UAIMH Newsletter

Utah Association for Infant Mental Health

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President's Corner

It has been 40 years since the first presentation of the seminal paper *Ghosts in the Nursery* (Fraiberg, Adelson, & Shapiro, 1975), marking the beginning of the field of Infant Mental Health (IMH). Rooted in Fraiberg's work, we have seen the formation and rise of many IMH organizations, including the World Association for Infant Mental Health (WAIMH), and local organizations in many countries and states—including Utah!

The field has come a long way. There has been a huge increase in research studies that show emotional, cognitive, and social knowledge and experience of infants is far vaster than anyone ever imagined before the *Ghosts*. Online resources are ever expanding, among which *Zero To Three* and the *Harvard Center on the Developing Child* are two that stand out; both of these organizations work relentlessly on disseminating information and instigating policy changes that benefit our littlest members of society—and they are not the only ones these days!

In addition, training programs have been created that enable professionals in relevant fields to become specialists in recognizing and treating IMH problems as early as possible. This growing group also helps to spread the word about the importance of this early stage so that problems may be prevented. Professionals from a wide variety of backgrounds, such as nursing, education, primary care, early intervention, psychology, and social work, can earn certificates or even entire degrees in IMH. Certificate programs, for example, are offered by the University of Washington, the University of Wisconsin Psychiatry Department, the University of Minnesota, and the University of Massachusetts in Boston, among others. Entire graduate degrees can also be earned; for instance, a master's degree in IMH at Mills College in San Francisco or at Chatham University in Pittsburgh, PA.

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All this progress suggests that IMH is emerging from its early infancy and starting to move around in the world. It appears like we are approaching the toddler stage. This is wonderful, but it also means that there is a lot more work still needing to be done. For one thing, education about infant mental health issues should become more prominent in the stages *before* students specialize. Time and time again I am struck when psychology undergraduates exclaim, "Wow, I did not know infancy was *this* important" and when they express their surprise about the existence of such a thing as IMH. If students are unaware of career opportunities during their undergraduate studies, they will not even consider them as they are furthering their education. Of course, it is still possible to specialize in infant and early childhood mental health at a later stage. However, the more students begin to specialize, the less they may consider this wonderful field.

Another obstacle that stands in the way of the development of IMH as a field is also its great strength—the relational focus of the field. Because early development is always necessarily embedded in—and interwoven with—the important relationships in the infant's life, all prevention and intervention efforts need to support those relationships. However, when interventions are necessary at the level of the relationship, then who will pay for them? Insurance companies generally require diagnoses in order to reimburse the costs of therapy. There are special programs (e.g., in home visiting), but only for those who qualify. Therefore, a lot more needs to be done to make IMH care more widely accessible and affordable.

Last, if students do not know about the field, many parents and professionals do not know about it either. What about the young mother who is beginning to feel despair at her infant's constant crying? What about the daycare teacher who notices an exceptionally aggressive toddler and does not know what to do about it? What about the pediatrician who is picking up a potential developmental problem but is unsure who to refer for further assessment and possibly intervention? In Utah, we are lucky to have *The Children's Center* as a major resource of knowledge about early childhood mental health. We are also very fortunate to

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have *Help Me Grow*, a vital resource for parents, caregivers, and professionals. There are many other excellent resources in Utah, such as Early Intervention and the State Home Visiting Program, and many more. But we still need more work at getting the services that exist to the people who need them and in creating new services where gaps exist.

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Fortunately for Utah, a group of specialists in the field of early childhood mental health has recently been getting together to identify gaps. This group is led by Colleen Murphy, the Early Childhood Interagency Coordinator for the Bureau of Child Development at the Utah Department of Health. UAIMH is joining this group in efforts to spread awareness about the importance of infant and early childhood mental health, increasing options for advanced education in this field, and hopefully expand the pool of qualified professionals in this area. Together, we can make a difference!

