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Journal of ZERO TO THREE: National Center for Infants, Toddlers, and Families

Responding to Violence, Disaster, and Trauma

Understanding Historical Trauma and Colorism

Trauma-Informed Early Intervention

Early Childhood Policy Implications

Fostering Resiliency and Recovery

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THIS ISSUE AND WHY IT MATTERS

Family and community violence, natural disasters, and traumatic life events touch the lives of even the youngest children. Many believe that we live in a more violent society than in the past. With new technologies, there is more opportunity to be a consumer of violence, whether it is depicted in news media or in the entertainment industry. In just the past year, our country experienced the trauma-related events of Superstorm Sandy, the Sandy Hook Elementary School shooting, the Oklahoma tornado, and the Boston marathon bombing. Even when families are not directly involved in a traumatic event, they can be affected by it through the media coverage of frightening images and feel a heightened sense of vulnerability and stress.

The burgeoning knowledge of how early life experiences impact later development brings a new urgency to addressing the needs of very young children and their families who are suffering due to violence, disaster, or trauma. Parents and other caregivers play a crucial role in how children cope with and are affected by adverse experiences. Creating effective systems of support requires comprehensive and accessible approaches to identification and treatment, and public policies that help children and families and protect society.

The articles in this issue of *Zero to Three* address a wide range of potentially traumatic experiences, from widespread events to interpersonal experiences. The authors share their experiences and insights about how to coalesce community support, how to meet the unique needs of infants and toddlers, and how to foster family resilience and recovery. The articles reveal how challenging experiences often present the opportunity for growth in individuals, families, programs, and communities that lead to more resourceful solutions and resilient outcomes.

We hope this issue of *Zero to Three* provides early childhood professionals some ideas, resources, and tools to better address the effects of traumatic experiences in the lives of young children and their families. For additional resources, please visit the ZERO TO THREE web site (www.zerotothree.org) for a variety of publications, podcasts, and links to related information.

Stefanie Powers, Editor

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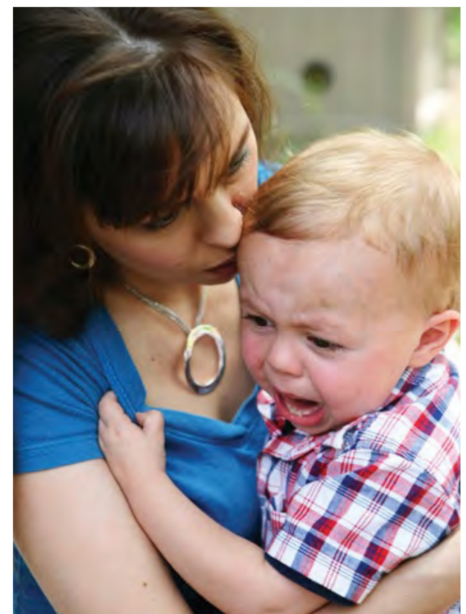

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Child Exposure to Violence as a Public Health Emergency

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The enormous national scope and urgency of children's exposure to violence was highlighted by the release in December 2012 of the Attorney General's National Task Force Report on Children Exposed to Violence (Listenbee et al., 2012). This report was endorsed in August 2013 by the American Bar Association House of Delegates, which unanimously approved a resolution supporting the implementation of the report's recommendations. After reviewing the report, Attorney General Eric Holder declared,

> *What we have learned has been a wake-up call, and warning bell, for all of us. We found that the majority of our kids—more than 60%—have been exposed to crime, abuse, and violence—many in their own homes...The problem of children's exposure to violence is an urgent one, one we can't afford to ignore. Nor is it an issue the Department of Justice—or any one agency or organization—can take on alone. It will take all of us, working together.* (U.S. Department of Justice, 2012)

While efforts to create public awareness and a collective momentum to protect children from violence are not new—more than 20 years ago, then Surgeon General C. Everett Koop labeled violence "a public health emergency" (Koop & Lundberg, 1992)—children's victimization within the family and in the public sphere of neighborhoods and communities remains a critical threat to their safety, health, and ability to become competent adults. The Attorney General's report sets out a clear path to solving the problem, drawing on the latest science and highlighting successful programs to underscore the critical importance of undertaking specific actions to protect children and help those harmed by violence to heal and thrive.

Emphasizing that government action is essential in stemming the epidemic of child exposure to violence, the report leads with the recommendation that the Executive branch should designate leadership at the highest levels of government and Congress should work with the executive branch to make legislative action on the report's recommendations a bipartisan priority. The remaining 55 recommendations are divided into six different categories, each addressing one of the following goals:

1. End the epidemic of children exposed to violence,
2. Identify children already victimized by violence,
3. Make trauma-informed services and evidence-based trauma-specific treatment accessible to all children exposed to violence,
4. Promote safe and nurturing homes where children are protected rather than hurt,
5. Enable communities to rise up out of violence, and
6. Make the juvenile justice system trauma-informed.

Abstract
Children's exposure to violence is a national crisis. The high prevalence of exposure to violence in infancy and early childhood has implications for lifelong health and development because early experiences are most influential in shaping the structure and functioning of the brain, the quality of attachments and other relationships, and the child's readiness to explore and learn. The authors highlight the urgency of creating effective approaches to identification and treatment as well as public policy initiatives that protect both children and society.

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These goals address the multifaceted nature of children's victimization and the importance of targeted approaches to prevention and treatment in homes, communities, and systems.

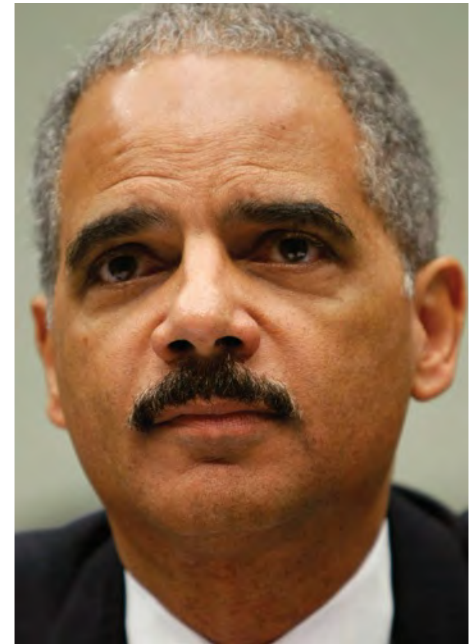
Prevalence and Patterns of Child Exposure to Violence

The stubbornly high national statistics of child exposure to violence across the age range should serve as an immediate call to action. The National Survey of Children Exposed to Violence (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009), a comprehensive survey of 2,000 children from 2–17 years old selected through random digit dialing, showed that 70% of the respondents (either the child or the parent in the case of younger children) reported at least one episode of experiencing or witnessing violence, and 64% of this subsample reported at least one additional, different source of victimization during the same time period. Of these children, 20% reported five or more types of violence exposure in a single year (Finkelhor, Ormrod, & Turner, 2007). Infants are not spared. A nationally representative sample of 300 children less than 2 years old revealed that one third of them had experienced some form of violence (Turner, Finkelhor, Ormrod, & Hamby, 2010).

One tragic manifestation of the routine exposure of children to violence is the frequency of violent death associated with it, with homicide listed as the second leading cause of mortality for children and youth 10–24 years old (U.S. Health Resources and Services Administration, 2011). Children from birth to 5 years old are at the highest risk for abuse and neglect, most often by parents or primary caregivers. In 2011, maltreatment rates were highest in the first year of life (21.2 per 1000); 47% of the reports involved children less than 5 years old; and 82% of maltreatment fatalities known to child welfare agencies involved children less than 4 years old (U.S. Department of Health and Human Services, 2012). Children less than 5 years old are also more likely than older children to reside in homes with domestic violence (Fantuzzo & Fusco, 2007), illustrating the extensive overlap between violence against a parent (most often the child's mother), and direct maltreatment (Edleson, 1999). This high prevalence of exposure to interpersonal violence in infancy and early childhood has stark implications for children across the age range because early experiences are most influential in shaping the structure and functioning of the brain, the quality of attachments and other relationships, and the child's readiness to explore and learn. The physical and mental health problems and learning difficulties of older children may have their roots in early victimization experiences that remain unidentified and unaddressed (Lanius, Bluhm, & Frewen, 2013).

Community violence simultaneously contributes to and exacerbates the damage inflicted by family violence. Millions of children experience violence in their schools and neighborhoods every year, with the National Survey of Children Exposed to Violence (Finkelhor et al., 2009) reporting that about 25% of children were exposed to community violence (Costello, Erkanli, Fairbank, & Angold, 2002; Finkelhor, Turner, Ormrod, & Hamby, 2010). There is extensive research documenting that victims of violence may become the next perpetrators of violence (O'Leary, Smith Slep, & O'Leary, 2007; Slutkin, 2012). Parents who were abused as children are also at greater risk for perpetrating abuse against their own children and toward others outside the home (Renner & Slack, 2006). When traumatized parents feel helpless to protect their children and themselves from drive-by shootings, gang violence, and street crime, their heightened stress may find expression in harsh corporal punishment of their children in a misguided effort to instill good behavior or necessary survival skills. In turn, traumatized children may engage in dysregulated and aggressive behavior that triggers parental punitiveness, creating attachment patterns characterized by anger and fear. Children who are chronically afraid—both within the family and in their communities—are more likely to misperceive cues to danger and resort to aggression in an effort at self-protection (Dodge, Bates & Pettit, 1990). Through these multiple overlapping patterns, violence becomes a social virus that generates contagion at all levels of the family and community ecology and is transmitted through a combination of traumatic stress and social acceptance of violence as normative and inevitable (Harris, Lieberman, & Marans, 2007).

Family violence occurs at every socioeconomic level and violent attacks can take place anywhere in public spaces, but some sectors of the population are more burdened than others by the pervasiveness of violence. While poverty neither causes nor excuses violence, it is highly correlated to some forms of violence. Neighborhoods with high percentages of poor families often have the largest concentrations of community members who are struggling with multi-generational trauma and multiple exposures to violence, while also having fewer resources to meet those needs. This gap between level of need and level of services often makes it even harder for such families to address the multiple needs of their children while also engaging in their own day-to-day struggle for survival.



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Attorney General Eric Holder declared, "Exposure to violence can have a devastating and lifelong impact. I am asking all of you who have a role in a child's life to take action."

Cumulative Exposure to Violence

Regardless of income, single episodes of violence are the exception rather than the rule. Different sources of violence overlap and tend to occur repeatedly, as documented in Finkelhor and colleagues' (2007) survey findings that children report a mean number of 2.8 victimization episodes, and most children who reported one victimization event also reported at least one additional episode of a different kind. In child mental health settings, systematic screening during assessment shows significantly greater exposure to violence when compared to the initial disclosure at referral (Ghosh Ippen, Harris, Van Horn & Lieberman, 2011), with high percentages of children experiencing four or more different kinds of traumatic events (Crusto et al., 2010; Ghosh Ippen et al., 2011; Walrath, Ybarra, Sheehan, Holden, & Burns, 2006).

This high incidence of exposure to multiple traumatic stressors represents an urgent public health problem with long-term repercussions across the lifespan. Data from separate studies conducted with diverse populations and using different methodologies converge to demonstrate that experiencing multiple interpersonal stressors in childhood is strongly associated with a greatly increased risk for physical and mental health impairments from childhood through adulthood. This association is described as a *dose–response relationship* between adversity and impairment, so that the more categories of adversity are experienced, the more severe

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Children from birth to 5 years old are at the highest risk for abuse and neglect.

and broad-ranging are the associated impairments. Some key studies documenting this associated are briefly described in the next section.

Adverse Childhood Experiences

The Adverse Childhood Experiences (ACE) study (Felitti et al., 1998) was conducted with more than 17,000 middle-class, largely White adults seeking routine medical care at the Kaiser-Permanente health maintenance organization in San Diego, California. Exposure to violent events was high even in this socioeconomically advantaged sample: 25% of women and 18% of men reported childhood sexual abuse; 20% of women and 22% of men reported childhood physical abuse; 15% of women and 12% of men reported witnessing domestic violence against their mother (Edwards, Holden, Felitti, & Anda, 2003). Almost two thirds of the respondents reported at least one ACE, and 1 in 6 respondents reported four or more ACEs (Anda & Brown, 2010). ACEs were highly inter-related. A median 87% of respondents who experienced one category of ACE also reported at least one additional ACE category (Dong et al., 2004).

In retrospective and prospective analyses of massive amounts of data, the results were remarkably consistent with a dose–response hypothesis. Study after study of the ACE data showed that childhood exposure to four or more ACEs is associated with an exponential increase in the likelihood of physical illnesses that include the leading causes of morbidity and mortality in adulthood, including heart disease, cancer, stroke, diabetes, chronic obstructive pulmonary disease, skeletal fractures, hepatitis, and early mortality; behavioral patterns associated with health problems such as smoking, alcoholism, drug abuse, having more than 50 sexual partners, and sexually transmitted diseases; and psychiatric problems such as depression, suicide attempts in childhood, adolescence, and adulthood; and number of psychotropic medications prescribed for an individual (Anda et al., 2007; Brown et al., 2010; Dube et al., 2009). The ACE study is a landmark investigation of the long-term consequences of childhood exposure to family violence and related adversities because of its unique methodology: large sample size, nonclinical sample, longitudinal design, and reliance on prospective as well as retrospective data analyses. In addition, the importance of its findings is bolstered by confirming evidence from other large epidemiological studies. The cumulative impact of ACEs on complex adult psychopathology was also demonstrated in a study using the National Comorbidity Survey-Replication sample (Putnam, Harris, & Putnam, 2013), which showed that individuals with four or more childhood adversities had a significantly higher number of lifetime diagnoses according to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*; American Psychiatric Association, 1994); a higher number of four *DSM-IV* disorder categories (mood, anxiety, impulse control, and substance abuse disorders); and higher coexistence of internalizing and externalizing disorders, with synergistic patterns suggesting that women are more impacted by sexual abuse and men by economic hardship (Putnam et al., 2013). Another study, using data derived from the National Epidemiologic Survey on Alcohol and Related Conditions with 43,093 respondents, found that childhood physical abuse was frequently accompanied by other ACEs and frequency of abuse was associated with significantly increased odds ratios of a broad range of *DSM-IV* psychiatric disorders (Sugaya et al., 2012).

