UAIMH Newsletter

Utah Association for Infant Mental Health

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President's Corner

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As the leaves are turning into the golden colors of autumn and the political landscape is ever-changing, the Utah Association for Infant Mental Health continues to advocate for the wellbeing of our littlest members of society and their caregivers. Please be on the lookout for our one-day workshop on this topic, which will highlight things we can do to support infants and their families if babies have experienced some kind of trauma.

This past year, Utah has seen several events that have been important to infants and families, some of them related to trauma. For example, the Trauma and Resilience Collaborative had a well-attended event in May. Dr. Susie Wiet presented on how stress affects the body and mind, and she started out by discussing how the still-developing nervous system during pregnancy and the early postnatal years can be altered forever by stress and trauma. When affected so early, a baby's nervous system forever tends to be more on the alert for any new threat—however small.

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In this newsletter, we share with you several articles related to trauma and resiliency in infancy. Infants can experience birth complications; medical procedures; stress in the family; neglect of their needs for care, love, and protection; or even abuse. Sometimes, caregivers do all they can to dampen the baby's stress and sometimes they are too overwhelmed to do any of that. Sometimes they alternate between attempting to soothe and feeling overwhelmed and unable to deal with the baby's needs. As we know, infants gradually learn to self-regulate within the context of co-regulation with their caregivers. Pat Brehl, LCSW, describes this beautifully and discusses several ways that the relationship between the infant and caregiver can be a source of comfort and resilience. Jennifer Mitchell, PhD, in the Professional Spotlight, also touches on how the adults around an infant or young child can help relieve stressors and lead the child toward healing. Vonda Jump, PhD, describes several initiatives in Utah that work toward preventing adverse childhood experiences (ACEs) and/or their consequences.

The Concurrent Resolution proposed by Dr. Edward Redd that passed through the legislature this year and was signed into law by Governor Herbert is worth special mention here. This resolution acknowledges the impact of ACEs on people's lives and encourages interventions and practices that support resilience. This is a very important acknowledgement of the importance of the existence of ACEs and of doing work to prevent ACEs from happening whenever we can. UAIMH will continue to advocate for this important cause!

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Infant Trauma and Relationship Resilience

Pat Brehl, LCSW
Dragonfly Family Therapy

During the first year of life, an infant learns that she exists as a separate entity from those around her; she is building the foundations of connection in early relationships; she is developing emotion regulation strategies with the help of a regulation partner (i.e. parent/caregiver); she is building a foundation for problem solving by exploring the world; and she is developing agency and self-awareness of her own impact on the world (Blaustein, & Kinniburgh, 2010).

If this child is developing security, we will see her ready to explore and checking back in with her caregiver (also known as her "secure base"). She will also seem happy to see important adults in her life, and show those adults when she has discovered something exciting. When the world becomes scary or upsetting, this child will seek out her caregiver and accept comfort (also known as her "safe haven".)

But what if life events for the infant or her caregiver undermine the development of a secure attachment relationship? Perhaps the family has experienced a "Big T" trauma, such as violence, a natural disaster, or abuse that put their lives or the lives of loved ones at risk. Dan Siegel (2010) suggests that "small t" traumas are any events from childhood that produce a sense of helplessness, anxiety, shame, humiliation, and/or abandonment for which there has not been satisfactory repair from any caregiver. In infancy, this could include anything that leaves the caregiver unable to be a consistent secure base or safe haven, such as addiction, depression, bereavement, loss of employment, loss of adequate health care, marital troubles, health issues, and the list goes on.

How Does This Impact the Child?

When a caregiver provides a sensitive response to an infant's cues, the infant develops a sense that "I can ask for what I need, and someone will help me." Ultimately, in addition to learning how to effectively communicate in a relationship, she can develop an understanding that others are responsive and trustworthy, and that she is worthy of care. If something undermines the caregiver's ability to sensitively respond to the infant's cues, the infant may develop a strategy to communicate more strongly, or to stop communicating altogether. She may develop a sense that, "My needs cannot be met" or even "I am not worthy of care." Communication in other relationships may be misinterpreted, which can impact other early relationships (Blaustein, & Kinniburgh, 2010).