For the future, one of my dreams would be to help expand higher education opportunities for those interested in early development and IMH. Another dream is to create a one-stop center in Utah for IMH services for parents, caregivers, and professionals in this field. Would it not be wonderful to have a center that focuses exclusively on the earliest period in life (the prenatal period, infancy, and toddlerhood)? This center would offer parents and caregivers a wide range of services, including (but not limited to) primary health care, parenting classes and support, infant massage, educational resources, occupational therapy, and parent-infant psychotherapy. It could work alongside *The Children's Center* and other agencies in improving and ensuring that the early social, emotional, physical, and learning needs of infants would be met, and that parents and caregivers would be supported in order to provide the best care possible in this early stage, which sets the stage for the rest of life. I hope these dreams may one day become a reality. In the meantime, UAIMH keeps working alongside others to educate, inform, and work on a better future for our littlest ones!

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Supporting Caregivers and Children Exposed to Toxic Stress and Traumatic Experiences

The last edition of the UAIMH newsletter featured articles on toxic stress, childhood trauma, and the landmark Adverse Child Experience (ACE) study. This information documented the strong correlations between exposure to toxic stress and negative health and behavioral health outcomes. It has now been demonstrated that adverse childhood experiences constitute "the most basic cause of health-risk behaviors, morbidity, disability, mortality, and healthcare costs" (Anda & Filitti, 2012).

David Bornstein of the *New York Times* asked us to imagine a substance that increases the risk of cancer, diabetes, and heart disease—and increases the risks for smoking, drug abuse, suicide, teenage pregnancy, sexually transmitted disease, domestic violence, and depression. Try it as a thought experiment: imagine that a chemical agent had found its way into the Salt Lake City water system—and imagine that those who consumed more than a certain level would have their life expectancy reduced by 20 years. The ACE study informs us that this is precisely the case for a child who has been exposed to more than four adverse childhood experiences. In our thought experiment, the field would move quickly to implement universal screenings so that we could apply the indicated treatments. Certainly we would act assertively if two thirds of the population had experienced exposure—as is the case for adverse childhood events.

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We do not treat adverse events like we would a toxic agent—toxic stress is not a tangible toxin. When and how to conduct medical screenings has not been clearly defined. Perhaps most compellingly, we may not know how to support a child or caregiver when we suspect that a child has been exposed—and as a result we may be ambivalent about even *wanting* to know. The problem of toxic stress seems dauntingly complex and much more multifactorial than we feel that we can affect from our practices.

We have long known that trauma or chronic stress had deleterious effects on the psychological well-being and physical health of infants and children. But this knowledge was largely without any specific clinical relevance. The ACE study, however, is a game changer. We now know, in a demonstrably cause-and-effect way, how exposure to these experiences lead to specific health and behavioral problems. This knowledge creates a challenge for us as healthcare/behavioral healthcare providers: How do we become

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The challenge of addressing what we know about toxic stress is considerably less daunting when we can define some relatively simple, concrete actions. Specific screening, assessment, educational, and—when indicated, referral processes—can be implemented relatively easily and can become an efficient and routine practice of the office.

Screening

Several screeners for adverse events or toxic stress are publically available. *The Traumatic Events Questionnaire* (TEQ) and Safe Environment for Every Kid's (SEEK) *Parenting Screening Questionnaire* (SEEK PSQ) are two examples.

TEQ. The Children's Center has developed the TEQ and has made it available for use by pediatric and behavioral health offices. The TEQ is a caregiver-completed survey that queries the caregiver as to: (a) Any exposure to the identified most common traumatic experiences; and (b) If the child is experiencing any of the behaviors associated with trauma exposure. This questionnaire is administered in a matter of minutes and is easily interpreted by both the caregiver and the clinician.

SEEK PSQ. The PSQ screens for several common problems that are risk factors for child maltreatment: parental depression, parental alcohol/substance abuse, major parental stress, intimate partner (or domestic) violence, harsh punishment, and food insecurity. It has been tested in both low-income inner-city clinics and in suburban healthcare settings (see http://theinstitute.umaryland.edu/seek/seek_psq.cfm).