The Traumatic Impact of Violence on Health and Development

Violence has all the characteristics of a traumatic event. It tends to occur suddenly and unpredictably, threatens life or bodily integrity, and produces horror and helplessness that lead to a collapse in the individual's coping mechanisms (Pynoos, Steinberg, & Piacentini, 1999). When fear becomes a permanent state in response to ever-present danger, the chronic activation of the organism's stress response systems creates alterations in the structure and physiology of the brain and provides the underpinnings for a complex biological and psychological adaptation to ongoing threat that make the child particularly susceptible to a range of physical and mental health problems and cognitive dysfunction (Roth & Sweatt, 2011). Chronic stress overwhelms the body's capacity to adapt, disrupting basic regulatory processes (homeostasis) and creating a state of permanent overload that McEwen (2000) labeled as "allostasis." Allostasis is implicated in the breakdown of the stress response and immune systems, leading to a range of health problems and disruptions in the areas of the brain involved in the basic functions of healthy development such as appraisal of danger, affect regulation, information processing, motivation, memory, learning, and problem solving (Belsky & de Haan, 2011). Numerous research studies document that the severity of psychiatric dysfunction is associated not only with number of traumatic stressors but also with younger age of trauma exposure, a close relationship to the perpetrator(s), lack of intervention by bystander(s), and absence of protective relationships. These factors are in turn associated with the likelihood of retraumatization both in the present and through the life course (Follette & Duckworth, 2011).

The scope of sequelae of repeated childhood exposure to violence transcends the symptoms associated with posttraumatic stress disorder, a finding that prompted efforts to develop more comprehensive diagnostic categories such as Developmental

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Trauma Disorder (van der Kolk, 2005). Symptoms include persistent dysfunctions in affect regulation; alterations in the sense of self; distorted relational perceptions, including inability to trust others; problems in meaning-making (hopelessness, helplessness); disturbances in attention and consciousness (including dissociation); and somatization in the form of physical symptoms in the absence of medical etiology. Disturbances in these domains of functioning cut across psychiatric diagnostic categories and are the substrate for the complex adult sequelae of early life exposure to trauma (Ford, 2010).

The profound damage of children's trust in the parent's capacity to protect them is a core factor in the mental health problems associated with cumulative trauma. The protective shield that the mother or main caregiver represents for the child is shattered by the experience of trauma, particularly when that caregiver is the perpetrator of the violence or is unable to protect the child from another's violence (Pynoos et al., 1999). Attachment theory provides a useful framework for understanding the impact of trauma on childhood mental health because its foundational premise is that children are biologically equipped to seek proximity and contact with the mother figure in situations of danger or uncertainty (Bowlby, 1969/82). Decades of research support the hypothesis that the child becomes securely attached when the attachment figure is consistently responsive to the young child's signals of need and takes action to alleviate distress and assuage fear. Conversely, children's attachment acquires an anxious or disorganized emotional quality when the parent is inconsistent, unavailable, or herself behaving in frightened or frightening ways (Ainsworth, Blehar, Waters, & Wall, 1978; Lyons-Ruth, Bronfman, & Parsons, 1999; Main & Solomon, 1986). Quality of attachment influences the child's response and subsequent recovery from a stressful event. Predictably, maltreated children are much more likely to have anxious attachments (Carlson, Cicchetti, Barnett, & Braunwald, 1989) and traumatic stress reactions are found more often among traumatized children with anxious attachments, suggesting a breakdown in the mother's capacity to alleviate the child's fear (Lynch & Cicchetti, 1998). These patterns need to be understood in the context of the attachment figures' trauma exposure, which may render them unable to perceive and respond to their children's fear because of their own traumatic response (Lieberman & Amaya-Jackson, 2005). The reciprocal influences of trauma to the mother and trauma to the child must be carefully assessed to develop an effective approach to intervention because threat to the mother is a powerful traumatic stressor for children (Scheeringa, Wright, Hunt, & Zeanah, 2006).

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Family violence occurs at every socioeconomic level, and violent attacks can take place anywhere in public spaces, but some sectors of the population are more burdened than others by the pervasiveness of violence.

A Blueprint for Action

The plethora of research findings linking the epidemic proportions of child exposure to violence with immediate and life-long physical and mental health problems leads us to the inescapable conclusion that a personal problem, multiplied by the millions, becomes a social problem. The extent and impact of family and community violence highlight the urgency of creating effective approaches to identification and treatment as well as public policy initiatives that protect both children and society (Harris et al., 2007). Establishing systematic links that allow efficient communication and collaboration across all child-serving systems must be a priority in public policies designed to prevent and ameliorate the impact of child exposure to violence (Osofsky & Lieberman, 2011). Steven Sharfstein (2006) forcefully expressed the urgency of this need when he stated, in announcing the formation of an American Psychiatric Association task force on the effects of violence on children, that "Interpersonal violence, especially violence experienced by children, is the largest single preventable cause of mental illness. What cigarette smoking is to the rest of medicine, early childhood violence is to psychiatry."

Federal initiatives such as the National Child Traumatic Stress Network (NCTSN), which is funded by the Substance Abuse and Mental Health Services Administration, make an extraordinary contribution to developing, implementing, and disseminating effective treatments for child trauma. Established by Congress in 2000, NCTSN has the mission of raising the standard of care and improving access to services for traumatized children, their families, and their communities across the United States (NCTSN, n.d.). This initiative brings a comprehensive focus to child trauma. It integrates knowledge of child development with expertise in the full range of child traumatic experiences and with commitment to evidence-based practices; and it fosters close collaborations among frontline providers, researchers, and families to create and disseminate new resources and intervention approaches (Pynoos et al., 2008). One of the NCTSN centers, the Early Trauma Treatment Network, involves a collaboration of four university-based programs (at the University of California San Francisco; Boston Medical Center; Louisiana State University Medical Center; and Tulane University) with a specific focus on early childhood trauma. Through the Early Trauma Treatment Network, more than 1,000 clinicians in 28 states have been trained in child–parent psychotherapy (Lieberman & Van Horn, 2008)

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Chronic stress overwhelms the body's capacity to adapt, disrupting basic regulatory processes.

with the goal of raising awareness, improving identification, and disseminating evidence-based treatment for traumatized infants, toddlers, and preschoolers. Other important federal programs include the Promising Futures initiative, which helps domestic violence advocates work with mothers and children served by domestic violence agencies and ongoing efforts at the Department of Justice to identify best practices for serving American Indian and Alaskan Native children and youth.

These efforts are far from sufficient because the need is incomparably larger than the resources deployed to meet it. Effective treatments need to be brought to scale so that treatment is accessible to all those who need it. The systems serving children and families require a trauma focus that allows for accurate identification and intervention. For example, pediatricians and primary care providers, child care providers, and home visitors need to be equipped with the knowledge to identify child exposure to violence and make appropriate referrals. And, because an ounce of prevention is always better than the best cure, it is essential to address the social context for children's exposure to violence and tackle the enormous scale of poverty and its costs for the safety of children and families, which disproportionately affect those from ethnic and racial minorities. The recommendations of the Attorney General's National Task Force Report on Children Exposed to Violence (Listenbee et al., 2012) represent a painstaking effort to itemize, describe, and give a rationale for the steps that must be taken to protect America's children and safeguard America's future.

Almost 20 years ago the Violence Against Women Act was passed, ushering in two decades of progress in which domestic violence decreased by more than 60%. While the legislation itself was critical to this progress, it also served as an important marker in the long trajectory to reduce this most personal form of physical and emotional violence. The legislation served as the culmination of decades of relentless work, initially started by survivors and activists, to bring attention to the prevalence and harm caused by domestic violence and highlighted the dramatic change that was taking place in this nation. Men and women, survivors and those untouched by violence, joined together to say that they wanted this violence to stop and were willing to take action to do something about it. And while this journey is far from over—domestic violence still kills an average of three women a day in this country—its continued existence cannot obscure the progress that has been made and how that progress was achieved: increasing awareness, developing and highlighting solutions, and mobilizing with passion and urgency within communities and across the nation.

The progress made in decreasing the prevalence and social acceptability of domestic violence holds important lessons for the current epidemic of child exposure to violence. Our nation is at a tipping point in its response to children's victimization from violence, both witnessed and experienced. The tragedy at Sandy Hook Elementary School 2 days after the release of the Attorney General's report (Listenbee et al., 2012) made the message and recommendations of that report more compelling than ever. Children's exposure to violence is a national crisis. While the horrific and random mass shootings overwhelm the news, it is the equally cruel, if far less visible, daily attacks on children in their homes and neighborhoods that now demand action. Researchers have the data, and they know what can help. Now the armies of activists, those with bullhorns and those with laptops, must demand action and resources to once and for all stop the violence that threatens the innocence and joy of childhood itself. In the words of the report,

> *We, as a country, have the creativity, knowledge, leadership, economic resources, and talent to effectively intervene on behalf of children exposed to violence. We can provide these children with the opportunity to recover and, with hard work, to claim their birthright... life, liberty, and the pursuit of happiness. We invest in the future of our nation when we commit ourselves as citizens, service providers, and community members to helping our children recover from exposure to violence and ending all forms of violence in their lives.* (p. 5)

Alicia F. Lieberman, *PhD, is Irving B. Harris Endowed Chair in Infant Mental Health, professor and vice chair for Academic Affairs at UCSF Department of Psychiatry and director of the Child Trauma Research Project at San Francisco General Hospital. She is on the board and past president of ZERO TO THREE: National Center for Infants, Toddlers, and Families. Her research involves treatment outcome studies with infants, toddlers, and preschoolers from low-income and under-represented minority groups with a high incidence of exposure to family and community violence, maternal depression, and other risk factors. She is the senior developer of Child-Parent Psychotherapy, which has shown efficacy in comparison to other interventions in five randomized studies with young children and their mothers. She currently directs the Early Trauma Treatment Network, a four-site center of the Substance Abuse and Mental Health Services Administration-funded National Child Traumatic Stress Network. She has authored a book on toddler development, two treatment manuals, and numerous articles and chapters on risk and protective factors for mental health in infancy and early childhood, child–parent attachment, and cultural competence in intervention and treatment. She was born in Paraguay and received her professional training in Israel and the United States. This cross-cultural experience informs her commitment to closing the mental health services gap for low-income and minority young children and their families.*

Esta Soler *is founder and president of Futures Without Violence. One of the world's foremost experts on violence against women and children, Esta Soler is a pioneer who founded Futures Without Violence, formerly Family Violence Prevention Fund, 30 years ago and made it one of the world's leading violence prevention agencies. Futures Without Violence develops innovative strategies to prevent domestic, dating, and sexual violence; stalking; and child abuse. An Advisory Board member to the National Child Traumatic Stress Network, and a board member of The Lick-Wilmerding High School in San Francisco, Soler was until recently a trustee for the Blue Shield of California Foundation. She has been a consultant and advisor to numerous public and private agencies, including the Centers for Disease Control and Prevention, the Soros Justice Fellowship Program, the Ford Foundation/Harvard University Innovations in American Government initiative, and the Aspen Institute. Soler is co-author of* Ending Domestic Violence: Changing Public Perceptions/Halting the Epidemic.

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Colorism, A Legacy of Historical Trauma in Parent–Child Relationships

Clinical, Research, and Personal Perspectives

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Abstract
Practitioners need to be aware of the intergenerational transmission of historical trauma in families with young children. One legacy of historical trauma, *colorism*—valuing light skin over dark skin—occurs among many oppressed indigenous, ethnic, racial, and cultural groups around the world. The unconscious hierarchy and privilege associated with skin color may interact with other stressors and traumatic events resulting in the acceptance or rejection of children by parents. A clinical case explores the compounding impact of colorism with present-day traumatic stressors in the parent–child relationship of a Salvadoran dyad where the mother is a survivor of political trauma. The authors then present research, personal, and professional experiences of colorism within families and systems of care and discuss recommendations for therapists.

When infant mental health or child practitioners think about trauma they typically do not think about *historical trauma* (N. McConnico, personal communication, May 30, 2013). Historical trauma is defined as "a cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences" (Brave Heart, 2003, p. 7). Although the legacies of historical trauma are numerous and interconnected (see Sotero, 2006, for full discussion), we will specifically focus on the modern legacies of internalized oppression and the outcome of *colorism*—valuing lighter skin tones over darker skin tones—as it occurs among some members of subjected groups who have experienced historical trauma. The emotional experience of this unconscious social hierarchy of skin color variation may have a significant psychological impact on parent–child relationships.

A loving grandparent may make a teasing statement about a "nappy-haired, black as night chile," in reference to a disobedient toddler. Conversely, in some countries in Latin America (Ecuador, Mexico, Colombia) the term "Negrita/negrito" (diminutive of the word black in Spanish) may be used as a term of endearment and as an expression with positive connotations in songs and poetry. Depending on the socio-cultural context it may be used as a way to denote affection between partners, friends, or family members or as an offensive term (Whitten, 2003). Yet, issues related to colorism may be an unrecognized factor in assessments of parent–child interaction. The issues may be subtle but hurtful forms of rejection by caregivers or family members due to the dark or light skin color of the infant or child (Lewis, 2000, 2007).

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The legacy of colorism occurs among many indigenous, ethnic, racial, and cultural groups around the world (Bhattacharya, 2012; Hochschild & Weaver, 2007; Vasconcelos, 1928/1979). In this article we will address the *intergenerational relational trauma* (see box Definition of Relational Trauma) and emotional rejection of children within families and their communities that may be triggered by colorism. We then discuss how colorism negatively impacts parent–child relationships in two separate groups who experienced centuries of chronic historical trauma—an immigrant Salvadoran family, and African American descendants of enslaved Africans.

Historical Trauma

"Multigenerational transmission of trauma is an integral part of human history. Transmitted in word, writing, body, language and even silence, it is as old as human kind" (Danieli, 1998, p.2).

Historical traumas have occurred in groups across the globe, in numerous cultures and ethnic groups since recorded history (Hooker & Czajkowski, 2007). (See box Assumptions of Historical Trauma Theory.) The essential components of a conceptual model for understanding historical trauma in any group are (a) the historical trauma experience, (b) the historical trauma response (HTR), and (c) the intergenerational transmission of trauma (Sotero, 2006). Figure 1 presents the relationships among these components.

