me an exquisite vision into what **CAN BE** in the lives of children.

And so, I find myself here, back in my home state of Utah, doing the best work I can imagine in the pursuit of those ideals. I currently work in the Department of Health, for the Bureau of Child Development. My program responsibilities include coordinating state-funded use of the Ages and Stages Questionnaire (ASQ) by childcare and home-visiting programs, pediatricians, public school teachers, and other interested parties, and coordinating the statewide implementation of "Strengthening Families: A Protective Factors Framework," a framework encouraging agencies, programs, and parents to collaborate together to develop family characteristics empirically shown to improve family and child outcomes and reduce the incidence of child abuse. My job is a dream. The exact concepts and principles which spoke so powerfully and potently to me in my education are the very principles driving what I do every day: cultural sensitivity, parent advocacy and involvement, the power of personal connection, and interdisciplinary collaboration. Infant Mental Health may not be in my title, but it's infused in my work, and that's all that really matters. I'm ecstatic to be back home in Utah, involved with such great causes, at such a great time, surrounded by so many great individuals, with so many great things on the horizon. Frederick Douglass once said, "It is easier to build strong children than to repair broken men." This is the work we are in, this is the endeavor we make our business: the building of strong children, from the earliest of times. I'm proud to be a part of the Utah Association for Infant Mental Health.

Infant Mental Health may not be in my title, but it's infused in my work, and that's all that really matters.

"It is easier to build strong children than to repair broken men."

Frederick Douglass

Justin Nuckles, MS
Health Program Coordinator—ASQ & Strengthening Families
Bureau of Child Development

Reaching a Milestone: The 30th National Training Institute by Zero To Three!

In early December of 2015, Susan Dickinson and I set out to explore the many exciting offerings at the 30th annual NTI in Seattle, Washington. This was the first time I attended and the last time that the conference had this name! In the future, the conference will be called Zero to Three Annual Conference (in 2016, it will be held December 7-9 in New Orleans).

Keynote Speaker: Dr. Nadine Burke Harris

The NTI opened with a bang: Dr. Nadine Burke Harris, well known for her TED talk on Adverse Childhood Experiences (ACEs) opened the conference on Wednesday night. Her passionate account of the original ACEs study was already well known for many conference goers. But in this presentation, she was explained more about the model she developed to work with ACEs in practice. It is one thing to recognize ACEs and to start screening for them, but quite another to know what to do about it if ACEs are discovered. Dr. Harris, a pediatrician, shared more about how she works with ACEs in her comprehensive pediatric clinic, called the Center for Youth Wellness, in a high-risk area of San Francisco.

The protocol for clinical practice was summarized in her talk as Screen – Counsel – Refer. Dr. Burke and screens all her patients for ACEs but she does not specifically want to know which ACEs a patient has experienced. "We don't ask you to say which ACEs your child has; just tell me how many." Just knowing the number of ACEs is enough for Dr. Burke to gauge the health risks of this particular child, and she can start a conversation (counsel) and refer to specialized services. Of course, access to specialized services is a challenge for many, so another positive contribution by Dr. Harris and her clinic was a list of activities and recommendations, most of which can be provided by nonmedical professionals:

1. Exercise
2. Healthy nutrition
3. Sufficient sleep
4. Mindfulness practices
5. Supporting healthy relationships
6. Mental health interventions

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All of these interventions or suggestions are supported by research. For example, both exercise and mindfulness practice have been found to reduce anxiety and stress, and to boost the immune system. Dr. Harris' office can afford to offer a nutrition specialist and mental health services, which is a great model for pediatric offices. However, even if you work in a setting where such services can't be added, you can still utilize her other recommendations to help people deal with trauma from their ACEs.

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Research and Policy

The first full day of the conference opened with a summary of a recent focus-group study among millennial parents by Zero To Three and the Bezos Foundation. Some themes that were uncovered were: (1) parents struggle with discipline (they want to be effective, but not harsh). (2) Dads often feel devalued. For instance, when the media shows a dedicated father, it is presented as "special." Fathers want more respect for their role in the raising of their children. (3) Millennial parents have a deep desire to parent differently from their own parents. (4) Parents feel judged all the time! (5) These parents rely heavily on the internet, media, and friends. (6) These parents appreciate expert advice but wonder, "do you really know my child"? (7) Millennial parents have a deep desire to be the best parents they can be. They also understand that the first few years of life are foundational for the rest of the child's life and that parents play a large role in supporting optimal development.

The first full plenary presentation of the day was by Dr. Patricia Kuhl, an expert on early language learning and the brain, and Dr. Andrew Meltzoff (the one who is in all developmental psychology textbooks, sticking out his tongue to a newborn—doing this, he discovered that newborns can imitate certain facial expressions). This husband and wife team together run the so-called I-LABS at the University of Washington. Here, they both study how infants learn and interact, but their research is quite different. Dr. Kuhl's work focuses on how babies learn to talk, the role that adults play in this process, etc. Most of what she shared in her presentation was also presented in her 2010 TED talk, but in the meantime, her research is continuing and expanding, especially her research with the MEG brain scan machine that she uses to observe babies' brains while they listen to certain language sounds. Dr. Meltzoff has done a lot of research into how infants and toddlers imitate, and how they learn to perceive and use social signals, like eye gaze. The most interesting new research he shared will be relevant for those of you working with infants who are exposed to angry emotions. In the research situation, the infant (about a year old) sits with an experimenter in a research room, and the adult shows a rather odd behavior (Dr. Meltzoff has used behaviors such as touching a box with his head, making it light up, and seeing if infants would imitate; in this case, the adult was sticking a large stick into a box). Dr. Meltzoff shared a video from this research, showing the baby carefully observing the adult, and then imitating. They repeat this and, again, the baby faithfully imitates the behavior. Then, a second adult comes in and, when adult 1 does the action with the box again, adult 2 has an angry outburst with her. We observed the baby looking at the angry adult, and then back at the first adult, who again showed the action on the box. But this time, instead of imitating the adult's action, the baby appeared almost motionless. She kept looking at the adult who had been mad, even though she was now quietly reading a magazine. This experiment beautifully illustrated how even babies around 1 year of age are aware of the emotions that adults express around them, and that it can hamper their ability to act spontaneously. Even at this young age, babies can inhibit their actions out of concern for emotional threat.

