UAIMH Newsletter

Utah Association for Infant Mental Health

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http://www.uaimh.org

President's Corner

On October 15, a local conference was held on *Trauma and Resilience: Growing a Trauma Informed Community*, organized by the Academy on Violence and Abuse (AVA; http://www.avahealth.org). Researchers and practitioners presented on the far-reaching consequences of trauma on people's lives and on how the community at large can be made more aware of this. I was already aware of some of the long-lasting effects of trauma on infants' and young children's psychophysiological development, but I learned even more and got inspired by all the enthusiasm generated by the speakers for all of us to gather, get informed, and get going on preventing trauma for affecting so many people so deeply. It made me wonder, specifically, about our littlest citizens—our unborn children, babies, and preschoolers—and how we can protect them better from all kinds of trauma.

Trauma is everywhere. Several of the presenters noted that simple questions will often reveal what is right under the surface. Primary care physicians and psychotherapists can ask, for example, "what happened to you [in your life] to make you feel this way?" This simple question often generates answers that reveal pain and suffering from the past that is not yet processed and integrated. Brian Miller, Ph.D., director of the Trauma Program for Families with Young Children at The Children's Center (TCC), shared that the TCC has begun to ask caregivers (at intake) whether the child has experienced several situations or events indicative of trauma. Approximately 2,000 children are screened each year and they found that 69% of these children have experienced at least one traumatic event or circumstance. If children had exposure to one traumatic situation, there was approximately a 90% chance that they experienced another one. These situations included severe experiences like physical abuse, substance abuse in the family, separation from parents due to incarceration, and other traumatic events. The modal number of traumas was three (the number occurring most frequently in these screenings). Half of the children had witnessed domestic violence. These children are, on average, only about 4 years old (and come from all areas and socioeconomic status levels of Salt Lake County).

Approximately 2,000 children are screened each year [at the TCC] and they found that 69% of these children have experienced at least one traumatic event or circumstance.

The population of children served by The Children's Center is not representative of the population of young children in Utah at large. But there must be many other children out there who never get referred to mental health services. Only a minority of children (of all ages) who need intervention actually receive services (Weis, 2014). Who knows what actually constitutes trauma for a young child—or even an older child, teenager, or adult? Trauma is very personal. There are, of course, glaringly serious events that would likely be traumatic for anyone. For example, Stephen Allen, M.D., presented about trauma among veterans. About 12-15% of them develop PTSD. Some are more at risk than others (including those with a smaller volume of the hippocampus). However, when exposed to the trauma of combat, even those who were not particularly at risk before are likely to develop PTSD. Exposure to traumatic events is the biggest single predictor of a diagnosis of PTSD.

However, besides this *big trauma*, there is also *little trauma*, as explained by Kristan Warnick, CMHC, who founded both a trauma-informed clinical practice (*Healing Pathways Therapy Center*) and the Trauma-Informed Care Network (http://www.ticn.org). The TICN aims at increasing awareness and knowledge of trauma and evidence-based treatments and bringing together mental health and medical professionals engaged in trauma-informed care. Big trauma consists of the obviously traumatic events that include combat exposure and exposure to all kinds of other violence.

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Little trauma includes the snide comment, one made by a teacher or bully, the spurned young love that you were never able to get over, failing an important subject in school that your future plans depended on, and so forth. What does this mean for babies and little children? What do we really know about trauma—big and small—in infancy or early childhood? Do babies experience "little trauma"? If so, how would this affect their further development?

Recent research based on the "differential susceptibility to context" hypothesis (Ellis & Boyce, 2008) is shedding some light on the "little trauma" question. This hypothesis, dubbed "*the orchid hypothesis*" by journalist David Dobbs, of *The Atlantic*, states that there are those with sensitive dispositions, who are likely to suffer greatly if circumstances are adverse but also likely to bloom to great heights when raised in a positive environment. Research in this area has begun to show that infants with an inhibited temperament (those who startle easily, are difficult to soothe, etc.) are much more sensitive to how their parents treat them than infants with a sturdier disposition. Jude Cassidy and her colleagues, for example, conducted an intervention study for high-risk infants and their parents, which consisted of four home visits, including interaction-focused video feedback. Infants with only moderate irritably did not show any increased security after the intervention, but the most irritable infants showed a significant increase in attachment security (Cassidy et al., 2011). Grazya Kochanska and her colleagues have studied how temperament and attachment related to other measures of infant development and showed many differences in the development of less and more temperamentally vulnerable babies. In one study, Kochanska, Aksan, and Carlson (2005) found that 15-month-old toddlers were more likely to help their mothers (be compliant) in a cleaning up task when the mothers had been sensitive to the infant's needs. However, this effect was much stronger for toddlers who were temperamentally anger prone. In other words, it mattered more to these babies how they were treated. In another study, Kochanska and Kim (2013) observed babies and their mothers at various ages. When babies were emotionally negative at 7 months of age, but had good mutually responsive relationships with their mothers at 15 months of age, the babies showed better self-regulated compliance (e.g., in a cleaning-up task) at 25 months than those who did not have mutually responsive interactions at 15 months. But infants who were not emotionally negative showed moderate levels of self-regulated compliance regardless of the mutual responsiveness of the mother-toddler relationship at 15 months. All these studies suggest that certain individuals are more sensitive to what the environment has to offer to them—either positive or negative. I would suspect that the more temperamentally sensitive infants would be more vulnerable even to the "little trauma" of not having sensitively responsive parents, for example.