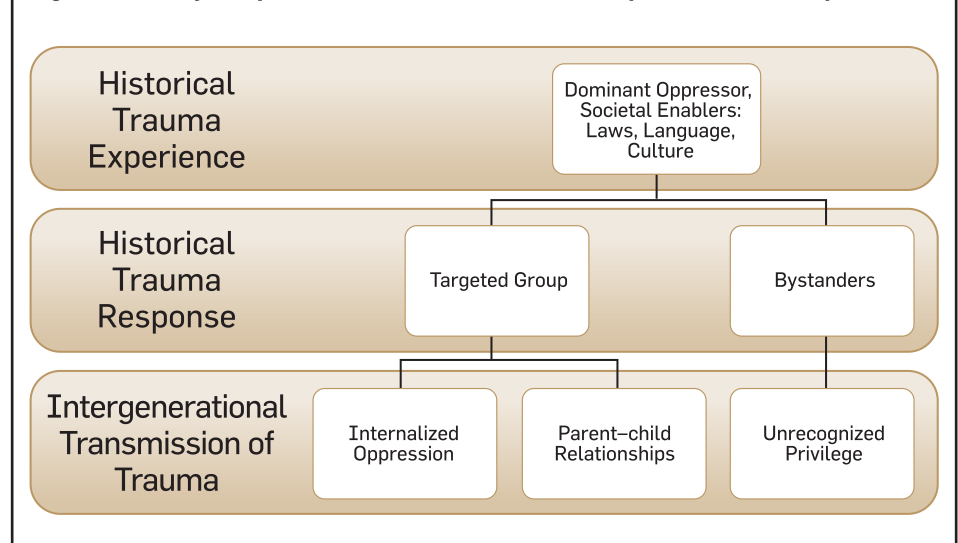
The subjected group may manifest the historical trauma experience as internalized oppression, and it may be expressed in parent–child relationships through the practice of colorism.

Historical Trauma Experience

The historical trauma experience in Figure 1 refers to the exposure of a group (based on a specific membership criteria, e.g., ethnic, racial, nationality, religious group) to deliberate perpetration of massive trauma. Historical trauma experiences exist on a continuum that includes experiences from colonialism; systematic discrimination based on a diversity characteristic such as race, gender, sexual orientation, or country of origin; to political violence, genocide, and generations of structural inequality (Duran, Duran, & Brave Heart, 1998; Eyerman, 2004; Healey, 2013; Hooker & Czajkowski, 2007; Noroña, 2011; Sotero, 2006).

The historical trauma experiences of families with young children descended from the colonized indigenous people of a country, such as American Indians; Mayan; Aboriginal people of Australia, the United States, India, Central America, South America, and Canada; or the enslaved Africans captured and brought to the Americas during the 400 year trans-Atlantic slave trade, have not been sufficiently addressed in research or clinical practice (Bhattacharya, 2012; Bombay, Matheson, & Anisman, 2009; Brave Heart, 1998; Coles, 1964; Danieli, 1998; Eyerman, 2004; Hooker & Czajkowski, 2007; Sotero, 2006).

Figure 1. The Key Components of Historical Trauma and Impact on Relationships



Definition of Relational Trauma

Relational trauma has been defined as "a type of psychological trauma involving interpersonal loss within significant care giving relationship" (Briere & Spinazzola as cited by Gardner, Loya & Hyman, 2013, p.3). It can have negative consequences for children's cognitive development, their possibility of self-regulation, the development of self-esteem, trust in the world, and how they may relate to others in the future. Children traumatized in their attachment relationships may have difficulties to empathize with their own children once they become parents and present mental health disorders.

Assumptions of Historical Trauma Theory

The phenomena of historical trauma in multicultural groups worldwide includes the following assumptions:

1. Mass trauma is deliberately and systematically inflicted upon a target population by a subjugating, dominant population;
2. Trauma is not limited to a single catastrophic event, but continues over an extended period of time;
3. Traumatic events reverberate throughout the population, creating a universal experience of trauma;
4. The magnitude of the trauma experience derails the population from its natural, projected historical course resulting in a legacy of physical, psychological, social and economic disparities that persists across generations.

Source: Sotero, 2006, p. 94

THE HISTORY OF EL SALVADOR

El Salvador's history reflects the oppression of communities of color in the rest of Latin America and offers a powerful example of "the struggles of indigenous peoples and of people of color within the context of multiethnic, multiracial societies dominated by lighter skinned descendants of Spaniards" (Comas-Diaz, Lykes, & Alarcón, 1998, p. 778).

After three centuries of colonial domination, the Indian population of El Salvador and other Central American countries was significantly reduced and lost their right to use their land. This loss represented a profound injury to their cultural identity (Comas-Diaz et al., 1998, Czajkoski, 2004) as their Mayan and Aztec ancestors revered the land as a sacred symbol. Cultural expressions through religion, language, dress, or beliefs were suppressed often by force or punishment and the indigenous Indians were indoctrinated into Catholicism. By the end of the colonial period the former Indian towns were in the possession of a small group of Spanish families that became the ruling oligarchy. These ruling families excluded *mestizos* (part Indian part European), *ladinos* (pure blooded Indians that assimilated to the ruling culture), and

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Indians from economic and social power. After El Salvador obtained independence of Spain (1821) the oligarchy and military abolished all village landholding, which added to the oppression of *campesinos* or peasants (Czajkoski, 2004). Monopolistic practices impeded the rise of a middle class, and the disenfranchised people of mixed races and colors constituted the masses of the poor… the poor having evolved from those with native "Indian" blood in the 15th century to all the underrepresented classless peasants of mixed race living in the 20th century and beyond (Czajkoski, 2004).

Land possession and distribution, class interests, socioeconomic inequalities, and structural racism originated mass traumas and political conflicts in El Salvador. The most known casualties are the massacres of *La Matanza* (1932) and *El Mozote* (1981). The massacre in the town of El Mozote is one of most brutal killings perpetrated by the government during the Civil War (1979–1992); approximately 900 civilians were tortured and murdered after being accused of aiding the guerrilla militants in the area. The Civil War was the result of the conflict between leftist revolutionary organizations and the military government, which was aided by the United States. It was especially violent and its victims were primarily women, children, vulnerable civilians, and *campesinos*. It is estimated that approximately 75,000 people were killed during the Civil War. There are also uncounted thousands of people who disappeared (United Nations Truth Commission, 1993). In 1992 the Peace Agreement was signed, putting an end to the war (United Nations Truth Commission, 1993); however, most of these crimes were left unpunished.

After the civil war and the natural disasters that followed, thousands of Salvadorans fled to other countries. Beginning in 1576 and through 2005 numerous earthquakes, destructive volcanic eruptions, droughts, landslides, and hurricanes have affected the country of El Salvador. These natural events resulted in significant trauma. For example the earthquake of 1986 resulted in 1,500 deaths, 10,00 injuries, and more than 100,000 people were left homeless.

Many members of small communities had seen or had known of a relative or a friend who was tortured or murdered or were incapacitated by serious physical and psychological injuries. Those who were able to escape to flee to other countries "brought with them a history of living terror and poverty" (Cohen, Mzorek, & Tan, 2013, p. 5).

THE PRACTICE OF SLAVERY

The practice of slavery has existed for most of recorded history. Although much is known about U.S. slavery from a historical, legal, and economic perspective, very little is written about the period of slavery as a collective and chronic experience of psychological trauma (Eyerman, 2004). Unique to the practice of slavery in the United States, the enslaved Africans were designated as "chattel"—the property of their owner for life (Bennett, 1964). As chattel the enslaved African people had no legal, social, or civil rights. The laws from the Supreme Court of the United States decreed they were counted as "three-fifths" of a man. The historian Kenneth Stamp in his seminal work *The Peculiar Institution* (1956) studied the everyday life of slavery in the American South. Based on an examination of historical records he outlined five psychological tactics used by slave owners to maintain strict subjection of millions of enslaved Africans in the southern regions of the United States. The colors "black" and "white" next to each tactic highlight the psychological precursors to colorism in modern interpersonal relationships within African American communities:

1. Maintain strict discipline (of blacks).
2. Instill belief of (black) personal inferiority.
3. Develop awe of (white) master's power (instill fear).
4. Accept (white) master's standards of "good conduct."
5. Develop a habit of perfect dependence (on whites).

These two historical traumatic experiences, a tortuous political regime and chattel slavery, in these targeted groups took place over centuries and across many generations. The chronic nature of the trauma then became part of the historical everyday experiences for families socializing their children for survival and is evident in modern child-rearing practices in their descendants (Branch & Newcombe, 1996).

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The emotional experience of the unconscious social hierarchy of skin color variation may have a significant psychological impact on parent–child relationships.

Historical Trauma Response at the Individual, Family Level

Dr. Maria Yellow Horse Brave Heart (2003), a descendent of leader Chief Sitting Bull (who was killed in the massacre of the Lakota American Indians in the Battle of Little Big Horn), has identified the concept of HTR. Figure 1 (see p. 12) shows the relationship between the historical trauma experience and the HTR in both the targeted group and the bystanders of the experience. In her clinical work in the Lakota community she noted a recurring array of symptoms experienced by different generations of the current descendants of the survivors of those massacred in 1849.

The trauma history of an identified group may be expressed through parent–child relationships in a variety of ways that impact young, developing children. Brave Heart (1998) noted an increase in child abuse in communities that included HTR descendants and wondered if this increase is due, in part, to unresolved experiences of historical trauma. Other manifestations of HTR in parent–child relationships may be in relation to socialization practices that highlight cultural histories of survival, hero or martyr stories, and myths related to group resilience and modern-day status. More likely there may be silence and omission of sections of history related to painful memories and traumatic events of the group (Hurmence, 1984; Tatum, 2012).

It is likely that the experience of mass trauma, like political violence in the focal generation, may create extreme fear in caregivers, which in turn leads to disruptions in the quality of attachments (Bar-On

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El Salvador's history reflects the oppression of communities of color in the rest of Latin America.

et al., 1998). These disruptions are evidenced by frightening (hostile) or frightened (helpless) behaviors with their children that have continued across generations (Lieberman, 2007; Lyons-Ruth, Bronfman, & Atwood, 1999; Main & Hesse, 1990; Weingarten, 2004). Children in these situations may develop disorganized strategies to gain control or attention in the parent–child relationship (i.e., eating or sleeping disruptions, controlling aggressiveness, excessive compliance, withdrawal from caregivers, engaging in contradictory behaviors with the caregiver; taking care of the vulnerable caregiver in the form of role reversal; Bellow, Boris, Larrieu, Lewis, & Elliot, 2005 ; Landy, 2005–2006).

Intergenerational Transmission of Trauma

The intergenerational transmission of trauma refers to the transmission of the effects of the mass trauma experience across generations (Connolly, 2011; Sotero, 2006). This transmission can happen through different mechanisms such as secrecy about the horrors of the trauma or, on the contrary, telling and retelling of the traumatic events and through heightened levels of stress and abusive tendencies in parent–child relationships as a result of the trauma (Ramos, 2013; Weingarten, 2004). The experiences of children of Jewish holocaust survivors illustrate the impact of historical trauma on the mental health of subsequent generations of descendants. In clinical work with the children of survivors of the genocide of Jews preceding the end of World War II (Bar-On et al., 1998) the children demonstrated the *survivor's child complex*, which was a fixation to trauma, where they repeated the event in a number of ways, such as through play or drawings.

Other clinicians working with the descendants of parents in groups that experienced historical trauma noted symptoms in children that included nightmares, perceived obligation to family, and unique coping strategies (Brave Heart, 1998; Duran et al., 1998).

As has been described above, one of most deleterious effects of group historical traumatic experiences is the possible transmission of disruptive patterns of attachment on the group's descendants, which can give place to relational trauma and therefore to cycles of neglect and violence in the parent–child relationships. Caregivers who are survivors of historical and intergenerational trauma may show limitations in their ability to maintain a focus on their child's mental states (e.g., organized, disorganized, dissociated) in the face of strong emotions (mentalization; Gardner et al., 2013) and to think and feel with compassion about their own and their child's thoughts and feelings (reflective functioning; Fonagy, Gergerly, Jurist, Traget, 2002). This limitation renders them unavailable to understand the meaning and motivation of their child's behavior and to help them manage their emotions. The diminished capacity of the caregivers may limit their ability to buffer the child from overwhelming stressors or fear. In order to protect themselves from disorganization and pain these caregivers may detach from their internal experience, thoughts, and feelings regarding their children and may be in danger of repeating with their children what happened to them and to their ancestors (Landy, 2005–2006; Schechter & Willheim, 2009).

Outcomes of Oppression

A common theme in each of these components of the historical trauma is that historical factors interact with current systems of oppression and modern stressors (including current traumatic events) and result in either problematic or resilient outcomes in individuals, families, and communities (Eyerman, 2004; Fast & Collin-Vézina, 2010; Hulko, 2009; Ruden, 2011; Sotero, 2006).

The most insidious emotional residue of historical trauma, including issues of colorism, is when the oppressed group internalizes the beliefs or stereotypes created by the aggressor group (Taylor & Grundy, 1996). Internalized oppression occurs when some members of subjugated people mimic and take on the beliefs of the dominant colonizer (Fannon, 1925/1961) in an attempt to make sense of a social world where they were not valued. Some traumatized group members may re-enact a cycle of self-hatred, as well as disdain and diminishment of one's own group, and act out their aggression on people who look like them (Bhattacharya, 2012; Fannon, 1925/1961; Hooker & Czajkowski, 2007). This phenomenon is also similar to the psychological behavior of learned helplessness in the face of chronic abuse (Seligman, 1975).

Colorism: A Mark of Oppression

Psychiatrists Abram Kardiner and Lionel Ovesey (1951) coined the phrase "mark of oppression" to characterize the psychological impact of the indelible and inescapable characteristic skin color of African Americans. The issue of colorism can be found in cultural groups around the world (Bhattacharya, 2012; Russell, Wilson, & Hall, 1992). Throughout history, members of societies with dark skin tones have traditionally been viewed pejoratively (Vasconcelos, 1979). For example, the darker skin tone members of India are relegated to the lowest caste in the social hierarchy. The lightest skin tones that approximate Whiteness are viewed as of the most value by members of every caste within societies in India (Bhattacharya, 2012). For centuries people in Latin American countries such as Brazil, El Salvador, or Nicaragua classified darker skin tones as ugly (Sotero, 2006; Vasconcelos, 1979). In countries such as Guatemala, El Salvador, Peru, and Ecuador, power has been in the hands of the White oligarchy while Indians, mestizos and the descendants from African slaves have been marginalized and regarded as inferior. Social divisions have been based on ethnic traits (determined by skin color), economic aspects, and academic and educational accomplishments (Comas-Diaz et al., 1998).