Infants begin to develop their emotion regulation skills with a co-regulation partner in their caregiver. With a consistent safe-haven, the infant may develop a sense that "I can handle big feelings." If this co-regulation is not consistent, or if the caregiver gets angry or threatening when the infant is distressed, the infant may develop a sense that "I can't handle big feelings. Big feelings are scary/dangerous."

Infants begin to make sensory connections that build the foundation for early problem-solving. For example, they may develop a sense that, "when I hear dad's voice, it means I get to play." These early connections in life are strong and long-lasting. In fact, it is during this early time that the right hemisphere of the brain is dominant in its growth, as it is the side of the brain that processes information in nonverbal signals (facial expression of affect, tones of voice, and gestures). It is believed that the right hemisphere is what mediates the retrieval of autobiographical memory, and may also be activated during flashbacks. The left side of the brain, which is all about linear,

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logical, and linguistic processing, develops later on. Early child abuse and neglect show a separation of the right and left brain, with an impaired corpus callosum that connects the two hemispheres (Siegel, 2003). When a child is exposed to violence, chaos, or neglect, a sense of danger and threat may pervade the child's sensory stimuli. (Blaustein, & Kinniburgh, 2010). She may develop a sense that "When I hear a man's voice, it means someone will get hurt."

When an infant feels safety with their secure base, she will explore the world through her senses and actions. Through this process, she also learns about her own impact on the world. She may develop a sense that, "I can see what this world has to offer, and I know I have someone looking out for me to help keep me safe." When a caregiver is unpredictable, the infant may decide to remain close to the caregiver instead of explore, developing a sense that "The world is not safe, I can't go out there alone." If the caregiver is consistently rejecting of the infant, she may explore despite danger and develop a sense that "I need to find what I'm missing out there."

Generally speaking, if an infant and caregiver have developed a secure attachment relationship, the infant is less likely to experience traumatic reactions following exposure to a traumatic event. This is largely due to parental response and the infant's development of her own coping skills from co-regulation experiences. By contrast, Barnett and Hamblen (2016) suggest that "*a child with a poor attachment could be expected to evidence behavioral difficulties (e.g., aggression, withdrawal) and might be more difficult to soothe, which could cause higher levels of frustration in his caregiver and in turn lead to maltreatment or attachment difficulties.*" A caregiver may have their own trauma history which may be triggered by otherwise typical infant behaviors (e.g., a caregiver who has experienced a sexual assault may be triggered by the infant's bids for physical affection).

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Even within a securely attached relationship, a traumatic experience could present an attachment injury to the system if the infant feels anger or confusion towards the caregiver for the perception that he/she did not keep her safe.

What Can We Do?

As mentioned above, one consequence of trauma in the early years of life is an impaired connection between the two hemispheres of the brain. Healing from trauma involves integration across these hemispheres through the telling of coherent narratives. While it is difficult to assist a preverbal infant with creating a coherent narrative of her experience, Daniel Siegel (2003) states that the "*most robust predictor of a child's attachment to a parent is the coherence of that adult's autobiographical narrative*" (p. 24). All parents of infants who have experienced traumatic experiences will likely benefit from support due to the challenging behaviors the infant exhibits, and parents who have had their own trauma history and insecure attachment as children may need more support than others, such as individual therapy.

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Below are some things that all parents can do to support their infants.

Responsiveness: Being able to read and respond to an infant's cues takes practice. It takes time for you to learn your baby's language, and for your baby to learn yours. Developing a schedule of your baby's daily routines can help with responsiveness, as it gives you an idea of when certain tasks will happen (i.e., eating, sleeping, diaper changes, playing, etc.) so that you can anticipate needs. The link http://www.parentingcounts.org/information/timeline/recognizing-baby-cues/ also provides some helpful instruction on how to read baby's cues. It is important to remember that responding to infants will not "spoil" them or make them unable to "self-soothe." The quicker and more consistent

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a caregiver is in responding to an infant's cues, the more likely that infant will be in developing their own emotion-regulation skills.