This experiment beautifully illustrated how even babies around 1 year of age are aware of the emotions that adults express around them, and that it can hamper their ability to act spontaneously.

Other plenary sessions at the conference included a roundtable discussion between several key political figures from Washington: Seattle's mayor, a major representative from King county (where Seattle is located), a state representative, and a representative from the Department of Early Learning. After learning more about the science of early learning (notably Dr. Kuhl's work), decision makers in Washington were inspired to offer more options for early learning and they built a system for it (though bipartisan action) that is unique in the country. More about that can be learned here: Thrive Washington. This website has a lot of information and several toolkits, including one that I learned more about in a break-out session: the NEAR@ home program, an ACEs toolkit.

(continued...)

NEAR@home

NEAR refers to: Neuroscience, Epigenetics, Adverse Childhood Experiences, and Resilience. The NEAR@Home toolkit was created, reviewed, and tested by home visitors, mental health providers, and other experts Alaska, Idaho, Oregon, and Washington. During the workshop, we learned more about how home visitors can screen for ACEs and then talk about these adverse childhood experiences with the parents that they are visiting. This workshop offered many practical tips for how to talk about such difficult issues with parents, but what struck me the most was the respectful and calm tone that the presenters used to share this information. The presenters, who had helped developed this model, emphasized that, in order for a home visitor to be able to talk about ACEs with a family and care for that family, the home visitor herself will also need to be taken care of. They highly recommended reflective supervision, to help the home visitor process any challenging emotions. They also emphasized self-care: if you don't feel good on a given day, then this is not the best day to bring up ACEs.

The screening process that this program recommends is the same as Dr. Harris uses: asking the parent *how many* ACEs they experienced, but not asking the details of which ACEs were experienced. However, in this program, there is more time for follow-up questions: "Do you want to talk about any of this?" If not, then that's okay. But if the parent does want to talk more, the home visitor takes an inviting stance and truly listens to the story. The program as a whole has five core elements: Preparing, Asking, Listening, Affirming and Remembering. The idea is that the difficult stories can come out, and parents who experience ACEs have a safe place to share their story, and be acknowledged as a person, so that they can process what happened to them. This then can help them to be more effective parents, for whom trauma stands less in the way of their parenting. Of course, all of this is challenging. One major issue that was brought up is that home visitors are not licensed mental health workers, and yet they are doing some of the work that therapists do. The presenters acknowledged that this is asking a lot from the home visitors, but they still believe the NEAR program is essential. Yes, the home visitor needs to be properly supported. But they can be major agents of change: there are many people who have experience multiple ACEs, and parents who receive home visiting services are likely to have experienced even more than average. There are not enough therapists around (at an affordable cost) to help this entire population. Of course, the home visitors will still refer parents to additional services if available and possible. But they can play a major role in helping to abate some of the suffering that is standing in the way of loving parenting (and of learning to be a better parent, as you cannot be open to learning if you are using all your energy to survive). The program very much emphasizes care for the home visitor, using mindfulness practices to support the wellbeing of the professional, offering reflective supervision or at least supervisor support, and offering lots of empathy. The NEAR program is based in science and meant for home visitors with at least one year of experience in their program.

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Dr. Alicia Lieberman

Another highlight at the conference was attending a session by Alicia Lieberman and her colleagues, about the Child-Parent Psychotherapy (CPP) program, and especially meeting Dr. Lieberman later, when she signed a copy of the second edition of *Don't Hit My Mommy: A manual for child-parent psychotherapy with young children exposed to violence and other trauma.* Alicia was very kind, and when we approached her and told her we were from Utah, she asked us to send her regards to Dr. Goldsmith of The Children's Center!

It was a treat to meet Dr. Lieberman and Dr. Chandra Gosh Ippen, who also signed our book, and to hear them speak about their work with traumatized young children. During a break-out session, they shared more about their work in different clinics that serve a high-risk population. And in a plenary session after that, they outlined the steps to take during the CPP therapeutic process and offered some beautiful examples of how a little, 2-year-old girl, who had endured severe trauma, was able to process her feelings and thoughts through play, and get reconnected with her loving foster parents.

I attended several other interesting sessions and presentations and met with wonderful colleagues (mostly from Utah)! We purchased streaming access to the presentations and UAIMH would love to share more with you of what we learned. It was a nourishing experience!

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Child Development Specialist, Help Me Grow Utah

Announcements/Upcoming Events

February 4-5, 2016, Bridging the Gap Annual Conference: Clinical Application of Attachment Theory and Research, Salt Lake Public Library, 200 E 400 S, Salt Lake City, UT. This year, topics include *Early Life Stress and Neurobiology* and attachment-based interventions. To register, or learn more about the conference, visit the website at: http://www.tccslc.org/bridging-the-gap.

Aspire Parent Groups: Parent-led support groups, to connect with other parents. Various dates. See more detail at: http://www.helpmegrowutah.org/your-community/aspire-parent-group.

Community Calendar: Things to do with young children around the state of Utah: http://www.helpmegrowutah.org/your-community/community-calendars

Watch former UAIMH President, Dr. Vonda Jump's TED talk: http://tedx.usu.edu/portfolio-items/vonda-jump/

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