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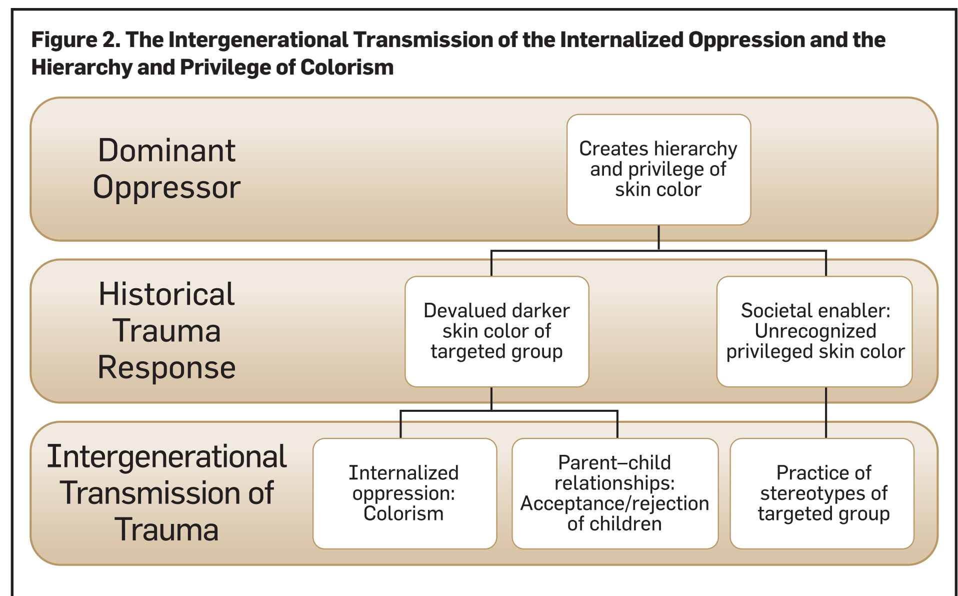
According to Falicov (1998) the underlying racial issues in many countries in Latin America mirror and recreate the relationship between the Spanish conquerors and the conquered Indians. From the time of the conquest of Latin America, "to be White (or güero) has implied the power or privilege of a higher social class. To be dark (or indio) has signified the conquered, dominated and intellectually inferior (tonto)" (p.95). This racial hierarchy continues to perpetuate the social order, discrimination, and oppressive practices against indigenous communities and people of color in Latin America (Falicov, 1998).

Figure 2 presents the Intergenerational transmission of historical trauma that may lead to internalized oppression and acceptance and rejection of children based on skin color.

Below we illustrate the modern-day manifestation of the legacy of colorism and its compounding impact with present-day traumatic stressors in the parent–child relationship of a Salvadoran family. We also describe a framework to engagement and treatment aimed not only at enhancing and restoring the child–parent relationship but at respectfully exploring, acknowledging, and including the family's historical context.

Figure 2. The Intergenerational Transmission of the Internalized Oppression and the Hierarchy and Privilege of Colorism



Trauma, Colorism, and Parent–Child Relationship

Alba is a 30-year-old undocumented immigrant from El Salvador. Racially she identifies as a *campesina mestiza*, a peasant having both Indigenous and Spanish heritage, and culturally as Salvadoran. Alba is the mother of two children, Jesús, 3½ years old, and Ken, 6 months old (at the time of referral). Jesús' father lives in El Salvador. When she was 28 years old, Alba fled from El Salvador with her 18-month-old son, Jesús, following a home invasion where she was violently attacked and raped by a group of thieves in front of the child. She entered the United States with the help of a smuggler with the promise of a job in a restaurant.

Alba and Jesús were referred to child–parent psychotherapy services by Jesús' early intervention specialist, because of concerns about the child's history of trauma exposure, sad affect, limited exploratory behavior, fearfulness, language delay, tendency to withdraw, and aggressive behavior toward his mother. The worker was also concerned that Alba seemed distant and at times unresponsive to Jesús.

When the clinician asked Alba what brought her to the program, Alba stated that she was ambivalent about services. She initially minimized any link between Jesús' presenting symptoms and "what he saw in my country or the problems that I had with Ken's father." When asked about her own functioning she stated that she had been struggling for years with extreme sadness, *ataques de nervios* (a culturally bound symptom; American Psychiatric Association, 2013), memory loss, and with periods in which she felt disconnected from everything. She had been in psychotherapy for the past year and reported feeling better. She did not have any concerns regarding her own state of mind and its impact on her children; however she agreed to start an assessment process. She stated that she was agreeing to the assessment because she was a good mother and wanted to follow up on the early intervention worker's recommendations.

COMPLEXITY OF TRAUMA EXPERIENCED

The clinician gathered information about the mother, Jesús, and the dyad's functioning. Ken was included in the assessment phase but Alba did not report any concerns about him, as he was "a perfect baby." When asked about traumatic experiences in her life Alba stated that Jesús's father betrayed her with another woman, that she was gang raped by a group of men in her country a little more than a year previously, that while she was trying to cross the border to the Unites States one of her trip companions died, and that her last partner was emotionally abusive (he threatened her with taking the baby away and reporting her to immigration).

The clinician then explored any traumatic experiences that were linked to Alba's family history or the history of her people and country. Alba shared in the form of a chronicle the following: She is the 11th of 14 children, of whom only 7 are alive. She was born in 1980 in a small village in the western part of El Salvador in the midst of the Civil War during which *campesinos*, like her parents, were being tortured, disappeared, or killed and whole communities were massacred. Her oldest brother, her elderly grandmother, and her aunt were tortured and murdered in front of her parents, and as she was growing up she heard multiple recounts of acts of terror perpetrated by the government toward her relatives and neighbors. She was delivered while her family was in an underground hideaway that her father dug to protect them. She reported that her twin baby brothers had died of starvation at the bottom of this ravine a few months before her birth, that her parents told her that she came to replace them, and that she survived because she "came to the world for a reason." She was given the name Alba to symbolize purity, hope, and a new day.

UNEARTHING THE GHOSTS OF COLORISM

When asked questions about how she chose Jesús's name, who he reminded her of, and what strengths and difficulties she saw in her child (Zeanah & Benoit, 1995), Alba stated that she chose the name because he was the first baby. She said that the child reminds her of his father and that it was unfortunate that he looked "*indiecito* [Indigenous dark-skinned Indian] just like his father," that his skin was darker when compared to Ken or to her, and that also he was "less Americanized" than herself or Ken. When asked to elaborate on this, she explained that the child reminded her of when she was a child in El Salvador. He takes his time when doing things and does not like much activity or change and therefore she worried that he will not be successful. The clinician validated the mother's protective wish for Jesús to acculturate and explored her experience of growing up as a *campesina mestiza* and of now being a woman of color in the United States. Alba painfully remembered desiring to look like the children of the owner of the farm where her family worked, saying they were *blanquitos* (diminutive for

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The trauma history of an identified group may be expressed through parent–child relationships in a variety of ways that impact young, developing children.

White), lived in a house "like people," went to school, and wore shoes "like kids of good families," and also so she could be protected from her father's violence. She also shared that she had a sense of profound disappointment as she had thought that immigration would offer her and Jesús a better way of life but that she had failed. Although she tried to run away from the violence and poverty, she found violence and poverty again. In her perception her skin color continued to marginalize her and her children; this belief, added to her immigration status, lack of formal education, and language barriers, made her feel unsafe and rejected. She was unable to find a job and felt constantly hunted by fears of being apprehended by the police and being separated from her children by deportation. It was important at this point to provide the mother with information regarding possibilities of legalizing her immigration status (U-Visa) and to tactfully reflect with her on her experience of not being White as a child and the parallel with her current sense of failure for not fulfilling the dream that was sold to her before she came to the United States. Acknowledging her country's history of colonization and racial discrimination, as well as the deceiving and oppressive way in which she was brought to this country, seemed to broaden her perspective of herself, her history, and of Jesús. These new meanings began to challenge her internalized oppression as she questioned the passivity and fear with which she had accepted the early intervention worker's recommendation and to work with this clinician as, in her words she "did not trust *blanquitas*." It was hoped that this perspective of thinking about contextual forces will continue expanding in the therapeutic work and that as she resignified the perceptions of herself as unworthy, bad, and "not like people" she would be able to reframe her distorted perceptions of Jesús, too.

When inquired about positive and loving figures in her history and about sources of strength to help her coping with pain or stress, Alba rendered warm and protective memories of her mother and even her father who dug the dirt hole in which she was born and that allowed her to survive. Her early trauma experiences were intertwined with memories of caregiving experiences where she felt safe, understood, and loved (Lieberman, 2007; Lieberman, Padron, Van Horn, & Harris, 2005). She identified her religion and the cultural practice of having altars (shrines) in memory of her dead family members as soothing and as a source of hope. She strongly believed that she survived the war, and the multiple traumas that came after that, because she had to serve a higher purpose in life. This belief was a source of motivation and pride.

THE PARENT–CHILD RELATIONSHIP

Initial observations of the parent–child interaction during the assessment process evidenced that mother and child seemed to adapt well to each other's temperamental styles. However, the moments when they were able to attune and to show reciprocity and enjoyment were brief. Jesús thrived on his mother' attention but had to make multiple attempts to engage her (e.g., showing her toys, pointing at interesting things, tapping her leg); although Alba was an involved caregiver she seemed to ignore or misunderstand Jesús' emotional states (e.g., need for closeness or independence, reassurance when distressed, containment when angry) which appeared to contribute to negative-seeking behaviors in him (e.g., hitting, biting, fits of inconsolable crying).

At times Alba's interactions with Jesús seemed to have an aggressive undertone, and she teased him with situations that frightened him. For instance, she pretended that she was leaving the room to see his reaction, hid from him, brought a dinosaur puppet to his face repeatedly despite his intense fear reaction, or laughed when he was crying. These behaviors appeared to confuse him about whether or not it was safe to approach his mother, and at times he seemed paralyzed or frozen.

Alba's attributions of Jesús and the resemblance with his father appeared to represent a traumatic reminder for her in terms of what the child's skin color meant in her socio-cultural history and in relation to the betrayal perpetrated by the father. This seemed to contribute to ambivalence and distancing from the child. She also appeared hypervigilant to Jesús' intense emotions (fear, anger) and dysregulated behaviors but was unable to provide consistent affection, containment, and predictability for Jesús and to join him and soothe him.

These observations, in addition to the information gathered related to the mother's and the child's functioning, raised concerns about how the mother's history of individual and collective trauma, her functioning, her perceptions of Jesús, the child's disorganized approach to his mother, and the parent–child shared trauma were placing the dyad at risk not only for emotional rejection and neglect but of possible aggression in their relationship.

The approach used in assessment proved to be effective in engaging Alba; her initial reluctance to participating in treatment seemed to dissipate as the assessment progressed. She eventually felt safe enough to report that she was experiencing significant levels of distress in parenting Jesús and that she was afraid of hurting him.

INCORPORATING A HISTORICAL LENS TO TRAUMA ASSESSMENT

Based on what has been exposed above it can be hypothesized that : (a) An attachment figure's unresolved legacies of historical traumas, including internalized oppression and colorism, can be transmitted to young children through disrupted parenting behaviors; (b) current traumatic events and systems of oppression affecting the caregiver and her children can exacerbate these unresolved legacies, trigger HTR, and increase the likelihood of abuse and neglect in the parent–child relationship; and (c) assessment

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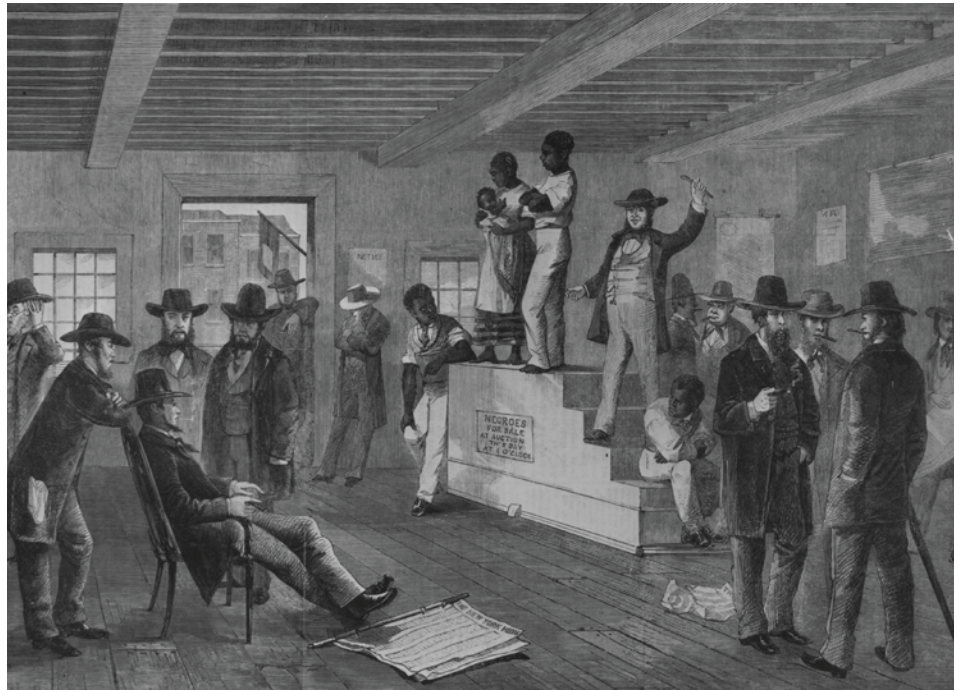
and intervention with these families need to include not only trauma, safety, and developmental lenses but also a historical and socio-cultural framework. Such a framework allows for a detailed analysis of how the sociopolitico-cultural contexts (Comas-Diaz et al., 1998) have impacted the family's identity and functioning. It also allows for the collaborative identification, with the family, of perceived local needs and resources (Ghosh-Ippen, Lieberman, & Van Horn, 2013) including cultural beliefs, traditions, and values as possible recovery forces, all of which facilitates engagement.

One of the trauma-informed interventions for young children that is consonant with this approach is child-parent psychotherapy (CPP). This relationship-based intervention for children less than 5 years old who were exposed to trauma has as its main goal the restoration of the quality of the parent–child relationship as this is used as the therapeutic vehicle of change (Lieberman & Van Horn, 2009; Reyes & Lieberman, 2012). It provides an opportunity for immigrant caregivers like Alba , who may be feeling disempowered, afraid, misunderstood, and unfamiliar with mental health services, to experience the clinician as hearing and understanding their point of view (Lieberman & Van Horn, 2009). Alba sought services out of fear of being judged as a bad mother and of ultimately losing her children. The clinician worked actively with Alba to consider Alba's views and beliefs about dyadic therapy, developmental expectation for Jesús, her feelings about play, her views about talking about the child's trauma history with the child in session, and to reach an agreement about what the child could be told about the trauma (Ghosh-Ippen, Van Horn, & Lieberman, 2013). The clinician also explained the assessment process in detail, which included providing a rationale for asking about her trauma history and symptoms and obtaining Alba's permission for exploring not only her individual and trauma history but the history of her family as well as the impact of the Civil War.



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One of most deleterious effects of group historical traumatic experiences is the possible transmission of disruptive patterns of attachment on the group's descendants.