Eye contact and face-to-face play: Lieberman and Van Horn (2008) state that the joy and spontaneity of playing with your baby can be therapeutic, in and of itself. Talking to your baby and using exaggerated facial expressions can be fun for both you and baby, and also provide time to help work on communication. "You can hold your baby and put your face close to hers. Make silly faces. Smile at your baby. Stick out your tongue. Yawn. Wait a few seconds and see if she tries to repeat your actions back to you" (ASQ-SE-2). You might also try the Mirror Game, where you imitate whatever your baby does, but with exaggeration – especially with facial expression, sounds and hand motions.

Talking to your baby and using exaggerated facial expressions can be fun for both you and baby, and also provide time to help work on communication.

Touch: Babies generally like to be held, rocked, and stroked. Touch can help reduce stress hormones and increase oxytocin, the "peace and calm" hormone. Lieberman and Van Horn (2008) state that *"stress and trauma expose the child and the parents to horror, helplessness and bodily sensations that may be re-experienced...encouraging age appropriate affection and protective physical touch between parent and child builds a sense of protection and safety, and encourages loving and pleasurable bodily sensations."* Carrying infants on the parent's body, in a safe and appropriate carrier, can increase bonding experiences for both infant and parent. Infant massage can be used as a part of bedtime, naptime, or bath-time rituals to provide extra soothing. Online searching will result in a vast amount of resources and instructions on this topic, and consultation with baby's pediatrician is recommended to ensure safety of this practice on your baby.

Stimulation: Providing your infant with a variety of sensory stimuli assist with her exploration of her world. Keep in mind that infants can only handle so much stimulation at a time before they need a break. Your baby will likely signal to you when she needs a break by either looking away, leaning back, or pulling on her clothes. Give her this time to reorganize everything she has just taken in, and she will then likely signal to you when she ready to begin again. Keep in mind that some children, for example those prenatally exposed to substances or exposed to traumatic events, may become easily overstimulated and will need additional safe guards from this issue such as lower light levels, sound cancelling headphones, or white noise machines. Some of these children may also rely on additional supports for sleep such as swaddling or blackout curtains.

You can try games such as *Gotcha*, where you walk your fingers up her legs and to her belly making silly rhythmic noises that get increasingly louder. When you get to her belly, tickle it and say "I got you!" Your baby will learn to anticipate the tickles and get excited and laugh. You can also have mini dance parties where you help your baby move to different types of music. Remember that everything in this world is new to your baby, so a simple walk or look out the window can be incredibly stimulating. You can learn what your "child is learning at each stage of development and offer experiences that give the baby a chance to imitate and practice emerging skills in all areas, from sound play to concept development" (Raikes & Edwards, 2009).

Promoting a secure base: You are the anchor for your child's exploration. She can go out to explore, return to check in, and then head out to explore again. Staying present and available is the key here, and noticing when your baby is checking in (e.g., she might turn to look at you and smile when she discovers something new, or she might crawl right back to you for a hug before heading out on the next adventure). It may also be helpful to establish greeting and goodbye routines (e.g., kissing hands or tummy) to signal to your baby when you will be separated. Your baby may also feel more at ease with a transitional object, such as a blanket or t-shirt with your smell, to assist with transitioning to other caregivers.

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Sensitivity: *"Sensitive parents are tuned in to their babies; when the baby expresses a need, the parent responds appropriately (i.e., matched to the need the child expresses). Sensitive parents listen and wait, phasing their interactions with the infant's and organizing the interaction so parent and child take turns"* (Raikes & Edwards, 2009). Babies start communicating from the moment they are born, and caregivers work to enjoy this exchange. You will know that you have responded appropriately when your baby has put out a signal, you have responded, and your child stops the signal.

For example, if your child cries, and you try to give her a bottle and she keeps crying, you know that was not what she wanted. If you continue to try and take off her jacket and she stops crying, you have likely responded sensitively to her need. Lieberman and Van Horn (2008) stress the importance of putting feelings into words as an important building block of affect regulation, and an opportunity to strengthen the bond between child and parents as they connect on an emotional level. Even if your child is pre-verbal, talking through interactions can help to lessen your own frustration as you work to figure out this puzzle, while also helping to slow you down to a response to your child's experience rather than being reactionary or going into autopilot (i.e. giving a bottle for each cry). For example, "Katie, I see you are so sad and mad. Do you want your bottle? Oh, that wasn't what you wanted. I wonder if you're too hot, let's try taking off your jacket. I see, that was it! Thank you for telling me." Keeping in mind that the more times you are sensitive and aware in your response, the more experience your baby has with having her needs met and seeing safety in the world.