Assessment

In behavioral health, the purpose of the screening process is to define the direction of the subsequent clinical assessment. At *The Children's Center*, we have found that the TEQ sometimes yields information about traumatic exposure not normally obtained in the clinical assessment—even though we asked about trauma exposure—because the screener itemizes experiences and asks the caregiver to consider each of them. When the TEQ is positive, this provides direction to the clinical assessment, which in turn, provides focus to the treatment selection.

In primary healthcare, the purpose of the screening does not always assume that a mental health assessment will follow. Rather, the screening must quickly lead to a clinical determination as to whether the screen was (a) negative for exposure (or for the sequella of exposure); (b) whether to provide focused psychoeducation and anticipatory guidance to the parent/caregiver, or (c) whether to refer for behavioral health assessment and treatment. Neither of the described screeners require calculation of clinical "cut scores" to make this decision, but rather, provide information that the clinician can use to make this decision with meaningful data after brief "at-a-glance" review of the positive items.

Education

One of the common elements in evidence-based trauma treatments (trauma-focused CBT, child/parent psychotherapy, etc.) is a psychoeducation component for providing the child and caregiver education about trauma. The goal is to explain the trauma experience and to normalize the emotional and behavioral reactions resulting from the traumatic exposure. In a primary healthcare setting, this education must be provided efficiently, and will often be supported by an educational handout that can easily be given to the child's caregiver.

Ultimately, the negative effects of toxic stress are produced by the neuro/chemical/hormonal response of the body to stress. This becomes harmful when the stress becomes chronic because the sympathetic nervous system remains in an unrelenting alarm state. In a clinic setting, focusing on education about this discrete fact becomes a good starting point.

In infants and young children, this autonomic arousal requires the help of a caregiver to resolve. With infants, "emotional self-regulation" is a misnomer—it is best understood as co-regulation with a caregiver. This self-regulation/co-regulation dynamic can be seen as a ratio in which self-regulation emerges only as the child matures (and is greatly supported by early attachment with the caregiver.) *Viewed this way, the primary focus of early intervention with toxic stress exposure is to focus on the emotional regulation environment of the child and the caregiver.* When we address this dynamic, we are addressing toxic stress.

The "Circle of Security" (http://circleofsecurity.net/) provides a simple model for addressing the child's need for a secure base and a safe haven to return to after exploration. The concepts are in a form that can be easily understood by the caregiver. This program provides information in English and Spanish that can be reproduced in handout form.

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The SEEK program (http://theinstitute.umaryland.edu/seek/seek_suppl_materials.cfm) has developed handouts for each positive item on the survey and can be easily distributed to patients based on identified areas of need. Topics include drugs and alcohol, discipline, depression, food assistance, and so forth.

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Referral

It is important that health/behavioral health clinicians, parents and caregivers, and allied professionals recognize that we now have a sound evidence base for selecting trauma treatments, and that these treatments have established effectiveness. Infant/child mental health and healthcare professionals should maintain a referral list of community mental health professionals who are trained in treatments that have been identified as evidence-based specifically for the treatment of trauma exposure and associated behavioral/emotional symptoms.

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Social Skills Promotion Is Bullying Prevention

The precursors to bullying and victimization begin in the preschool years and earlier (Banks, 1997), and are seen daily in aggressive behaviors and negative peer interactions in the preschool classroom. Aggressive and off-task behavior by young children is disruptive to the entire preschool classroom and interferes with the necessary learning needed to succeed in school. Preschool children who look or act different in some way are often targets of aggression (Vachou, Adreo, Botsoglou, & Didaskalou, 2011) and children with disabilities are at high risk of being a target.

These aggressive behaviors place a young child at risk of negative peer interactions that may spiral into more consistent and severe aggressive behaviors seen in bullying. This cycle can be stopped through effective teacher and parent interventions that promote active encouragement of prosocial and appropriate assertive behaviors that reduce the risk the child will become a bully or a victim in the school years.