REFLECTIONS ON COLORISM IN THE THERAPEUTIC RELATIONSHIP

In child-parent psychotherapy the therapeutic working relationship with the caregiver and child is used as a framework for trauma-focused treatment under the premise that quality of the relationship with the clinician affects the parent–child relationship (Reyes & Lieberman, 2012). Bearing witness to Alba's painful perceptions of Jesús, her difficulties at reading his cues when he was feeling afraid, her "turning off" in response to his tireless attempts to connecting with her, were emotionally challenging for this clinician. In order for the clinician to stay open to understanding the meaning of these perceptions and behaviors, and maintain an emotionally supportive therapeutic stance (Lieberman & Van Horn, 2008) with this dyad, it was necessary to become a learner of historical trauma and its multiple legacies of oppression. It involved exploring the racial and ethnic dynamic in El Salvador, its sociopolitical and historical context during the civil war, and gaining insight about the struggles across generations of its indigenous people and people of color for identity and voice (Comas-Diaz et al., 1998; Sonn, 2004).

It was also challenging to discover that Alba initially saw in the clinician a reminder of the "powerful others" who oppressed her people in her country or immigrant mothers like her in the United States. The clinician was surprised that Alba felt distrustful of her based on the perception that the clinician is *blanquita;* the clinician is considered a woman of color in the United States and her skin color is actually darker than Alba's. This fact was a powerful reminder of the importance of perception in trauma work and of the limitations of client–therapist language and ethnic matching in the work with survivors of trauma; it forced the clinician to examine and clarify aspects of her own identity. The clinician is an immigrant and belongs to an ethnic and linguistic minority group which has allowed her a close understanding of the impact of oppression and exclusion. However, the fact that she is an immigrant with a different cultural, social, psychological, and historical context means that she is situated differently than Alba in the broader social context. She can empathize with experiences of colorism and racism, and of feeling vulnerable and marginal. Nevertheless, she is still an outsider as she is not a *campesina mestiza* mother living in undocumented status in the United States (Sonn, 2004). Moreover, because of her social location and privilege, the clinician represented a reminder of oppressive others in Alba's socio-historical context.

Working with Jesús and Alba helped this clinician to see, hear, and listen to the child's and parent's worldviews (Sonn, 2004). Situating herself and the family within the broader sociopolitico-cultural context allowed this clinician to offer herself as a resource with potential to accompanying Alba and Jesús in the beginning of a healing process (Comas-Diaz et al., 1998).

The Legacies of Colorism From the Historic Trauma of Slavery

The biologically determined skin color of Africans was strikingly darker than their lighter skinned European captors. Their skin color became their "mark of oppression." The healthy bodies of the adolescent girls transformed them into targets for rape and abuse by their captors. Young men and women were forced to breed as many children as possible at the direction and behest of their all-powerful owners. These realities in part became the foundation for the modern-day intense emotional legacies associated with colorism. These legacies left generational family secrets, shame, depression, and

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unexpressed rage about the origins of the rainbow of skin tones within one family, ranging from light to dark skin color. Today their modern African American descendants still grapple with these legacies (Boyd-Franklin, 1989; Hardy & Lerner, 1989; Hochschild & Weaver, 2007; Russell et al., 1992).

In modern times, the legacy of these practices are evident in the hierarchy of color, educational, and work achievement and status within African American communities and families (Davis, Daniels & See, 1998). Thus the political leaders and high status members of the Black middle-class were often those with lighter skinned tones. Those with darker skinned tones typically were lacking job skills, education, and the ability to read and thus were less able to succeed in the years following emancipation from slavery. This pattern of stratification of socioeconomic success and achievement based on skin tone remains to this day. Recent studies document that darker skinned members of the community are more likely to be incarcerated, have lower paying jobs, and have less education (Hochschild & Weaver, 2007).

Nappy-Haired Ghosts in the Nursery and Internalized Oppression

A new developmental theory, childhood experiences of racial acceptance and rejection (Lewis, 2007), focuses attention on the potential impact of internalized stereotypes of Blacks on parents valuing their child on the basis of the child's racial phenotype. The internalization of emotionally toxic intergenerational legacies associated with African origin phenotypic racial characteristics—skin color, hair texture, and nose and lip-size—form the foundations of this theory. These experiences may also be part of internal working models of parent–child relationships that may account for some individual differences in the quality of attachment relationships.

Within the family, issues of skin color may be tied to attitudes about children (Boyd-Franklin, 1989; Lewis, 2013). The salience of skin color begins at birth. Newborns and young children may be either prized or discounted and negative attributions made about their behavior based solely on their skin color. Black infants are typically born with a temporarily light skin tone. The darker the tips of the fingers and ears at birth, the darker the permanent skin tone colors. According to anecdotal reports and observations by obstetricians and other medical staff in hospital delivery rooms, one of the first behaviors of African-American mothers and family members with their minutes-old infant is to check the tips of the infant's fingers and ears to determine what their skin color will be, (R. Maupin, personal communication, October 23, 2001).

> An attachment figure's unresolved legacies of historical traumas, including internalized oppression and colorism, can be transmitted to young children through disrupted parenting behaviors.

Other sources of family-related shame are "family secrets" related to the physical characteristics of children (Boyd-Franklin, 1989). Such secrets concern informal adoption and true parentage, unwed pregnancy, White ancestors, and skin color issues. These shame-inducing secrets may be passed down through the generations by some family members but not shared with other members, particularly the younger generations. These secrets may represent sensitive areas in the present family systems that are never discussed, yet generate varying degrees of stress and perhaps even shame or rejection.

Inherent in messages communicated to children about racial features is an emotional message of acceptance or rejection. If parents during their childhood were teased, denigrated, or constantly criticized by a significant attachment figure about race-related features, they may then as adults feel some degree of stigmatization, shame, or rejection (Lewis, 2002). Further, they may project these feelings onto their infant who may have similar or contrasting skin tone or hair type.

In a privately published memoir of growing up as a "colored Creole" in the city of New Orleans in the late 1950s, Aline St. Julien (1987) wrote, "My mother says I am Creole. My teacher said I am Negro. Some Europeans say I am Colored and others call me 'nigger.' Who am I?" (p. 2). She writes of experiences of racial acceptance and rejection of the children in her family within her own extended family group:

> *Creole ranged in color from white to dark brown with a lot of yellow and "teasing tans" in between. Hair texture, if straight, is described as "good hair" and kinky hair is considered "bad hair." A dark child in a Creole family is "better off" with straight hair, which means he is more acceptable. If he has kinky hair and dark skin, he is usually the butt of family jokes, like, "where did you get that one from?" or "someone must have slept in the woodshed with a nigger."* (p. 2).

Thus, experiences of racial acceptance or rejection may occur with people at all levels of their environments (Neal & Wilson 1989).

Parents may project the emotional responses to these experiences onto the relationships with their children. A parent who has a poor racial self-concept and intense negative or unresolved emotions associated with the racial features of her child, such as skin color and hair texture, may have difficulty responding to the natural cues of her infant. Adult self-concept and ethnic and racial identity formation may include the emotional residue of childhood experiences of racial acceptance or rejection and form a flash point for racial and ethnic identity (Lewis, 2002, 2007; Neal & Wilson, 1989).

Reflections on Experiences With Colorism

Below are the personal reflections of two women, both descendants of enslaved Africans, and their experiences of colorism by family members and others members of their communities.

Reflection #1: Being "Just Right"

Long before I understood the term historical trauma, I understood that my family's history shaped how I was being raised and socialized. As a young child I carefully listened to family conversations about how and why siblings from the same parents had drastically different skin tones—dark chocolate, milk chocolate, or vanilla cream. I watched my family guess how light or dark newborn babies would be once their melanin deepened. As I got a little bit older my grandmother would say "Hold your bottom lip in so it doesn't get so big," or "Don't go outside so much so you won't get any darker." My great aunt would remind me to "Comb your kitchen, chile." The term *kitchen* is commonly used in the African American community to refer to the hair at the nape of the neck. This hair is usually coarser or curlier than the hair on the rest of the head.

What I watched and experienced within my family system, I also experienced living within my Black and Latino community. As a child, I was constantly bullied and teased by a neighbor about my facial features. "Mouse lips! Big nose!" by neighbor yelled at me from elementary school through junior high. I felt tormented—so much so that I would not want to play outside with friends or walk to school by myself because of what she may say or what she might threaten to do. Her stinging words haunt me even to this day, well into adulthood. I am reminded of them when I hear someone comment on someone else's facial features, or when I am reminded that societal standards of beauty do not mirror my beauty.

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My mother tried everything in her power to counteract my grandmother's perspective and my bully's ridicule. Whenever my grandmother, who can be described as "light-skinned" or light brown, would say something about my medium brown skin, my mother was careful to respond with the saying "The blacker the berry the sweeter the juice," to remind me that I was beautiful. My mother intentionally hung and displayed black art in my bedroom and around our apartment as constant reminders of my beauty. I do the same in my own home today.

My understanding the legacy of colorism has evolved. Throughout childhood and adulthood I continue to participate in conversations with "light-skinned" members of my family as they struggle with feeling not "black enough" because of their lighter complexions. I do not have that struggle. I am not "too light," nor am I considered "too dark." My medium brown tone skin color is "just right." I am not forced to prove my blackness, nor am I shunned for being "too dark." But the struggle for others on the color spectrum is ever present. The film *Dark Girls* by actor Bill Dukes, shown on the Oprah 'OWN' network, reminds us of the ongoing legacy of colorism in American society. Further, the emotionally painful interviews with a variety of dark-skinned women recounting their experiences of rejection based on their skin color reinforces the intergenerational transmission of the trauma originally experienced by African American ancestors and the continued presence of within-group status delineations based on complexion.

I recently started seeing a new practitioner to help me with some of the physical imbalances in my body due to running and general wear-and-tear. In my quest, I found a cranial-sacral therapist who also does body-talk. Body-talk is a noninvasive technique used to synchronize the body's energetic systems so that the body can heal itself (International Body Talk Association, 2013). Body-talk, along with other mind/body/spirit healing modalities, believes that the body stores the experiences of your ancestors (K. Thomas, personal communication, 2013). In my session, I learned that I was carrying 15 generations of neglect and abandonment in my body. I was told that these experiences are from my father's side of the family and each generation is approximately 20 years. Later that day, I calculated that 15 generations is 300 years ago. My first thought was that 300 years ago the United States, West Africa, and the Caribbean were engaged in the trans-atlantic slave trade. I'm not sure what that means but I can only speculate that perhaps this means that my father's ancestors felt abandoned and neglected by their family/tribe/community during the slave trade. Perhaps this means that my ancestors made the journey to the United States during that time, and as such, each generation since has carried a sense of loss, abandonment, and neglect and has relived these feelings in new forms.

Reflection #2: "Forgive Them Lord, for They Know not What They Do"

While the enslavement of African Americans occurred more than 400 years ago, many may believe that these events are irrelevant to the present and future, and that as a nation we are done with that event. This naïve thinking could not be further from the truth. One may wonder why a discussion of historical trauma and intergenerational trauma is important. Why is it necessary to have discourse about events, circumstances, and situations that happened hundreds of years or decades ago? The devastating legacies of slavery exist for all of us despite the color of our skin, race, ethnicity, or culture we claim heritage to.

As I think about historical trauma, intergenerational trauma, and the connection to my journey as an accomplished African American woman, I am flooded with a plethora of emotions. Happiness about the resiliency, courage, and determination of my ancestors who endured the torture and ridicule of individuals who believed them to be less than and who demonstrated power and dominion over other human beings. I feel horror, outrage, and anger as I think about the unspeakable acts that were committed by one group of people at the expense of my ancestors. I feel sadness at the fact that we live in a world still plagued by discrimination, racism, and oppression of marginalized groups of society.

As a young child, I was the victim of significant bullying and ridicule due to my hair texture and length. Since I lived and attended school in a predominately upper middle class community one may assume that the perpetrators of the bullying were my Caucasian peers who were living in a society that in some ways was created for them and catered to their needs, but in fact, the opposite was true. My Caucasian and non-African American peers of color accepted me and provided me with refuge from the peers that "looked" like me.

Circumstances that were not subject to my control, but rather fixed phenotypes that were a part of my genetic make-up, caused me to be the target of extreme ridicule and rejection. Although the color of my skin was not the focus of the teasing, I made an association between the amount of pigmentation in my skin and the texture of my hair and, thus desired to have lighter skin. Characteristics that I should have been proud of that make me uniquely me, I despised at the very core of my being.

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Inherent in messages communicated to children about racial features is an emotional message of acceptance or rejection.

Although I was accepted by most of my Caucasian and non African-American peers of color, there was still a part of the little girl that felt like she did not quite belong with them either. They had something that she wanted—something that to her defined beauty and femininity. The most important thing was that they had long, flowing hair and a decreased amount of melanin in their skin that represented the societal standard of beauty. If I did not feel as though I belonged with those who shielded me and the peer group that was a part of my cultural and ethnic heritage did not accept me, where did I belong? Where could I fit in? This is a question that I struggled with throughout my childhood and adolescence.

For a child who is suffering and experiencing a psychological conflict about her identity that is based on skin color and hair texture, one natural place to find solitude may be from family members with whom she has developed a secure attachment. While my family members were able to provide comfort and reassurance about my value and worth, they too were bound by the same negative stereotypes, perceptions, and images of African Americans that were rooted in colorism, oppression, and racism, and, as a result, often made demeaning comments about members of their own racial group. This resulted in conflicted messages being communicated and modeled at home. Given the experience encountered with

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my peers and my family, as a young child I was left feeling confused and conflicted about my physical appearance and identity. I struggled to make sense of what was happening and often asked the question "why." Why was this happening to me despite my friendly and jovial personal qualities?"

As I grew older and gained more knowledge through high school and college, I became aware that while there was likely something about my peers and members of my family that they did not like about themselves—perhaps they were compensating for a need for peer acceptance and status, or low self-esteem—it felt like there was also something bigger and more systemic at play. The legacy of generations of my ancestors being oppressed and being made to feel as though they were less than simply due to the color of their skin helps explain this behavior. As has been illustrated this notion of colorism that was introduced more than 400 years ago has proven to have long-lasting negative effects and has shaped the way that many African Americans, including myself, view the world and themselves in it.

I have come to understand the perspective of my peers and family members as internalized oppression and do not hold them accountable or responsible. I realize that the events occurred out of unconscious memories and messages that were communicated by the dominant members of society who created the history of African Americans in this country. The beliefs and reactions that African Americans have about members of their racial group based on those beliefs can be viewed as a defense mechanism. As an attempt to distance oneself from the origins of their ancestors that were degraded and oppressed, and alleviate themselves of the anxiety and horror that results when having to internalize these negative views about themselves, one may adopt the negative stereotypes that exist about their group. Rather than seeing these stereotypes as something that the dominant society may perceive as true about them, these negative images become imprinted in the perceptions of some African Americans as truths about other members of their racial group. By adopting this view and creating a "me versus them" one can superficially boost their own sense of power and status and create a fictitious inflated sense of self. While one may attempt to enhance their ego strength there still lies underneath a wounded ego and sense of self.