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Remember that there is no manual written on your specific child. Each baby comes with her own set of needs, cues, and temperament. It takes time and patience to get to know your baby. Even if things do not start off well, and your baby develops traumatic responses, you can also work to heal some of those early injuries and develop a secure attachment with your baby. There is no "perfect" here, there is just "good enough."

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Adverse Childhood Experiences in Utah: Hope and Resilience

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Exciting initiatives are happening in the state of Utah around protecting children and supporting parents in

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the demanding, joyous, and challenging situations that arise in the context of parenting. Several of these were highlighted in the May 19 and 20 meeting that was organized by the Trauma and Resiliency Collaborative, convened by Dr. Susie Wiet. Whereas about one hundred attendees participated in their first conference in 2014, this year more than 300 service providers and audience members showed up to learn more about what trauma is, how it can affect development, and how we can foster resilience.

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Here, I am going to focus on several initiatives aimed at preventing adverse childhood experiences (ACEs) or dealing with the trauma responses that result from ACEs. But the programs described are only a few examples of the hard work that is being done in Utah to educate and support parents and children in the prevention of ACEs and/or their consequences.

The Adverse Childhood Experiences (ACEs) Study

For those of you who have not heard of ACEs, Vincent Felitti and Robert Anda conducted a seminal study in the late 1990s with individuals who were part of the Kaiser Permanente health care plans (Felitti & Anda, 1998). Over 17,000 people (mostly white, college-educated) were asked to disclose what happened to them as children in terms of parental domestic violence, substance abuse, mental health issues, incarceration, child abuse (physical, sexual, or psychological) or neglect, or separation due to divorce/relationship issues. What was surprising being that almost two-thirds of respondents had experienced at least one ACE, and 12% of the population had experienced four or more ACEs. What was even more surprising was that there is a dose dependent relationship between the number of ACEs that one has experienced and their later health outcomes: the more ACEs one has, the higher the likelihood of experiencing a number of negative health outcomes, including cancer, heart disease, COPD, liver disease, etc. Four or more ACEs translate to death an average of 20 years earlier than those with no ACEs. Utah prevalence data closely approximate these findings, similar to findings throughout the country.

What we now know is that when one experiences adverse childhood experiences, particularly in the absence of a supportive adult to help deal with the experience, the architecture and chemistry of the brain develops differently than it does for people who have not had such experiences, or who have had the experiences and supportive adults to help them cope (Anda et al., 2006). This disrupted neurodevelopment is more likely to result in negative coping behaviors such as alcohol abuse (Dube, Anda, Felitti, Edwards, & Croft, 2002; Strine et al., 2012), drug abuse (Dube et al., 2003), early sexual activity and multiple sexual partners (Hillis, Anda, Felitti, & Marchbanks, 2001), teen pregnancy (Anda et al., 2002; Hillis et al., 2004) and smoking (Ford et al., 2011). In other words, people try to make themselves feel better through various behaviors and they continue to do it over time to keep helping themselves feel better momentarily. When Dr. Felitti came to Utah a few years ago, he said that the behaviors that seem to be problems to us (e.g., addiction) are solutions for problems we cannot see (ACEs). Unfortunately, these "solutions" often lead to more difficulties with jobs, relationships, parenting, and life in general.

There is Hope!

While this sounds like gloom and doom, there is a lot of hope! Dr. Felitti and his colleagues found that when they were just asked about what happened to them, patients had a 35% reduction in repeat office visits (HNC Corporation, Health Appraisal Study Final Report, unpublished data, 1996). People felt better when they were able to get the weight of what happened to them off their chests. After all, who wants to go around like a deer looking at headlights? But that

Trauma could be the root of many of our societal ills. Instead of asking "What is wrong with you?", we can powerfully impact people by asking "What happened to you?"