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Regarding trauma, of course the research has mostly focused on big traumatic events. Notably the longitudinal study on Adverse Childhood Experiences (ACE; http://www.avahealth.org/ace_study) showed that all kinds of health problems in adulthood are related to the amount of ACEs that a person experienced in childhood. ACEs include all types of abuse and neglect and also exposure to a dysfunctional household (see http://www.cdc.gov/violenceprevention/acestudy/prevalence.html). The more ACEs a child has been exposed to, the higher the likelihood of developing a range of medical and psychosocial problems. According to a draft version of a white paper by Dr. David Corwin and colleagues (2013), "Higher ACE Score individuals acknowledge increased incidence of addiction, mental illness, social malfunction, health care utilization, chronic diseases, prescription medication use and premature mortality" (pp. 3-4). Research about ACEs in the Netherlands has shown that the burden of disease related to ACEs is higher than that of all non-ACE related common mental disorders combined. It is clear that the impact of adverse childhood experiences is profound and reaches far into the child's future.

A type of trauma that is typically not a major focus of studies on ACEs is a type of trauma that is unfortunately befalling an increasing number of children worldwide, who are the victims of geopolitical instability—the topic of this newsletter. There are (young) children who are homeless and those who are moving between countries, fleeing from violence, or serious threats with their families. Even infants and young children are exposed to unspeakable atrocities at times—both in this country and abroad. Dr. Laura Bennett-Murphy is an expert in this area. She has both clinical and research experience with refugee families who worked and conducted research. Please read on to learn more about this very important trauma-related work!

We are excited that Dr. Bennett-Murphy will come and present during our Annual Membership Meeting on November

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4, to which you are all invited! She will speak about Infant Mental Health in Utah, followed by a discussion about this topic. A lot of good things are being done for infants and young children in this state, but there is also a lot of room for improvement. For example, how are infants impacted by trauma—big and small—and how can we prevent ill effects of trauma in our littlest ones? UAIMH plans to explore that question further in our annual full-day workshop that we are planning for in April of 2015. We will also continue to work on educating professionals and caregivers about the importance of infant mental health and wellbeing. Thank you for being a part of these efforts!

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Items of Interest:

The ***2014 Nobel Peace Price*** was awarded jointly to Malala Yousafzai (now age 17), a Muslim, who, at the age of 15, was seriously wounded by a Taliban gunman in Pakistan in 2012. She has become an "impassioned advocate for peace." The other recipient is Kailash Satyarti, an Indian "child rights campaigner" who has fought for three decades to end child slavery in India (*The New York Times*, Saturday, October 11, 2014).

Informative Reading:

Graça Machel (2001). *The impact of war on children*. This report focuses on the ground breaking 1996 United Nations Report that drew global attention to the devasting impact of armed conflict on children. Available from UNICEF (http://www.unicef.org/graca/)