The notion of a wounded ego and sense of self is paramount to understanding the effects of colorism on the development of self-esteem. The outcome is a self-fulfilling prophecy in which some African Americans, especially males, become what is believed about them and expected of them by the dominant members of society (Cose, 2002). African Americans get negative images from society, school, family members, and peers. Because of such messages, many do not recognize their behaviors and perceptions as the result of historical and intergenerational trauma.

Today I am an accomplished African-American woman, mother, and wife and enjoy some luxuries that my parents and most of my siblings have not been awarded. Despite all of these successes and accomplishments, I still carry around a piece of the sting that has played a significant part in shaping the internal representation that I have of myself.

As I reflect back on my experiences with colorism and racism and ask myself how I persevered, I am reminded of Maya Angelou (2010). She speaks so eloquently about individuals that come into your life who serve as "rainbows in the clouds" from whom you draw strength, courage, determination, hope, and wisdom to persevere during times of turmoil. For me there are many sources: teacher, husband, expressing oneself through the arts, and my spiritual faith. How do practitioners transform these experiences for very young children and provide them with their rainbow in the clouds? How do other significant adults help them to see their potential and worth? What are some of the protective factors?

Learn More

The Diversity Informed Infant Mental Health Tenets
www.imhdivtenets.org/Infant_Mental_Health_Diversity_Tenets/Diversity-Informed_IMH_Tenets.html

Transforming Historical Harms Manual
D. A. Hooker & A. P. Czajkowski (2007)
Presented by Coming to the Table: A project of Eastern Mennonite University's Center for Justice and Peace Building , this manual presents a comprehensive model for healing historical harms to indigenous populations around the world. The intention of the manual is to provide tools and actions to heal individuals and communities from historical harms.

The Colorism Project at Indiana University
http://jyottigupta.org/blogs/understanding-colorism/
Based on the research of Dr. Radhika Parameswaran, in Bloomington, Indiana, provides tools and resources for understanding colorism, or skin color based discrimination.

Protective Factors and Recommendations

Because of an array of psychosocial factors, not all members of an oppressed group may respond with internalized oppression. Similar to the individual differences of resilient responses to difficult life circumstances, there are individual differences in responses to historical trauma within subjugated groups. There also may be protective factors that contribute to the resiliency of children whose caregivers are experiencing historical trauma. Positive, caring, and supportive relationships with significant adults such as parents, grandparents, and teachers are paramount to help facilitate the healing process (Ghosh-Ippen & Lewis, 2006). These relationships can serve as protective factors that may help to re-establish a sense of safety, security, and hope within these young children.

Many people across many professions and disciplines lack the awareness and the understanding of the long-lasting effects of years of oppression and derogation.

Other research highlights the positive influence of the quality of parent–child attachment and parenting styles as mediators in the transmission of the effects of trauma (Chu & Lieberman, 2010). The intergenerational transmission of trauma, like the immediate outcomes linked to a traumatic event, depends on the complex interplay of different community, individual, and psychosocial factors and of contextual and structural factors (Bombay et al., 2009).

Teachers can be an incredibly powerful source of support and serve as a buffer for the trauma (negative factors) that are endured as a result of constantly being given damaging messages about yourself as an individual and a human being. Mental health clinicians also play a pivotal role in helping to facilitate the healing process. While most may think of the clinician's role as one of supporter or facilitator when thinking about what is helpful in working with children and their caregivers who have been haunted by the trauma of their ancestors, clinicians can help facilitate the healing process for their clients and themselves. For example, facilitating a family's process of "re-storying" their group's past and other narrative therapy techniques may be powerful tools for practitioners to interrupt intergenerational legacies of trauma (Hooker & Czakowski, 2007).

Recommendations for Therapists

It is important that therapists also are aware of their own history and experiences and how these have impacted them and that they be willing to discuss them (Tatum, 2012). The Diversity-Informed Infant Mental Health Tenets highlight the critical role of

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self-awareness when working with families across professional spheres (St. John, Thomas, & Noroña, 2012). For Caucasian therapists it is important for them be open and make themselves vulnerable to the uncomfortable, undeniable reality of White privilege and power that exists in American society but goes unrecognized and repressed by most (St. John et. al, 2012; Wise, 2004). Being willing to explore and acknowledge the devastating effects that slavery has had on themselves and other racial groups is essential to the healing process of all involved.

Worldwide the trauma experienced by a targeted group is shared by the perpetrators of the trauma as well as those bystanders (Hardy & Lerner, 1989; Hooker & Czajkowski, 2007). Within many societies the helper may be the descendant of a historically privileged group and the client the descendent of an oppressed minority group. So the helper may be White and the client Black or the helper from a light-skinned Brahmin caste class in India and the client from the dark-skinned lower caste of the society. In the case reported earlier about the mother and child from El Salvador, the helper (CN) was aware of the historic power dynamics of her ethnic group heritage. A relationship-based approach to practice based on a multi-systemic, intergenerational knowledge mandates that helpers' personal journeys become part of their practice (Heffron & Murch, 2010). Further, some professionals within these systems may operate from unconscious stereotypes of African Americans and immigrant families. Hardy and Lerner (1989) proposed that social relationships between Black and White Americans continue to be shaped by the practice of slavery. They noted that American have had less time as a society since the abolishment of slavery—146 years—than the time that slavery was practiced in this country—300 hundred years. Slavery must be conceptualized as a collective experience of trauma.

Therapists bearing witness to all of this while being present in the "here and now" with their clients is also important (Kivel, 2012). Being cognizant that out of struggling with and processing one's pain and grief comes learning, growth, and awareness that can guide each person as he navigates through life. This is true for both the survivor as well as the clinician. For clinical interventions to be effective with ethnic or racial minority, immigrant, and refugee young children and their families affected by trauma, clinicians must also use the lens of intergenerational transmission of historical trauma and internalized oppression to address the distinct developmental and psychosocial needs of these children. Finding culturally informed ways to mitigate chronic intergenerational stress within families is of critical importance. Brave Heart (1998) developed a clinical intervention for the descendants of the few Lakota survivors of Wounded Knee. She proposed that the clinician must educate the participants to increase their awareness of the original trauma, provide the opportunity to share the affect surrounding the memory of the event to provide relief to the participant, and understand that grief resolution could be achieved through collective mourning and healing which would create a positive group identity and commitment to community.

The Need for Courageous Conversations

In a society with increasing diversity, it can be difficult to know and understand the historical and contemporary experience of the different groups in which one is working. However, as noted earlier, a diversity- and trauma-informed framework may be the first step in helping individuals, organizations, and systems begin to heal from historical trauma (see box, A Trauma-Informed Framework). The Tenets (St. John et al., 2012) offer professionals a conceptual framework and stance for moving from the status quo to a more informed practice. They force professionals to acknowledge their own history, rework long-held conventions about other groups, and take specific steps toward combating historical and contemporary oppression. This action includes the intersectionality of the way historic traumas may interact and compound the stressors currently experienced by members of these groups, such as domestic violence, maltreatment, sexual abuse, suicide, poverty, immigration stress, and persistent discrimination (Fast & Collin-Vézina, 2010).

The United States has long been composed of ethnic, racial, cultural, and linguistically diverse families. Currently, there are increasing numbers of immigrants and refugees arriving from a variety of cultures, ethnic groups, and countries. The successful delivery of services to the parents and young children in these families also rests upon the extent to which service providers are sensitized to how indigenous, racial, and ethnic minorities may be impacted by historical trauma.

A Trauma-Informed Framework

It is necessary to expand the definitions of what has been proposed as trauma to include a framework that:

1. Allows for the exploration of the legacies of oppression and collective trauma in individual members and families of historically traumatized groups (Fast & Collin-Vézina, 2010; The National Child Traumatic Stress Network, 2012; Sotero, 2006).
2. Examines the effects on these individuals of current stressors of various types within a historical and socio-cultural context (Bombay et al., 2009).
3. Includes cultural beliefs, traditions, and values as possible recovery forces and protective factors for indigenous communities. The impact of historical trauma response is considered at the individual, family, and community level.

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appropriate, trauma-informed equitable systems of care for young children and their families. She works closely with early childhood mental health advocacy and public policy organizations and other community organizations serving vulnerable populations. Her experiences include policy and program development on behalf of under-resourced families and communities.

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Igniting the Policy Conversation

Bringing a Trauma-Informed Approach to Early Childhood System Building

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The issue of early childhood trauma is increasingly prominent in early childhood policy discussions, driven by a growing recognition of the potentially devastating impacts of trauma and violence on infants, toddlers, and families. Sadly, the issue has garnered attention in part through the proliferation of high-profile news stories that highlight tragic situations involving gun violence, domestic violence, or child abuse. However, policy conversations involving trauma have also gained traction because of recent advances in the fields of child development and neuroscience. Research suggests that wiring in some areas of the brain is contingent upon early experiences (National Research Council & Institute of Medicine, 2000). Therefore, early, acute, or sustained exposure to trauma can influence the brain's biochemical architecture, preventing infants and toddlers from fully developing the neural pathways upon which later functioning depends.

In this article, we provide a brief overview of a few important facts about the impacts of trauma and other adverse early experiences on child health and development. We then present examples of state, community, and tribal policy responses that aim to prevent and mitigate the effects of trauma on very young children. Finally, building on the experiences of these and other efforts, we provide action steps for policymakers and advocates.

Background

Traumatic experiences early in life disrupt foundational, psychological, and biological processes and may produce a cascade of consequences across a range of developmental domains. While very young children may react to trauma differently than older children or adults—perhaps not recalling or being able to articulate details of the event—even experiences the child doesn't remember can have lifelong effects (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012).

There are a variety of circumstances and events that may be traumatic for infants and toddlers: domestic violence, child abuse and neglect, homelessness, community violence, medical trauma, environmental deprivation, parental depression, natural disaster, serious accidents, forced separation from a parent or caregiver, and grief. Reactions to trauma are challenging to predict; they may occur immediately, weeks later (Osofsky, 2009), or long after the threat has been removed (SAMHSA, 2012). Signs of stress in infants may include: crying more than usual, sleeping all the time or having trouble sleeping, eating more or not wanting to eat, becoming less responsive, withdrawing, or startling easily (Safe Start Center, 2009). Toddlers may react with the same symptoms as infants. In addition, they may display more frequent temper tantrums, behavior characteristic of a younger child (e.g., accidents when already potty trained or speaking in "baby talk"), and

Abstract
The issue of early childhood trauma is becoming more prominent in early childhood policy discussions, driven by a growing recognition of the potentially devastating impacts of trauma and violence on infants, toddlers, and families. This article provides facts about the impacts of trauma and other adverse early experiences on child health and development. Examples of state, community, and tribal policy responses to prevent and mitigate the effects of trauma are presented, along with action steps to advance trauma-focused policy strategies.

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clinging behavior (Safe Start Center, 2009). Toddlers who are using words may repeatedly ask questions about the traumatic event but may fail to be soothed by a parent's responses (Safe Start Center, 2009). In extreme cases, children may experience dissociation, an attempt by the brain to block out an experience and dampen emotional response (Zindler, Hogan, & Graham, 2010).

When young children are exposed to traumatic events, they rely on parents and caregivers to protect them (Osofsky, 2009). A child's reaction is strongly influenced by the reactions of his parents (Osofsky, 2009). If the adult is calm, responsive, and able to maintain a sense of normalcy through daily routines, the child will feel safer and symptoms will be minimized (SAMHSA, 2012). Research has shown that sensitive and responsive caregiving from a parent or child care provider can moderate a child's emotional and physiological stress responses, even decreasing stress hormone exposure in children highly vulnerable to stress-system activation (National Scientific Council on the Developing Child, 2005). An anxious and overwhelmed adult, on the other hand, may cause the infant to feel unprotected. In cases of domestic violence or child abuse, this most fundamental need—to be able to rely on a caregiver for consistency and protection—is threatened. These situations pose a sort of double jeopardy for the child's well-being: the trauma itself is compounded by tenuous access to a positive caregiver (National Scientific Council on the Developing Child, 2005). The assumption that the caregiver will help keep the child safe is one of the first casualties of growing up in a violent home (SAMHSA, 2012).

In light of emerging research describing the potentially devastating impact of early childhood trauma, there is an urgent need for policy- and systems-level responses. States, communities, and tribes can begin by adopting a trauma-informed approach when building their comprehensive early childhood system. The system's response to supporting the well-being of young children must consider whether there is a history of trauma, not just the symptoms that a child is currently displaying. A trauma-informed approach is rendered even more critical by the number of services and funding sources at the federal, state, and community levels that are serving young children and their families who have experienced trauma. While the effects of early childhood trauma have the potential to be pervasive and far-reaching, early identification and treatment can minimize long-term negative outcomes and may result in cost savings over time. For these reasons, the evidence provided in this article on the impact of trauma and other adverse early experiences should be used to not only raise awareness but to develop initiatives, create programs, and develop more responsive state and community policy.

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Traumatic experiences early in life disrupt foundational, psychological, and biological processes and may produce a cascade of consequences across a range of developmental domains.

Systemic Responses to Early Childhood Trauma

States, communities, and tribes have developed a range of policy responses and initiatives to mitigate the impact of trauma on infants, toddlers, and families. While these entities are the central actors in all of the approaches we highlight below, the federal government also plays an active role setting priorities and serving as a strategic funder for some systemic approaches to trauma and promotion of well-being.

Reducing Trauma for Children Being Removed from Their Homes: Pre-Removal Conferences

Maltreated infants and toddlers are exposed to a variety of early traumatic experiences including the abuse itself and the disruption and absence of the parent–child relationship. For those young children who are removed, traumatic experiences include the action of the removal itself and, while in foster care, the potential for multiple placements, infrequent contact with their parents and siblings, and barriers in achieving permanency. One of the most traumatizing experiences for a young child and her parents is being removed from home. In response, the Iowa Department of Human Services (Iowa DHS), Polk County Attorney's Office, and members of the ZERO TO THREE Safe Babies Court Team in Polk County, Illinois, conceptualized the pre-removal conference (PRC). The purpose of the PRC is simple: to reduce trauma for children (Cohen & McInroy, 2012).