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is what happens when children experience intense levels of stress without anybody to help them make sense of it: their stress hormones stay on high alert so they can be ready for the next event. That is great if you are in danger, but it is not helpful when trying to focus at school, have normal interactions with friends, pay attention at work, etc. Dr. Felitti and his colleagues did not provide therapy, although they certainly could refer people to appropriate resources as needed. What they did was to listen for a moment, and by listening, people were able to verbalize the experiences that had often been kept secret for many decades. Rather than avoid the topic, Dr. Felitti hit it head on, and hit a home run in the process: the realization that unresolved trauma is at the core of many negative health behaviors and poor health outcomes we see in our country. Trauma could be the root of many of our societal ills. Instead of asking "What is wrong with you?", we can powerfully impact people by asking "What happened to you?"

What do we do with this information? First, we begin to get the word out so people begin to connect the dots for themselves and understand the impact of what happened to them or those they care about. Next, we develop programs to deal with the experiences that people have had and quite importantly, we talk about ways we can support parents so that they have additional tools for effective interactions with their children. As anybody with a child knows, parenting, even in the most ideal situation, is difficult. For those whose brains were impacted by childhood traumas (most of us, although the presence of a supportive adult is a key factor in our resilience), parenting could be even more difficult, and it is possible, although studies have not been conducted to date, that those with higher ACE scores could have more difficulty with parenting.

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What is Happening in the State of Utah?

Several newer initiatives in Utah (and many others) are actively working toward relieving ACEs and their consequences in our state. For example, the Utah Coalition for Protecting Childhood (UCPC) began in September 2015 to support local efforts in Utah to prevent child abuse and neglect. The group is co-chaired by Deondra Brown, co-founder of the Foundation for Survivors of Abuse and musician in The 5 Browns; and Brent Platt, director of the Utah Division of Child and Family Services (DCFS). The goal of the coalition is to provide coordination efforts to help align various community level coalitions that develop throughout the state; in other words, to help support ongoing efforts and to help connect coalitions in the state.

Several newer initiatives in Utah...are actively working toward relieving ACEs and their consequences in our state.

The Protective Factors for Utah's Families (PFUF) coalition, spearheaded by Barbara Leavitt, Cassie Selim, and others, is spreading knowledge, awareness, and skills related to the five protective factors that have been proven to be related to reduced child abuse and neglect: (1) parental resilience, (2) social connections, (3) knowledge of parenting and child development, (4) concrete support in times of need, and (5) social and emotional competence of children. When these factors are strengthened, families are strengthened and child development optimized. In Utah, we now have about thirty trainers who can train your organization in this framework. If you are interested, please contact Tami Hansen (see below).

The Utah Valley Trauma Resilience Initiative is coordinated by the Family Support & Treatment Center in Utah Valley and hopes to increase awareness and provide education about the threat of ACEs so that informed adults can help identify and support at-risk children and youth. The UVTRI has focused on educating teachers, school staff, and parents about ACEs and how we can help people recover from traumatic events.

The Trauma-Informed Care Network (TICN) consists of a group of mental health and medical providers who are specializing in trauma-informed treatment and are

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gathering regularly to share trauma-specific treatment information. This group was initiated by Kristan Warnick, CMHC, in 2013. Please see their website for more information!

The Trauma Resiliency Collaborative (TRC) was begun by Dr. Susie Wiet and colleagues in May 2014 in Salt Lake City to provide a vehicle for multidisciplinary stakeholders and community providers to increase awareness of trauma, and discuss and implement strategies that promote healing and build resilience. The long-term goal of the collaborative is to prevent trauma across the life-span. The collaborative has held two symposia to help others understand the impact of trauma, and meets every other month.

Our coalition members include parents, school personnel, physicians, clergy members, business leaders, community and governmental organizations, and judicial and law enforcement members. We hope to galvanize action in each of these areas to ensure that children are protected.

Finally, I would like to discuss our initiative in northern Utah, the *Northern Utah Trauma Resiliency Collaborative*, which had its first meeting on May 10, 2017. Our goal is to increase awareness of ACEs and their impact, and to call the community to action to protect children whenever possible and to buffer the impact of trauma when it occurs. The coalition is co-chaired by Representative Ed Redd, Esterlee Molyneux, and myself, Vonda Jump Norman. Our coalition members include parents, school personnel, physicians, clergy members, business leaders, community and governmental organizations, and judicial and law enforcement members. We hope to galvanize action in each of these areas to ensure that children are protected.