Research suggests that if a child has not developed a basic set of social skills by age 6, he/she could be at risk for social problems into adulthood (Boyd, Barnett, Leong, Bodrova, & Gomby, n.d.). Many early education teachers, however, lament that the children just do not know how to interact socially rather than think about the context of the social environment in their classroom, and how they should actively promote a positive social environment. A teacher may sigh, "You need to share." "You need to be nice to each other." But how do children learn to get along with others, to share, to delay playing with a toy that they want to play with? Think about how you learned to get along with others. Think about people you know. Some people are better at interpersonal interactions than others, and some people seem to have no social skills at all. The reality is that we must actively teach these skills, and the preschool period is a wonderful time to do so, as children are great enforcers of "rules," whether they are rules for the science area or rules of getting along with others.

During the 2013-14 school year, we had the privilege of working with various Head Start programs throughout the state of Utah to prevent bullying through actively promoting a positive social environment and social skills development of young children, thanks to an Interagency Outreach Training Initiative grant from Utah State University. We also worked with many of these programs on implementing the *Second Step: Social Emotional Skills for Early Learning* curriculum (Committee for Children, 2011). Parents were included in this process. Parent meetings were held where parents were provided practical information on helping their children develop social skills and what to do if bullying was suspected.

> *...how do children learn to get along with others, to share, to delay playing with a toy that they want to play with?*

While not shocking, we have been pleasantly surprised to hear stories back from teachers and parents about how their children are using their new skills to solve problems, make friends, and get what they want in a positive way. One focus this year has been on helping parents and teachers to use a simple process to teach children how to solve their own problems rather than depending on adults. It consists of approaching children calmly, ensuring children are safe, noting children's emotions and asking what happened (listening to all sides of the story), paraphrasing each child's version of the story to ensure that you heard it correctly, and then asking the children what solutions they suggest to solve the problem. If they are fighting over a toy, you should hold the object in question until the children solve the problem.

Second Step is an evidence-based curriculum that provides activities to help children learn social-emotional skills such as empathy, emotion management, problem solving, and self-regulation (http://www.cfchildren.org/second-step/early-learning.aspx). Activities are suggested for every day of the year and a parent involvement component is included (but not used by all teachers). Teachers using *Second Step* reported high rates of satisfaction with the curriculum and positive changes in children's social skills.

What we saw in the classroom and heard from parents is that it

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Teachers who used Second Step *reported...positive changes in children's social skills.*

worked! Parents reported that children looked at them like they were shocked at first, but then the children quickly took responsibility for their problems. Teachers in all programs reported improvements in children's social skills. During an observation in a classroom in Enoch, a little girl and boy began spontaneously talking about what to do if there is a problem during breakfast. "You have to use your words to solve a problem." "If you have a problem, you have to work it out. You both think of ideas to solve the problem, and then you work it out." True to their word, I observed children solve several problems (who was going to go first, fighting over a toy, pushing a girl down). I also saw a time when the children could not work it out and the teacher came over and gently began working on the above steps with the children. With her support, the children were able to find a solution without the teacher having to solve it for them.

We saw similar actions in all of the programs involved in this project. In St. George, teachers prevented problems through communicating well with children, and helped the children communicate well with each other; when there were problems, teachers implemented the problem-solving steps to ensure that children owned and solved their problems. In Ogden and Layton, we saw children engaging in steps (in which they were trained) that allowed them to calm down, recognize their feelings, and problem solve with other children.