Supporting Infants and Mothers Who are Refugees

Each year, Utah becomes home to just over 1,000 newly arrived refugees (Refugee Services Office of Utah, n.d.). Arriving from Iraq, Afghanistan, Somalia, Nepal, the Democratic Republic of Congo, Syria, and dozens of other nations, these individuals and families join our community seeking safety from persecution. Most, if not all, have witnessed unspeakable horrors. They have lost friends and family members, often to violent and brutal deaths. They have been threatened, assaulted, targeted, and even kidnapped. They have listened to the sounds of gunfire and explosions, of planes overhead. "We were waiting to die," one woman explained. Refugees have been targeted because of who they are, not what they have done, and social structures and governments have been unable to protect them. Political violence, forced migration, and relocation often occur over periods of years with accumulating trauma. While relocation brings safety from war and organized violence, it also introduces tremendous stress. Social position and educational/occupational attainment may be lost. Individuals may confront "nostalgic disorientation" (Papadopoulos, 2002). Challenges associated with poverty, social marginalization, racism, not speaking the dominant language, and trying to acculturate all demand tremendous psychological resources. Parenting a child in a new world with few resources is not easy. The historic ghosts that invade the nursery are often carrying weapons. Threats to the infant of refugee parents are many. First, the mother and infant may have experienced exposure to toxins and malnutrition during the pregnancy (Centers for Disease Control, 2013). Second, high levels of maternal stress during pregnancy are implicated in infant and child behavioral, physiological, and emotional dysregulation (Glover, O'Connor, & O'Donnell, 2010). Thus infants of refugees may be more vulnerable to developmental challenges. Finally, there may be greater risk for insecure or disorganized attachment as the impact of war may adversely affect parental states of mind.

Refugees have been targeted because of who they are, not what they have done

Preliminary work in Belgium, Denmark, and the Netherlands is examining how the chronic and cumulative traumatization of refugees affects parental states of mind regarding attachment, as well as attachment narratives in children ages 4-9. Early findings are striking. While positive family

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relationships can buffer the adverse impact of political violence and migration, persecution places "extreme pressure" (De Haener, Grietens, & Verschueren, 2007) on the parent's capacity to respond to the infant with emotional sensitivity. Parental distress increases the likelihood of insecure parental states of mind and less responsivity to the infant. Thus, children of refugees may be at heightened risk for insecure or disorganized attachment styles and narratives (De Haener, Grietens, & Verschueren, 2010; De Haene, Dalgaard, Montgomery, Greitens, & Verschueren, 2013). The unique stories and histories of refugee families are important. One mother, whose infant often appeared disorganized, saw the face of her murdered husband reflected in her child's eyes. Overcome with guilt and grief, this mother could not bear to look at her baby's face. Another mother lost so many babies during pregnancy and infancy that she could not imagine this one living. She appeared withdrawn and disconnected when with her infant. Infants of refugees carry the horror from the past and the hope for the future on their tiny shoulders. Sometimes these shadows from other "time zones" make it difficult for parents to see the child in their arms. When parents are able to draw upon histories of security and personal meaning to create a coherent narrative of the family, infants benefit.

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So what can we do as care providers? De Haene and colleagues argued that host societies must actively create socially supportive conditions to help restore parental caregiving functions. Establishing connection and continuity are primary tasks for refugee parents in creating the meaning and safety necessary for healing. Making sure that our refugee families have access to legal and psychosocial supports and remedies becomes a primary goal.

Developing relationships with our clients is necessary. Listening to the narratives of "life before" helps us to identify the "ghosts" so that parents can find the baby. Ask your families, "How was your child named?" Ask about the past. Ask about dreams for the future. Ask what the parent notices in the child. Most of all, listen. All of us need opportunities to weave our life story. As refugee families retell their stories, meaning and coherence may develop. If coherence does not develop, consider a referral to the agencies in town that serve the needs of refugees. Life in exile is difficult, but all of us are strengthened when our community embraces the richness and resilience of our refugee neighbors.

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Local Resources

Asian Association of Utah
Catholic Community Services
International Rescue Committee
Refugee Services Office (Department of Workforce Services)
Hser Ner Moo Welcome Center (United Way of Salt Lake)
Utah Health and Human Rights

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Population Displaced: Homeless Parents and Children

As a parent what do you want for the future of your child? Common responses included: *to be happy*, *to succeed*, and *be healthy*.

Do homeless parents want these things as well? Of course! The common responses came from a mixture of nonhomeless and homeless parents. It is incredibly important to remember that all parents are doing the best that they can. However, there are constant stigmas and myths trailing behind homeless parents; such as "All

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homeless people are hopeless and not trying hard enough." Or there are questions like "Why would they let their children live like that?" and "Why don't they just get a job?"

Most parents are trying to learn how to create a functional family—be it education for their children, coping with life struggles, or money management—you name it. So what is the difference? As a caseworker from the Salt Lake City *Road Home* Shelter commented:

> *"I think that it's important to remember that everyone is doing the best they can. Many individuals did not grow up with great examples of how to run a family, manage money, or appropriately cope with life's struggles and so they turn to things that are familiar to them, though their choices may seem "wrong" from the outside looking in. Others come to the shelter because they have fallen on hard times. They may have lost their job, be far from family and friends, and just have nowhere else to go."*

Many people do not realize that homeless parents have jobs but are still homeless. "How can you have a job and be homeless?" is a question I have heard various times from affluent people. I respond telling them to think of it this way, in order to get a home you need to have a stable income, a deposit is required, then the first month's rent. What do you do with your kids if you barely have money to pay for rent let alone daycare and so on? On their own it becomes a difficult task.