The movements around the state have even more energy now, thanks to a Concurrent Resolution that was introduced by Dr. Edward Redd and unanimously passed in both the Utah House and Senate, and signed into law by Governor Herbert:

> "This concurrent resolution encourages state officers, agencies, and employees to promote interventions and practices to identify and treat child and adult survivors of severe emotional trauma and other adverse childhood experiences using interventions proven to help and develop resiliency in these survivors."

There is currently no funding attached to the resolution, but acknowledging there is an issue is the first step. The coalitions throughout the state will work to improve conditions within the state of Utah for those who have been traumatized, and will strive to prevent traumatic events from happening in the first place.

What is the impact of such efforts in other states? One great example is what has happened in Walla Walla, Washington, where they have seen a 33% decrease in domestic violence, a 59% decrease in youth suicide attempts, and a 62% decrease in high school dropouts. Let us work on similarly positive outcomes for Utah! When we come together collectively to act, we can succeed.

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Weblinks

- ACEs in Utah: http://health.utah.gov/opha/publications/hsu/1507_ACE.pdf
- ACEs in Walla Walla, WA: https://www.facebook.com/ResilienceTrumpsAces/videos/vb.194804447282921/894994250597267/?type=2&theater
- Concurrent Resolution HCR10: https://le.utah.gov/~2017/bills/static/HCR010.html
- Protective Factors at the Center for the Study of Social Policy: https://www.cssp.org/young-children-their-families/strengtheningfamilies/about
- Protective Factors for Utah Families: http://www.parentadvocacycouncil.org/protective-factors; contact Tami Hansen at tami@theparenthoodproject.org
- Trauma Informed Care Network: http://www.ticn.org
- Utah Coalition for Protecting Childhood: https://www.facebook.com/1UCPC
- Utah Valley Trauma Resilience Initiative: http://www.utahvalleyfamilysupport.org/prevention-services/trauma-resilience-initiative-2/ (contact praleigh@utahvalleyfamilysupport.org or 801-229-1181)

Professional Spotlight: Jennifer Mitchell

In my current professional role, infant mental health is central in much of the work I do. I knew early in my doctoral training that I was passionate about early intervention and wanted my career to focus on the youngest and most vulnerable of populations. At The Children's Center, I am fortunate to be able to work with a diverse clientele of young children and their families. Children are referred for a variety of reasons ranging from concerns about a possible Autism Spectrum Disorder, expulsion from childcare or preschool for behavior problems, and language delays. Regardless of the referral concern, every child that walks through the doors is given a broad-based, trauma-informed, mental health assessment. This is critical because without a thorough history and general assessment, important aspects of a child's development may be overlooked. Another area I believe that is an integral part of the assessment and treatment process is gaining understanding of the cultural and family norms that influence a child's development. Each child and family are unique, and it is my job to be open to learning about them and using the information I obtain to provide culturally sensitive, individualized treatment.

It is critically important that all interventions are focused on similar goals, despite alternative pathways to the goals.

One of the tenets I operate from is that the best treatment is nothing without a strong and ongoing assessment process. A primary area of focus in treatment is the relationship between the caregiver and the child. Does the child check-in with his caregiver and how does the caregiver respond? Does the child seek comfort or reassurance from the caregiver, and how does the child respond when the caregiver provides it? For new mothers, I am also keenly aware of the role maternal mental health plays in a child's development. Assessing issues related to sleep, feeding, and independent skills

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provides valuable information as I formulate a picture of a child's functioning and possible sources of stress in the parent-child relationship. In watching children play and interact I am also focusing on a child's speech and language, social skills, cognitive abilities, motor control, expressed emotion, regulatory capacities, and possible sensory-seeking/sensory aversive behaviors. This information is critical in beginning to assess for possible delays or concerns in need of further assessment, intervention, and possibly referrals to other providers.