In many programs, we listened as parents reported how happy they were that the techniques worked, and the parents did not have to keep solving problems for their children. One parent in Fort Duchesne observed how often she had to solve her children's problems before, and she realized that she was probably partially responsible because she did not necessarily pay attention to her children when they got along. She began to realize that there might be a link between her attention and the misbehavior. Another parent said that she struggled to let her children decide what the solutions should be because she did not trust that they would be able to solve their problems. By trusting her children, with support, they did work together to solve problems and she noted that her children get along better now than they ever have

We found over and over that the teachers and parents needed help in letting children struggle to solve their problems. In role plays at the beginning of the year, several teachers (and parents) wanted to just take the toy away because the children could not share, to make the children not play with each other because they were hitting each other, and to punish a little girl who was trying to exclude other children. Over the course of time, teachers saw that the children would not learn anything from such strategies, and the problems would continue. However, teachers and parents both said that when they gave responsibility to the children, the children came to them less often to handle a problem, and the children began solving their problems without needing as much help from adults. Another benefit was that the children were able to express their feelings, say what they wanted, and negotiate if needed. These children will be leaders in helping others learn to solve their problems in kindergarten.

For programs working with parents and young children, and as professional development opportunities or parent workshops are being planned, we recommend considering sessions on active facilitation of a positive social environment and children's social skills. In one program that was not able to meet as part of our project until the end of the school year, teachers repeatedly commented in the evaluation that this training should have been done earlier in the school year so teachers could practice the skills with children, that the training should be longer, and that there should be follow-up training afterward so teachers could ask for help if they were struggling with using the strategies. Cook, Williams, Guerra, Kim, and Sadek (2010) suggested problem-solving skills training should be implemented for bullies, victims, and those children who are bully-victims, as their research indicates a lack of these skills. Our argument is that if we teach positive social skills and interaction strategies when the children are young, perhaps they will not become a bully or a victim. They will have the skills that will allow them to have successful peer interactions as they enter elementary school.

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Building Empathy in Our Littlest Ones

Bullying is a serious problem. Strikingly, new research discovered that bullied children continue to experience the effects of bullying long into their adulthood. At 50 years of age, adults who had been frequently bullied as children were experiencing more depression, anxiety, and suicidality. They also had poorer social relationships and experienced their lives as having lower quality overall than adults who had not been bullied as a child (Takizawa, Maughan, & Arseneault, 2014).

Bullying is not something we expect to see among babies and toddlers, so why ponder the topic in a newsletter about infant mental health? Little children typically do not follow around the same peer repeatedly to systematically hurt this other child. However, even in little children we can see the roots of social behaviors, including prosocial ones (like helping and sharing) but also antisocial ones (like hurting someone physically). Increasingly, research suggests that bullying is related to low levels of empathy, especially on an emotional level. Bullies may cognitively understand what they are doing to their victims, but not resonate with their victim's pain on an emotional level (Eisenberg, Eggum, & Di Giunta, 2010). Therefore, if we can stimulate empathy and prosocial developments early on, this can help children to grow into more empathic, helpful individuals who are unlikely to bully and more likely to stand up against bullying.

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Early Development of Empathy, Sympathy, and Prosocial Behaviors

As amazing as it is, newborn infants come into the world with behaviors that suggest a rudimentary sense of empathy. Minutes after birth (when babies are awake and alert), they are able to mimic other people's facial expressions. The most famous facial behavior copied by neonates is tongue protrusion, which Dr. Andrew Meltzoff of the University of Washington demonstrated decades ago. Around the same time, Dr. Tiffany Field showed that newborns will also mimic basic emotional expressions, such as surprise. The facial expressions shown by adults have to be very clear and exaggerated, and the newborn most likely is not aware of copying the expression, but the fact that they can do this suggests an inborn capacity to resonate with others' feelings. Later research showed that newborns also respond differently to hearing their own tape-recorded cries than to hearing other newborn's cries.

Just a few months later, babies show the beginnings of moral understanding. When shown puppet shows featuring helpful versus hurtful puppets, even 3-month-old babies prefer the helpful characters. For example, this video clip of Karen Wynn's research shows a puppet show in which one puppet (Tiger) tries to open a box, but he does not succeed. Then babies see two other puppets (in alternating order): a dog that then helps to open the box, and another one who jumps on the lid of the box so that it keeps closing. At 3 months, babies already gaze longer at the helpful character when shown both puppets after the show.