In October 2006, the Illinois Department of Human Services piloted the PRC while the Safe Babies Court Team tried a similar approach—engaging families at removal hearings. In both efforts, teams worked to expedite services and referrals that would meet the needs of the children and their families. Throughout the piloting process, a PRC Advisement Group, which included Iowa DHS, the County Attorney's Office, and the Safe Babies Court Team community coordinator, used each experience to improve the PRC process. By January 2007, PRCs were being requested in all cases across the state. Instead of an emergency removal in which both the parent and child are left traumatized, a PRC allows parents to bring members of their support system to a meeting with child welfare workers, medical providers, a parent mentor who's successfully navigated their own child welfare case with their children, and a trained facilitator to discuss how the removal and subsequent placement will occur. The group is able to make recommendations about needed supports to meet the safety, mental, physical, and educational needs of the children. Meetings are strengths-based

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Sensitive and responsive caregiving from a parent or child care provider can moderate a child's emotional and physiological stress responses.

and child-focused: centering on issues such as whether a relative could care for the children, how frequent contact can be safely initiated, supports that are needed, evaluations, transportation assistance, and the evaluation of medical needs.

To anticipate and prevent emergencies, the Advisement Group engaged in substantial crisis planning prior to the first PRCs. Law enforcement was notified in case a family became violent. Plans were made in case the family tried to flee with the children or failed to show up. The first PRC occurred with no problems—parents showed appreciation, and the professionals were ready for the next case. Because a plan is developed in consultation with the family, staff members receive fewer phone calls from upset family members after the removal. In many cases, children are placed with family members, and the parents are able to have regular contact with their children prior to the preliminary protective (removal) hearing (Cohen & McInroy, 2012). Courts also benefit from the PRCs: more time is available for disputed issues, hearings are shorter, and the court can build on the work done at the PRC to problem-solve and identify additional resources for the family.

From the beginning of the case, time is spent moving forward toward the goal of reunification. Prior to PRCs, families felt alienated, judged, and "policed" in the whole process involving their children. Through the PRCs, families now experience less traumatic removals, the children are put in more appropriate placements with input from the parents, and children can count on seeing their parents very soon after removal.

The Promoting Resiliency of Trauma Exposed Communities Together Initiative

The U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau provides funding for Early Childhood Comprehensive Systems (ECCS) grants to help states and communities build and integrate early childhood service systems that better meet the needs of children and families. Since ECCS began in 2003, 49 states, the District of Columbia, Guam, the Republic of Palau, and the commonwealths of Puerto Rico and the Mariana Islands have received federal funding to participate in the program. The grant program seeks to improve the healthy physical, social, and emotional development of children during infancy and early childhood by improving the quality and availability of services in communities throughout the nation. Its five key components are: access to health insurance and medical homes, social–emotional development and mental health, early care and education, parenting education, and family support.

The federal fiscal year (FY) 2013 ECCS funding announcement "Building Health Through Integration" provided states with a unique opportunity to improve early childhood systems and services by focusing their work on infants and toddlers. Successful FY 2013 applicants could choose to implement one of three strategies:

- mitigating toxic stress and trauma in infancy and early childhood across multiple systems;
- coordinating developmental screening activities in early care and education settings statewide; or
- improving state infant–toddler child care quality initiatives by incorporating *Caring for Our Children* (*3rd ed.*); American Academy of Pediatrics, American Public Health Association, & National Resource Center for Health and Safety in Child Care and Early Education, 2011) standards into state licensing standards, quality rating and improvement systems, or professional development, or a combination of these.

The FY 2013 ECCS grants were awarded in August and September, and the majority of applicants chose to focus on mitigating the effects of toxic stress and trauma in infancy and early childhood, further reinforcing the critical nature of this issue. The Illinois ECCS project Promoting Resiliency of Trauma Exposed Communities Together (PROTECT) Initiative is one of the 26 grantees focusing on toxic stress and trauma (D. Green, personal communication, August 29, 2013).

Across Illinois, professionals in health care, mental and behavioral health, family support, home visiting, education, and other fields share a commitment to providing trauma-informed, quality services for children and families at risk. Therefore, when the FY 2013 funding announcement was made public, Illinois was ready to bring key stakeholders to the table. Relationships already existed across professional disciplines and systems, yielding a climate ripe for collaboration and innovation. The resulting PROTECT Initiative brings leaders from key early childhood programs, state agencies, and initiatives together to address three key strategies:

1. building community capacity by identifying relevant, existing screening tools and services (training, consulting, and coaching) for providers serving families with young children; and ensuring that these tools and services are both widely available and coordinated between systems;
2. providing educational materials on trauma, adverse childhood experiences (ACEs), and toxic stress for caregivers and practitioners to share with families; and
3. facilitating robust and intentional coordination among systems by adopting system-specific best practices and protocols for children impacted by trauma, including referral and feedback forms that can be shared among all appropriate systems.

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While a variety of allies in PROTECT (see box Allies in the PROTECT Initiative) brought unique expertise and skills to the planning meetings, the group decided that Illinois Chapter of the American Academy of Pediatrics (ICAAP) would be the initiative lead and the fiduciary agent. Having ICAAP as the project lead will ensure that the medical community is heavily involved, bringing pediatric health care experts and community-based medical homes to the table and building on the important work of the American Academy of Pediatrics, which has made trauma-informed care an important priority for the national organization. They have developed numerous resources on helping families, especially adoptive or foster families, with trauma.

The PROTECT Initiative will work in six Illinois communities over a 3-year period to identify existing training, coaching, and consultation initiatives on trauma for early childhood service providers. These six communities are already engaged in the Illinois Maternal, Infant, and Early Childhood Home Visiting Program project and were selected because of their identified need and the presence of an infrastructure for the initiative to build upon. The communities—the Englewood, West Englewood, and Greater Grand Crossing communities in the city of Chicago; Cicero Township; the city of Elgin; the city of Rockford; Macon County; and Vermillion County—lack sufficient access to early childhood mental health care and trauma-related services including domestic violence screening and trauma-related therapy. The hope is to bring more resources to the six communities so they will be better served going forward.

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Homeless parents have often experienced chronic physical and mental health problems, substance abuse, and domestic violence or other forms of abuse.

Allies in the PROTECT Initiative

Allies in PROTECT include but are not limited to the following:

- Governor's Office of Early Childhood Development
- Illinois Department of Human Services
- Illinois Department of Children and Family Services
- Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative
- Ounce of Prevention Fund
- Voices for Illinois Children
- Advocate Health Care
- Illinois Childhood Trauma Coalition
- Illinois Children's Mental Health Partnership
- Heartland Health Outreach
- Illinois Chapter of the American Academy of Pediatrics (ICAAP)

The PROTECT Center, a virtual, on-line technical assistance center, will coordinate training, coaching, consultation, and other resources for early childhood systems and professionals working to integrate trauma-informed practices into their existing efforts. To improve coordination of care, a parallel initiative will develop strategies for communication among health, early childhood education, home visiting, and other state agencies and organizations. The resulting care coordination protocol will aim to alleviate the burden for families navigating multiple systems.

Finally, PROTECT will seek to identify and affect policy changes in order to motivate, incentivize, or require service providers to become trauma-informed. In each of its various efforts, PROTECT will remain mindful of the intergenerational transmission of trauma, understanding that children are affected not only by their own direct experiences but also by trauma, stress, and violence in the early lives of their parents and grandparents.

Project Linking Actions for Unmet Needs in Children's Health

Nationwide, there are 35 projects receiving funding from SAMHSA to invest in the physical and emotional health of young children from birth through 8 years old through Project Linking Actions for Unmet Needs in Children's Health (LAUNCH; SAMHSA, 2013). The goal of Project LAUNCH is for all children to reach social, emotional, behavioral, physical, and cognitive milestones so that they can thrive in school and beyond. Through state-community and tribal partnerships, grantees implement a range of evidence-based strategies to support young children's wellness and work to improve coordination among child-serving systems, build infrastructure, and improve methods for providing services.

The Red Cliff Band of Lake Superior Chippewas is a federally recognized tribe and a Project LAUNCH grantee located in northern Wisconsin. As in other tribal communities, families in the Red Cliff Band face a range of risk factors, including trauma; however, intergenerational transmission of the resiliency and wisdom of Red Cliff's ancestors has left a legacy of wellness that continues to strengthen the community today (SAMHSA, 2008). Bringing together Project LAUNCH strategies and traditional tribal values has allowed Red Cliff to create a supportive, family-centered, and accessible system of care. Services are provided to approximately 255 children and more than 500 family members a year. The services have been designed using a relationship-based and strengths-based approach, and there is an inherent focus on trauma, prevention, and recovery built into everything they do.

Change has come about with the help of everyone in the Red Cliff community—it is not a top-down initiative. In order to take a comprehensive approach to planning, Red Cliff created the Young Child Wellness Council, which includes decision makers and representatives from primary care, maternal and child health, mental health, early

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The Playspace Program is based on the belief that play is an essential driver of healthy development.

childhood, child welfare, domestic violence, county social services, school superintendents, parents, and cultural consultants. The group meets monthly to talk about ways they can enhance the system of care for children. The group coordinates many of the trainings and activities for children and their families (prenatal through 8 years old). Red Cliff also uses annual focus groups and surveys to ensure the "community's voice" guides policy and practice change. Culturally based family strengthening activities and a community resource guide were direct results of community feedback. The community resource guide, updated annually, contains a range of resources for families: domestic violence programs, early childhood programs, mental health programs, job placement programs, and health care services.

With the help of Project LAUNCH, Red Cliff has been able to hire family resource coordinators. Families are individually paired with coordinators in order to address their unique needs. This allows families to develop relationships with coordinators before a crisis occurs, ensuring comfort and ease by allowing families to reach out for help when needed. It also aims to reduce the risk of escalation into crisis by providing preventive services. Family resource coordinators help families access primary care, home visits, mental health services, and early childhood programs; coordinate services with other agencies including the Red Cliff Indian Child Welfare Program; help parents with job training services, education programs, and obtaining a drivers license; and provide parenting guidance and resources for those families who have been reunited after a child abuse and neglect situation.

Funding has also allowed Red Cliff to carry out groundbreaking work in their early childhood center (prenatal to 5 years old). Mental health consultation and opportunities for reflective practice are provided to staff. And when making changes to the center, staff considered neuroscientific research on the effects of early childhood trauma. The center was designed to ensure a comfortable environment for all children—even children with sensitivity due to exposure to trauma or some other special need. Rooms were painted in soft natural colors, acoustic ceiling tiles were added to help prevent loud noise, consultation services of a pediatric occupational therapist were obtained to better understand regulation in young children, and an extra teaching position was created in the infant room to reduce the child–teacher ratio.

In addition to creating a workforce and an environment that supports mental wellness, Red Cliff made use of several system-wide strategies. Tribal-wide training in the Touchpoints model for more than 100 providers created a common language of child development and family engagement, strengthening the early childhood service system. Enhanced collaboration between the primary care clinic and early childhood center now allows for screening to be administered in either venue. In response to persisting gaps between early childhood and primary care communication and data systems, several providers collaborated to form a "young child team." This team developed into the *Netaa Tikinaaganikejig* (*skilled cradleboard makers*) pediatric workgroup, which now meets monthly. The workgroup was responsible for conceptualizing the tribal home visitation proposal that was recently funded by Administration for Children and Families. Through this program, a nurse practitioner comes to the early childhood center every morning and touches base with teachers, providing basic information on physical health and wellness.

In order to address transportation issues for parents, a variety of classes and activities are offered on site at the early childhood center, including a GED program, nutrition classes, and a sewing class. There are also a variety of cultural activities such as storytelling, a traditional weekly Pow Wow where children learn the teachings of the drum and dance, and, to revitalize the language, Ojibwe language tables for parents.

Working closely with the Brazelton Touchpoints Center Research and Evaluation team, Red Cliff has been able to show developmental improvements over time, including significant improvements in language and social skills. Red Cliff is using the insight and feedback garnered from the Wellness Council and annual focus groups to hone future directions. Employing a perspective that integrates traditional healing with trauma-informed evidence-based practices, Red Cliff has been able to create a comprehensive, supportive, family-centered, and accessible system of care (SAMHSA, 2008).

Horizons for Homeless Children

Early childhood homelessness is unrecognized as a driver of both acute trauma and chronic stress. Each year, 1 in 45 children in the United States experiences homelessness (Bassuk, Murphy, Thompson, Kenney, & Beach, 2011). Because of the unique vulnerabilities faced by parents of young children, infants and toddlers are disproportionately affected: In homeless shelters and transitional housing, more than half of children in families served are less than 5 years old (McDonald, 2012). Research demonstrates that children who experience homelessness early in life not only suffer from higher rates of physical and mental illness but are also more likely to have witnessed domestic and community violence, to be separated from family members, and to endure the chronic insecurity that comes with unstable access to food and shelter (McDonald, 2012). As a result, homeless infants and toddlers are more likely to exhibit developmental delays, learning disabilities, and emotional and behavioral disorders than are peers in stable housing (Bassuk et al., 2011). Indeed, 20% of homeless preschoolers demonstrate clinically significant emotional disturbances (Bassuk et al., 2011). In early childhood, this constellation of stressors confers unique risks to cognitive, social, emotional, and relational development (McDonald, 2012). However, more than 75% of homeless

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children do not receive adequate treatment (McDonald, 2012).

Compounding these risks are parents' own histories of trauma and adversity as well as systems-level barriers to procuring appropriate services. Homeless parents have often experienced chronic physical and mental health problems, substance abuse, and domestic violence or other forms of abuse. Homeless families are also more likely to face separation due to child welfare involvement, shelter policies (e.g., women-only shelters that will not house teenage boys over a given age), or economic necessity. Likewise, homelessness can be a barrier to reunification for children in foster care: Parents may be required to obtain stable housing prior to reunification. However, in many cases, adults not living with children are pushed to the bottom of the list for housing assistance. This lack of coordination between child welfare and housing agencies often places parents and children in limbo for long stretches of time (U.S. Department of Housing and Urban Development, 2012).

In order to interrupt this accumulation of risk, Horizons for Homeless Children provides a multilevel intervention for young homeless children and their families. Established in 1988, Horizons has enacted a comprehensive strategy for bringing high-quality early education, developmentally appropriate play opportunities, and critical social supports to young homeless children and their families in Massachusetts. Through the organization's Playspace Program, which operates out of family homeless shelters, and its comprehensive early education centers, more than 5,000 children are served annually across the state.

The Playspace Program is based on the belief that play is an essential driver of healthy development. Through the program, 98% of children living in homeless shelters in Massachusetts have access to developmentally appropriate space and time to play. Stocked with books, developmentally appropriate toys, and art supplies, each Playspace includes distinct areas to nurture literacy, art, motor development, and dramatic play. Each Playspace also offers an area suited to the unique needs of infants. Fifteen hundred trained volunteers make it possible for more than 2,700 children to access the Playspaces each week (Horizons for Homeless Children, 2013).

The three early education centers, known as Community Children's Centers (CCCs), support the social–emotional, physical, and cognitive development of homeless children; engage families in their children's education; and deliver high-quality teaching. The CCCs serve children 2 months through 5 years old and are open year-round. Each CCC takes an individualized, developmental approach to early learning.