A second tenet I operate from is that *it takes a village to raise a child.* I see not only the value and importance, but also the genuine need, of linking providers and caregivers. A child, especially one with special needs, can often have a number of providers and caregivers all working to improve outcomes. It is critically important that all interventions are focused on similar goals, despite alternative pathways to the goals. I make a strong effort to encourage caregivers to allow providers access to each other, including childcare providers, pediatricians, other therapists, and anyone else the caregiver designates as playing an important role in the care of the child. Collaboration among providers can help to increase skill acquisition and generalization, and ultimately improve outcomes related to inclusion across settings. A strong example is a case where I provided support to an occupational therapist who was struggling to engage a highly anxious child. Together the two of us worked to decrease his anxiety and increase his self-regulation through specific interventions. These interventions were shared with and implemented by his childcare. His childcare reported improved functioning in his classroom and they no longer threatened expulsion. Had the three providers not worked together, it is not likely the outcome for the child would have been as successful.

As a society, we already know so much about what children need. Where we are failing most is working together to ensure those needs are met.

While I find this work extremely rewarding, it is certainly not without its challenges. Despite efforts made, sometimes collaboration never occurs among providers. I have had multiple caregivers come to sessions saying they were "fired" by other providers, often because the child refused to talk or participate due to heightened anxiety. Some childcare providers are also less apt to allow observations of the child in their setting or outside support in managing the child's behaviors. As a society, we already know so much about what children need. Where we are failing most is working together to ensure those needs are met.

A third tenet that guides my practice is the belief that everyone does the best they can at any given moment. Childcares, therapists, as well as child welfare workers all are in their respective fields because they are committed to serving children and want to help them live fulfilling lives. That said, we are all humans and respond to stress in often less than ideal ways. When backed against a wall, sometimes people opt to checkout as opposed to reach out for help. Remembering that everyone is doing the best they can has often saved me from despair when I feel stuck with a client and I am unable to gain support from other providers in the community. It is in these moments that I go back to the basics where it all begins and where it all returns: the caregiver and the child. When I find myself here, I know that I still have a lot to work with. For it is in the relationship between the child and caregiver where the magic of connecting, repairing, and growing can happen. This is the space to sit, reflect, and go back to the drawing board. How can I as the provider, help this child grow and develop through the relationship she has with the most important person in the world? How can I help the caregiver remember the joy parenting has to offer? How can I help them realize that even if there is no one else, together they can make it?

As a Parent-Infant Mental Health specialist, everything I assess and treat is focused on both the child's development and the role of the caregiver. I firmly believe that the best outcome is one in which the caregiver is empowered to help the child progress and succeed, and one in which learning becomes fun for both the caregiver and the child. My approach to treatment is to first see the child and family where they

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are, but always hold in mind where they could be, from both a skill and a relational perspective. For it is this critical, early parent-child relationship from which all else is built.

Raising Our Babies: The Most Important Job in the World

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

On March 23, 2017, several hundred visitors gathered in the Hinckley Caucus Room at the University of Utah College of Social and Behavioral Sciences (CSBS), to discuss the important question of what babies need in the earliest days, weeks, and months of their development, and what parents need in order to provide this care. Along with the Hinckley Institute and CSBS, this event had been organized by the Departments of Psychology and Family and Consumer Studies (FCS).

Vice President Ruth Watkins opened the event with a call to support development and learning better and earlier, so that students come ready to learn as they embark on their academic journey at the University. Dr. Cindy Berg, Dean of CSBS and Professor of Psychology, then welcomed everybody and introduced Mary Nickles, KUTV anchor, who moderated the event. Mary did this gracefully and skillfully, showing her passion for supporting early childhood development. She shared that she was inspired by her mother, who had been an advocate for young children in the state of Washington.

After watching a clip from *The Raising of America,* outlining how economic struggles and work-related stress make it difficult for modern parents to offer the attentive care and sensitive responsiveness that babies need to thrive. This is especially true in the absence of good parental leave policies and high-quality, affordable child care. A panel discussion led by four researchers from the Psychology and FCS departments highlighted the state of current research on these issues: Dr. Cathleen Zick (FCS) discussed accessibility to (and cost of) childcare; Dr. Russ Isabella (FCS) talked about the different roles that parents' responsibilities are divided among the many roles they have; Dr. Lee Raby (Psychology) shared research findings about the Attachment and Biobehavioral Catch-up intervention program by Dr. Mary Dozier that aims to increase sensitive responsiveness in parents and secure attachment in children; and Dr. Elisabeth Conradt (Psychology) discussed recent research on epigenetics and maternal struggles with anxiety and depression. All emphasized that science has learned that child development can be supported by supporting caregivers. Students, professionals, and members of the community debated these questions in an engaged and occasionally passionate manner and were left inspired to use what we know from science to improve the lives of infants and their caregivers!