"How can you have a job and be homeless?"

A father who was at the *Road Home* had some comments:

> *"You have been through so many risky things that there just comes a point in your life where you just don't care what you do as long as your kids are taken care of."*

This was his first time coming into the *Road Home*. He made comments of how he was just too proud to come in for help. He had been working at multiple part-time jobs trying to make ends meet. He had applied for a few apartments before but was either denied or just could not keep up on rent. As the caseworker from The *Road Home* also commented:

> *"Most of the families that I work with are working really hard to get back on their feet and move into a new place. The program that we offer is 'Housing First,' meaning that we remove all barriers and our priority is to get these families into a home. I think the stereotype is that most homeless individuals are panhandling and are drug addicted but that is not the case. The families that we serve are doing their best to get their family out of this situation. The individuals that you see on the corners of streets or even right outside The Road Home are most often not utilizing our services."*

The father who spoke to me also mentioned that he has been heckled on the streets before from people in their cars yelling rude comments like "get a job you bum!" All the while he is with his 2-year-old daughter working part-time jobs, applying to full-time jobs, and on the track to getting an apartment. Parents already go through a tremendous amount of stress—negative remarks never enhance the situation.

> *"I want to yell back some days, you know, I'm trying. Do you think I want to live in my car with my daughter? Hell no! It's hard road block after road block. I'm just glad that my kid can't really understand what's going on yet. She doesn't have to feel any hurt yet. That's why I keep trying—she's my world, you know, my kid."*

Being homeless definitely affects the parents but what about their children? Homeless children are without a doubt affected as well as their parents; however, in differing ways. I try to get this across to people who are not quite understanding yet. For example, would you want your children to hear these stereotypes and insults against you as a parent? What about at school, how would being homeless affect that section of their lives? As they get older, the children of these homeless parents start to feel what the parents are going through. I have personally spent time with the homeless adolescent population and see how they are feeling the daily stress. As an adolescent they already go through the regular self-confidence hardships, now place all the stigmas and negative attitudes of being homeless on top of them. The *Road Home* caseworker contributed to this issue and said:

> *"For our kids, it is really hard to go to school dirty, without school supplies, and possibly behind the other students in your class. A lot of our children experience bullying for these reasons so I think something for the general public would be to teach your children to befriend people that are different from you, rather than make fun of them or ostracize them."*

Homelessness is a pressing issue for adults as well as for children—children who are important factors to our society. Nevertheless, homelessness and the struggles of the homeless are often culturally focused on adults and stereotypically include the struggles of the jobless, the drug addicted, and the lazy. We tend to forget that this is clearly not the

...teach your children to befriend people that are different from you...

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case and that these individuals have families, which makes this an even more pertinent issue for the general population. As our populace continues to grow, we need to further emphasize and address this important social issue to the general public in order to dispel negative stereotypes and myths about the homeless population.

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Working With Refugees Presents Special Challenges

According to the *Office of Refugee Resettlement*, almost 11,000 refugees have settled in the state of Utah since the year 2000. Many of these individuals have arrived after fleeing the most tumultuous situations found on earth. Further, a disproportionate number of these survivors are children, as the Utah Department of Workforce Services reports that 42% of refugees in the state are under the age of 18. To meet the challenges facing refugees in Utah it is important to better understand the dire circumstances they left behind and the processes unique to these communities as they face a new life in what often seems like a strange, overwhelming new setting.

The *Immigration Nationality Act* defines a refugee as someone who is "unable or unwilling to return to his or her country of nationality because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion." For Utah specifically, refugees meeting this criteria primarily come from the Tibetan-Himalayan regions of Burma and Bhutan, Middle Eastern and Central Asian countries of Iraq, Afghanistan, and Iran, as well as nearly a dozen Sub-Saharan African nations including Somalia, Eritrea, Burundi, Sudan, and others. According to reports from *Amnesty International* and *Human Rights Watch*, the circumstances that have compelled this migration vary as widely as the cultures represented by these countries. For example, refugees from Burma have left a context that involves ethnic cleansing of minorities, religious persecution, systematic rape campaigns by the military junta, and the human trafficking and forced labor of children. Meanwhile in Somalia, local warlords interested in creating an extreme Islamic state have engaged in chopping off hands and stoning as forms of justice, as well as other atrocities that have displaced up to 1.1 million people in that country. Children are once again at the forefront of this humanitarian crisis, as Somali boys as young as 10 are abducted and forced into military roles while young girls living in refugee camps are under the constant threat of sexual abuse. Similar circumstances define most refugees who after resettlement suddenly find themselves living along the Wasatch Front.