All of this suggests that babies come into the world with a basic sense of what is right and what is wrong, and basic capacities for "feeling into" the feelings of others, which can later develop into real empathy. According to leading researcher Nancy Eisenberg, *empathy* can be defined as, "…an affective response that is identical, or very similar, to what the other person is feeling or might be expected to feel given the context—a response stemming from an understanding of another's emotional state or condition" (Eisenberg et al., 2010). This ability is not yet fully present in babies and toddlers, but it is emerging over the early years.

Feelings of empathy (i.e., feeling what another person is feeling) can evolve into other feelings, most notably *personal distress* or *sympathy*. If the emotional feeling is too intense or overwhelming for the child to handle, than the child may become distressed by feeling another's emotion. In young children, this is not uncommon. When little children get flooded with the emotions that they are picking up from others around them, they need support in regulating these emotions.

Feelings of empathy can also evolve into feelings of *sympathy*. Sympathy is a more advanced response than empathy alone. It is defined as, "an affective response that often stems from empathy, but can derive solely (or partly) from perspective taking or other cognitive processing, including the retrieval of relevant information from memory" (Eisenberg et al., 2010). It is different from empathy because it involves concern for the other person, rather than just feeling the same emotion that the other is feeling. This, then, can lead to prosocial behaviors (e.g., helping to alleviate another's distress).

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Amazingly, children as young as 12 months begin to try to comfort others who are in distress (Zahn-Waxler, Radke-Yarrow, Wagner, & Chapman, 1992). Of course, at this early age, infants are not cognitively advanced enough to understand why the other person might feel a certain emotion, or to see things from the distressed person's perspective. But they can recognize emotional states and do what they can within their limited developmental possibilities, like offering a teddy bear to someone who seems sad. Zahn-Waxler and her colleagues asked mothers to observe their infants in situations in which someone else was distressed and found that the majority of toddlers tried to make things better for the person

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in distress. More than half of the toddlers had shown at least one prosocial response to others' distress by 13 months and all but one of the children had done so by their second birthday. Initially, they mostly showed physical attempts at comforting (e.g., hugging) but by 18-20 months they showed a wide variety of behaviors. For example, toddlers would ask, "You okay?" or share food with their sister to help her feel better.

As early as 14 to 18 months of age, toddlers also work to help others attain their goals (Warneken & Tomasello, 2009). For example, if an adult tries to get something but it is just out of reach, a little toddler will try to help the adult get the object. Young children show such helpful behavior without receiving any tangible reward. By 2 years of age, young children are already able to interpret the physical and psychological states of others, to experience other people's emotional states, and to act in ways that might alleviate the other's distress (Zahn-Waxler et al., 1992).

...secure attached infants are likely to grow into more empathetic children who tend to help, share, and care about others' emotions.

For example, in the famous 'broccoli experiment', Dr. Alison Gopnik asked 14- and 18-month-olds to share a snack with her (Repacholi & Gopnik, 1997). The experimenter would first pretend to taste two types of snacks: broccoli and goldfish crackers. Most little kids, of course, love goldfish! But the experimenter would show that she loved goldfish for some of the children who were tested, while she showed them that she loved broccoli for other participating toddlers (she would say, "Yum, broccoli!" and "Ugh, crackers!"). Gopnik then wanted to know if the children would share the food that she (the experimenter) had preferred earlier. Passing both bowls of snacks onto the toddlers, she would ask, "Can you give me some?" At 14 months of age, toddlers tend to share only what they themselves prefer (generally, you guessed it: goldfish crackers!). But at 18 months, toddlers would give the experimenter exactly what she preferred to eat, even if it did not match their own food preferences. This shows that 18-month-old children have a sense of what other people prefer and they help accommodate such preferences as well.