...science has learned that child development can be supported by supporting caregivers.

Baby Watch Social and Emotional Training

Catherine Hoelscher, MPH
Program Coordinator
Baby Watch Early Intervention Program

The Utah Baby Watch Early Intervention Program (BWEIP) was thrilled recently to be able to provide a day-long workshop emphasizing social and emotional development in infant and toddlers. BWEIP is currently in Phase III of the federal Office of Special Education's (OSEP) mandated State Systemic Improvement Plan (SSIP), which focuses on improved social and emotional outcomes for children enrolled in early intervention. This measure is also a component of the Governor's Success Initiative. Social and emotional development is recognized as the foundation for all early childhood development and the field of early intervention is adapting service delivery to include relationship-based concepts in working with children and their families.

The workshop was conducted by Dr. Karen Moran Finello, an internationally renowned child-developmental psychologist with a focus on early identification and intervention for birth to 5-year-old children at risk for later learning and behavior problems and has conducted research on appropriate service delivery models, effects of home visiting during the first 5 years of life, and the impact of infant and toddler behavior on families. She began her work with BWEI in 2016. Dr. Finello's interactive presentation included, *Acknowledging the Expertise in the Room, Infant/Toddler Social & Emotional Development, Role of Relationships in Early Intervention, Developing Appropriate Intervention Outcomes & Strategies, Coping with Challenges in Service Delivery, and The Value of Collaboration.* Over 300 Utah providers participated and gained the knowledge and skills to infuse social and emotional concepts including caregiver/child relationship building into their daily practice.

> *Social and emotional development is recognized as the foundation for all early childhood development....*

Announcements/Upcoming Events

Utah Association for Infant Mental Health (UAIMH) *Trauma and Resiliency in Infancy: What is it and What Can We Do?"* UAIMH one-day mini-conference. Presenters will include Jennifer Mitchell, PhD, Vonda Jump, PhD, Heather Kunz, LCSW, Ilse DeKoeyer-Laros, PhD, & Susan Dickinson, MS. Using case examples, we will discuss what trauma and resiliency in infancy looks like and provide you with practical tools that you can use in working with parents, caregivers, and infants. *Date and location TBA*.

October 20, 2017, 8:30 a.m.-5:00 p.m.: Perinatal Mood & Anxiety Disorders: Advanced Clinical Skills Workshop, presented by Christina G. Hibbert, Psy.D. Location: 885 Baxter Drive, South Jordan, UT. Registration and information: http://www.drchristinahibbert.com/products/pmad-advanced-clinical-skills-workshop

November 10 & 11, 2017: Perinatal Mood and Anxiety Disorders: Screening, Identification & Treatment: Two-day workshop on how to recognize, screen for, and treat perinatal mood and anxiety disorders. Day 1 is for all Healthcare Providers working in Maternal Newborn Care, and Day 2 is for Clinicians providing direct service who have attended Day 1 as prerequisite. Day 1: November 10, 2017, 9:00 a.m. - 4:00 p.m.: **Screening, Identification & Treatment for all Healthcare Professionals, presented by** Amy-Rose White, LCSW & Ellois Bailey, DNP, APRN. Day 2: November 11, 2017, 9:00 a.m. - 4:00 p.m.: **Treatment, Assessment & Intervention for Psychotherapists**, presented by Amy-Rose White, LCSW, Leah Jaramillo, LMFT, & Kate Rodgers, Ph.D. Held at the UNI Auditorium, 501 Chipeta Way, Salt Lake City, UT 84108. Registration: http://events.constantcontact.com/register/event?llr=g4zzsf8ab&oeidk=a07eeimcb7c5039e1f8

***SAVE THE DATE:** February 8 & 9, 2018: Bridging The Gap Conference,* The Children's Center. Held in the Salt Lake City Main Library Auditorium.

UAIMH on Facebook

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

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