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Research on Burmese refugees, Utah's largest refugee group, indicates that more than a quarter of Burma's Karen people (one of the most persecuted ethnic groups in Burma) directly experience torture....

All immigrants moving to a different country face cultural barriers, and many also hail from impoverished regions with high crime. But it is the extreme and harsh realities that refugees face that present challenges specific to their experiences. Research on Burmese refugees, Utah's largest refugee group, indicates that more than a quarter of Burma's Karen people (one of the most persecuted ethnic groups in Burma) directly experience torture, leading to numerous mental health outcomes such as stress, anxiety, and post-traumatic stress disorder (Shannon, Cook, Vinson, Wieling, & Letts, in press). More broadly, research suggests refugees go through different stages of adjustment when entering a new society (Stein, 1986). The first stage, encompassing the first months in a new land, is the most difficult. During this period, refugees experience the loss of cultural identity, which often leads to nostalgia, depression, anxiety, and frustration. Understanding the general adjustment issues associated with refugees, as well as the specific tragedies experienced by those fortunate enough to escape severe global conflict, is crucial.

Dealing with trauma and the loss of cultural identity are not unrelated challenges. Recent scholarship has indicated that universalistic approaches to mental health problems may not be as beneficial as those that integrate cultural coping mechanisms from refugees' homelands (Clark & Borders, 2014). Indeed, refugees have benefitted from standard mental health practices being complimented by indigenous

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systems of meaning, with this fusion approach serving as a protective factor for displaced children (Reed, Fazel, Jones, Panter-Brick, & Stein, 2012). By including important cultural components, refugees can improve mental health while retaining a sense of connection to their culture and undergoing acculturation processes in a new society. While the resilience of refugees is evident from their survival in the harshest of circumstances, the challenges associated with refugees may necessitate novel approaches fitted to their unique situations.

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Announcements/Upcoming Events

November 12, 2014, 8:00 a.m. - 9:30 a.m., Help Me Grow Networking Breakfast. *Utah Valley Regional Medical Center Clark Auditorium, 1034 N 500 W, Provo, UT.* Dr. Kristi Kleinschmit will be speaking on access to child psychiatric care in Utah. Please confirm your space at http://www.helpmegrowutah.org/health-care-providers/networking-breakfasts

February 5-6, 2015. Bridging the Gap Annual Conference: A Forum for Developmental Research. To be held at the Salt Lake Public Library, 200 E 400 S. Stay tuned for additional information about registration, CEUs, and more. Visit the website at: http://www.tccslc.org/bridging-the-gap-annual-conference/

The Children's Center Lecture Series

Register for any of the following exciting and informative classes online at: http://www.childrenscenterutah.org/lectureseries/

November 11, 2014: 21st Century Digital Citizenship for Parents. The instructor for this class is Ben Smith, M.S., who recently received a Masters degree in Instructional Design and Educational Technology from the University of Utah. Learn how to navigate the challenges of an increasingly digital world. You won't want to miss this lecture about kids in the digital era.

January 13, 2015: Protecting Your Marriage. The instructor for this class is Suzanne Pratt, LCSW. She is one of only four Certified Gottman Therapists in the sate of Utah. She will discuss ways for couples to strengthen their bond and improve physical and emotional connections. She will discuss the predictors of divorce and their antidotes, and how to have productive conflict.

March 10, 2015: Help! My Kids are Driving Me Crazy! The instructor for this class is Adina Hamik, Ph.D. Dr. Hamik is currently the director of "The School Next Door." She will guide parents in how to successfully address the most common behavior obstacles in kids of all ages. She will provide tools, offer demonstrations, and answer parent questions. This lecture will help you learn to interact with your kids with strength and positivity.

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UAIMH Website

The UAIMH website continues to be updated. Find news, helpful resources, informative links, past newsletters, and so much more! Visit the website at: http://www.uaimh.org. You can also join UAIMH or continue to renew your membership by:

1. Clicking on the "Join UAIMH" link on the left side of your screen and completing the *Membership Application and Questionnaire Form* on the UAIMH website, and then

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

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