On the other hand, young children are also notorious for acting aggressively and without any concern for the other person's feelings. Zahn-Waxler and colleagues (1992) found that it mattered whether 1-year-olds had *caused* the other's distress, rather than merely witnessing it. When the toddlers had caused the other person distress, the toddlers were more likely to either become distressed themselves or to act aggressively. Boys were more likely than girls to become aggressive after having caused another person distress. Interestingly, when toddlers merely witnessed someone else getting upset, they hardly ever showed aggression. In addition, some toddlers actually showed positive affect after causing someone else distress (but not when witnessing distress).

How Can We Help Children Become More Sympathetic Toward Others (and Less Aggressive)?

Interestingly, some research has found that aggressive preschoolers actually show higher levels of empathy than nonaggressive ones (Eisenberg et al., 2010). This surprising finding can be explained by higher levels of emotionality or physiological arousability in these children: their bodies simply respond more strongly to emotional situations, which may lead them to act out aggressively, but also to notice other's emotions and try to help out. Alternatively, such children may just tend to have a more social orientation so that their attention is more continuously focused on other people.

Early childhood appears to be a sensitive period for altering pathways of aggression, empathy, and prosocial behaviors. In general, aggression and other externalizing problems are related to lower levels of empathy and sympathy (Eisenberg et al., 2010) but this relation becomes stronger with age. At 4 to 5 years of age, surprisingly, no differences were found in prosocial behaviors between children who were high and low in behavior problems (both internalizing and externalizing). However, *only for the high-risk children* was there a decrease in concern for others from ages 4 to 5 years old to ages 6 to 7 years old. At first-grade level, children who showed more behavior problems were less empathic and showed fewer prosocial responses. However, children who showed more concern for others at ages 4 or 5 were likely to show a reduction of behavior problems by first grade. These findings suggest that we need to intervene early, when children are still more open to others' emotions (even when they also show aggression).

So, what helps? Multiple studies have found that parenting matters. When parents are more empathic with their children's emotions and are able to help regulate emotions, it helps children to also become (or stay) more empathic. For example, secure attached infants are likely to grow into more empathetic children who tend to help, share, and care about others' emotions. Further, the discipline strategy of induction has also been shown to make a difference: if parents can talk with their young child after the child hurt someone, and focus attention on the other person's feelings, this will enhance awareness of the other's emotion and of a willingness to help alleviate distress in the other.

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Announcements/Upcoming Events

June 14-18, 2014, 14th WAIMH World Congress. Babies: Their Contributions--Our Responsibilities. Edinburgh International Convention Centre, Edinburgh, Scotland. For more information, visit the conference website at: http://waimhcongress.org/

June 23-26, 2014, Early Childhood Summer Institute 2014: Beyond ABCs--The Whole Child Initiative. *Hilton Salt Lake City Center, 255 W Temple, Salt Lake City, UT.* You will enjoy presentations about best practices in learning, curriculum, and assessment, addressing the trends that are happening nationally so that you can implement initiatives locally. To register and learn more about the conference, go to http://www.ECSummerInstitute.com.

September 29 2014, 8:00 a.m. - 5:00 p.m., Building Resilient Families. *Miller Conference Center, 9750 S 300 W, Sandy, UT.* Keynote: Dr. John Hodge: Supporting Parents in Building Childhood Resilience. Stay tuned for more information.

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. Community resource providers, health care providers, parents, and others with an interest in child psychiatric care are invited to share ideas and resources over breakfast. Please confirm your space at http://www.helpmegrowutah.org/health-care-providers/networking-breakfasts

UAIMH on Facebook

UAIMH now has a Facebook page! Here we keep you updated on news, events, etc. Please take a moment to "like" us at https://www.facebook.com/UtahIMH

UAIMH Website

The UAIMH website has been updated. Find news, helpful resources, informative links, past newsletters, and so much more! Access continues to be via 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:

Janet Wade, Treasurer
c/o The Children's Center
350 S. 400 E.
Salt Lake City, UT 84111