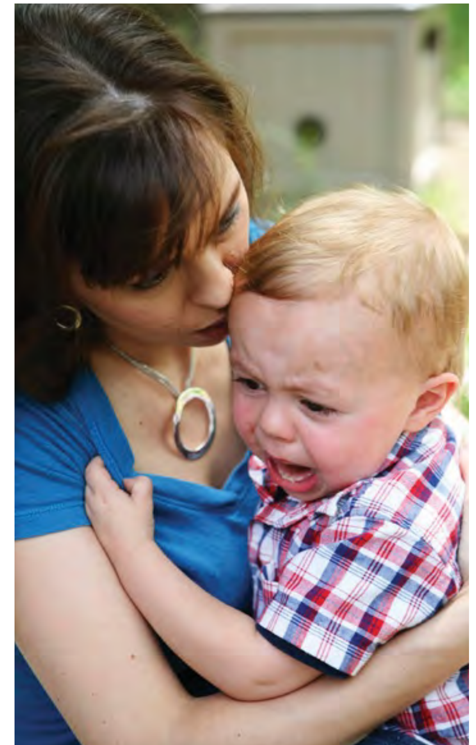
Teachers in the CCCs are trained in the Pyramid Approach developed by the Center on the Social and Emotional Foundations for Early Learning (CSEFEL). The approach, founded upon nurturing secure relationships and healthy social–emotional development, teaches caregivers to read young children's emotional and behavioral cues and identify threats to social–emotional development that may require mental health intervention (CSEFEL, n.d.). Horizons serves as CSEFEL's infant–toddler demonstration site for the Pyramid Approach in Massachusetts. In addition, all children entering the CCCs are assessed using the *Ages and Stages Questionnaires* (*ASQ-3* and *ASQ:SE*; Ages and Stages Questionnaire, n. d.). This provides a baseline developmental screening that is followed by quarterly observational screenings by teachers (A. Urbano, personal communication, August 21, 2013).

Because parental engagement is central to a child's well-being, families receive additional support services from family advocates both during and after their involvement with the early education centers. Home visits provide connections to early education programs, community services, workforce training, and financial literacy classes.

With this innovative model, Horizons intervenes in multiple domains of young children's lives, providing the kind of comprehensive response necessary to affecting developmental outcomes in this vulnerable population. Children served by Horizons are connected with pediatricians, registered for kindergarten, and assessed multiple times per year for psychosocial and developmental disorders (Horizons for Homeless Children, 2013).

In recent years, Horizons has also become an important voice for young homeless children at the local, state, and federal levels. By bringing together stakeholders from different state agencies, Horizons has sparked new interagency communication critical to expanding synergistic services for the youngest homeless children. For example, because of the success of a recent training for both early childhood educators and frontline workers in housing on the effects of homelessness on young children, Horizons has been asked to develop a curriculum for educating shelter workers about parents and early childhood development. These kinds of efforts expand the adoption of developmentally informed models of care across multiple systems that serve vulnerable children.

In Massachusetts, Horizons has served as both educator and change agent, broadening recognition among policymakers and the public of the cascade of risks that homelessness introduces to the well-being of children, families, and communities.



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Safe, stable, caring relationships with parents and other adults can shield young children from the effects of toxic stress.

Applying Adverse Childhood Experiences Research to Statewide Planning

ACEs are broadly defined as incidents during childhood that harm social, cognitive, or emotional functioning (Child and Family Policy Center, 2012). Exposure to such experiences may cause acute trauma or toxic stress, damaging the architecture of the developing brain (Iowa Department of Public Health, 2011). Research has demonstrated that ACEs increase risk for poor physical and mental health, chronic disease, lower educational achievement, and lower economic success in adulthood (Minnesota Department of Health, 2013). Indeed, the Adverse Childhood Experiences (ACE) Study identified specific long-term consequences of multiple ACEs, including increased likelihood of stroke, diabetes, cardiovascular disease, cancer, and early death, as well as lower job performance and employment (Felitti et al., 1998). The study also found that the more ACEs a person experiences, the more likely these negative outcomes become. Incorporating ACEs-related questions into state Behavioral Risk Factor Surveillance Systems (BRFSS; Centers for Disease Control and Prevention, 2013) provides an essential catalyst for programmatic and policy changes, yielding better integration of systems serving children and families, more meaningful diagnoses, and

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early and improved treatment of exposed children and their caretakers (Anda & Brown, 2010). Minnesota and Iowa are examples of two states that have used ACEs data to take action.

IOWA

In 2011, a presentation on the ACE Study inspired several central Iowa organizations to take action to address its findings, forming the ACEs 360 Steering Committee. The Steering Committee brought together a diverse group of organizations to collaborate on efforts to measure ACEs data in Iowa, raise awareness of the study across the state, and identify effective interventions to minimize the risk of ACEs. A variety of organizations were involved (see box Organizations Represented on the ACES 360 Steering Committee).

After much discussion, the group decided that affecting appropriate policy change in the state would require an Iowa-specific ACEs study. In fall 2012, the CDC ACE module was incorporated into Iowa's BRFSS.

In June 2012, nearly 800 people across the state gathered for the Iowa ACEs Summit in Des Moines. Participants heard presentations on the impact of toxic stress on early brain development and its link to poor adult health outcomes. They also heard a presentation from Washington State on their innovative state- and community-based response to the ACE Study. Several months later, the Steering Committee formed four subcommittees: Policy, Partnering and Convening, Communication, and Data and Research. The Policy Subcommittee works to raise awareness of the ACE Study findings among Iowa legislators. By integrating information on ACEs into meetings with policymakers, subcommittee members have established the topic as relevant to state policy: In January 2013, the Iowa Senate Human Resources Committee heard testimony on the ACEs Study.

At the time of this writing, plans are underway for the 2013 Iowa ACEs Summit, *Data Into Action: Crafting a Response to Iowa's ACE Score*. The objectives of the summit, to be held in October, are to share findings of the Iowa ACE Study; to understand how various sectors are using the original ACE Study and trauma-informed principles to improve services to children, families, and adults; to learn how communities are addressing problems through multidisciplinary teams that focus on trauma as the root of many shared challenges; to identify available resources for increasing awareness of ACEs and their impact; to learn how communities can work to reduce and prevent ACEs in Iowa; and to develop a plan for community-level response to the challenges highlighted in the study. Although this will be the first time that the Iowa-specific data is shared, the hope is that the summit will provide an opportunity for influential participants (including legislators and funders) to engage in the conversation. Once the Iowa data is officially released, representatives across multiple systems and professional disciplines—education, child welfare, human services, public health, business leaders, health care providers, philanthropy, and other child and family advocates—will come together to develop recommendations for policy briefs and to implement changes in service delivery across the state (Iowa Department of Public Health, 2011).

MINNESOTA

The Minnesota Department of Health surveyed residents in 2011 using the BRFSS. More than half of respondents reported experiencing at least one ACE in childhood. The five most common were verbal abuse, living with a problem drinker, separation or divorce of a parent, mental illness in the household, and physical abuse. The state found that not only are ACEs common among Minnesota residents, but that ACEs frequently occur together: 60% of residents have two or more, and 15% have five or more ACEs (Minnesota Department of Health, 2013). They also found that ACEs have a strong and cumulative impact on the health and functioning of adults in Minnesota: The risk for anxiety, depression, and smoking increases as the number of ACEs increases (Minnesota Department of Health, 2013). The Minnesota Department of Health released the findings and issued a set of recommendations in a report that was published in 2013. Governor Dayton's Children's Cabinet hosted a community forum to release the data and to convene a panel discussion focused on what impact the data might have on Minnesota's policy efforts in the areas of health, education, social services, and criminal justice.

The policy recommendations provide clear strategies to reduce ACEs and to build resiliency in Minnesota's communities. Policy recommendations include:

1. work with the state's education, child welfare, mental health, public health, health care, substance abuse, juvenile justice, corrections, and public safety systems to increase awareness of the impact of ACEs on the people these agencies serve;
2. support and develop resilience through investments that support community, government, and philanthropy partnerships;
3. designate funds to continue the collection, analysis, and dissemination of ACE data from Minnesota residents;
4. develop a thorough inventory of existing agency and community efforts to reduce ACEs and support resilience; and
5. develop a communication strategy that focuses on the social and economic benefits of reducing and preventing ACEs in Minnesota (Minnesota Department of Health, 2013).

In response to the ACEs work, a team was formed and dubbed the Minnesota SAMHSA Policy Academy on Prevention of Mental and Substance Abuse Disorders. The team has been meeting since September 2012 with a vision to create a statewide system that aligns education, promotion, prevention, and early intervention related to trauma and resiliency. The team includes a broad array of systems—mental health, substance abuse, public health, early childhood, education, and public safety—and community representatives from the University of Minnesota and Prevent Child Abuse Minnesota. They supported the development of a Minnesota team of 25 community resilience coaches equipped to provide training on ACEs, brain development, and resilience.

The team also organized a visit to Washington State to learn about that state's prevention efforts. Participants included 16 leaders from public health, education, Prevent

Organizations Represented on the ACEs 360 Steering Committee

- Child and Family Policy Center
- Des Moines Public Schools
- Early Childhood Iowa
- 1st Five Healthy Mental Development Initiative
- UnityPoint Health/Blank Children's Hospital
- Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program
- Orchard Place Child Guidance Center
- Polk County Health Department
- Prevent Child Abuse Iowa
- Project LAUNCH
- Trauma Informed Care Central Iowa Stakeholders
- Primary Health Care, Inc.
- Project Iowa
- United Way of Central Iowa

Please note: 1st Five Healthy Mental Development Initiative and MIECHV are both programs of the Iowa Department of Public Health.

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Child Abuse Minnesota, the University of Minnesota, the governor's Children's Cabinet, the Chemical and Mental Health Services Administration of the Minnesota Department of Human Services (DHS), and private citizen leaders. The group met with 40 leaders in three cities from state departments, university research institutes, local networks, and foundations. On the basis of the shared insights from this experience, a set of recommendations on prevention and community capacity development will be proposed for state leaders. Other team efforts include: developing strategies to support ongoing data collection on both ACEs and resilience indicators; developing a tool to evaluate awareness of ACEs and resilience in different sectors and fields; and identifying gaps in services at the state and community levels in order to adopt a shared vision for Minnesota children, youth, families, and communities.

In response to the ACEs data, the Minnesota DHS also created a Well-Being Workgroup. The purpose of the workgroup is to develop an agency-wide plan to support individual, family, and community well-being and to prevent intergenerational trauma. The plan will include efforts to build awareness of the life-long impact of trauma and to foster promotion of health and preventative interventions. In implementing the plan, the workgroup will seek to align DHS programs and services according to a shared vision for individual, family, and community well-being while also cultivating collaboration among state agencies. The workgroup will oversee enactment of the plan, including prioritization and implementation strategies. In doing so, the Well-Being Workgroup aims to develop a system informed by ACEs research and to ensure reliable and coordinated implementation of these practices across DHS programs and policies.

Advancing Trauma-Focused Policy Strategies

Research has demonstrated that early exposure to trauma and violence—including witnessing threats to caregivers, being the victim of violence, or experiencing ongoing violent or stressful environments—jeopardizes children's physical and mental health and development. Although recent events covered widely in the media—school shootings, hurricanes, tornadoes, women held captive in a neighborhood home for more than a decade—call attention to the issue of violence and other trauma, the impact of these events on the young children involved is rarely acknowledged in the media.

It is therefore imperative that policymakers and advocates redouble their efforts to mitigate the impact of trauma on infants, toddlers, and their families. The examples in this article illustrate a range of effective trauma-focused prevention and intervention initiatives that have been developed in states, communities, and Native American tribes. These examples are intended to inspire conversations among policymakers and advocates. However, more work is needed to expand and sustain the successful initiatives, to call attention to the impact of trauma on very young children, and to galvanize efforts to address these issues at the policy level. The following suggestions provide starting points for bringing early childhood and trauma into focus in policy conversations:

- **Ask, "What About the Babies?"** A first step in preventing or reducing the impact of trauma on young children is to acknowledge and raise awareness about the serious impact of early exposure to violence and other trauma. Policymakers who are concerned about school readiness, health care costs, mental health, and growing prison populations and who want to make a change should support the very earliest prevention and trauma-focused care and should invest in program evaluations that measure impact on child and family outcomes as well as on economic costs and benefits (World Health Organization, 2010). In any state or community effort to reduce violence and address trauma where children are considered but the youngest overlooked, advocates must ask, "What about the babies?" This includes discussions of domestic violence, adult mental illness, child welfare, and homelessness.
- **Intensify Cross-System Collaboration.** Trauma influences every aspect of child and family life. Policymakers and advocates should redouble efforts to work across sectors—housing, education, mental health, public health, child welfare, home visiting, Part C early intervention, law enforcement, juvenile and family justice, and substance abuse—both to increase awareness of the impact of trauma on very young children and to increase the capacity of these systems to address the needs of the youngest victims. The newly funded ECCS grants will contribute to this effort by demonstrating trauma-focused system-building strategies.
- **Advocate for the Use of Evidence-Based Interventions While Building Evidence for Promising Approaches.** Promising strategies for trauma-focused prevention and intervention are being nurtured through federal grants as well as through locally funded efforts and university-based research projects. States and communities could adopt and support promising approaches such as the PRCs used by the Safe Babies Court Team in Iowa or strategies used in Project LAUNCH tribal and community sites. States and communities seeking progressive, preventative strategies for families exposed to violence and other trauma could adopt empirically supported treatments and interventions (National Child Traumatic Stress

Learn More

ZERO TO THREE Trauma Resources
www.zerotothree.org/maltreatment/trauma/trauma.html
Information about the impact of trauma on infants and young children, building resilience, and mobilizing trauma resources for young children.

Supporting Infants, Toddlers, and Families Impacted by Caregiver Mental Health Problems, Substance Abuse, and Trauma, A Community Action Guide
http://store.samhsa.gov/product/Supporting-Infants-Toddlers-and-Families-Impacted-by-Caregiver-Mental-Health-Problems-Substance-Abuse-and-Trauma/SMA12-4726
Using a case study approach, presents resources that service providers, advocates, and practitioners can use to better understand and engage the community in responding to children whose caregivers are negatively impacted by mental illness, substance abuse, or trauma.

The National Child Traumatic Stress Network
www.nctsnet.org
A wealth of resources and research on traumatic stress, tools to measure the impact of trauma, and a listing of effective treatments.

Adverse Childhood Experiences Study (ACE)
www.acestudy.org
Information about the ACE study, ACE scoring, and access to peer-reviewed publications resulting from the research.

Early Childhood Comprehensive Systems
www.mchb.hrsa.gov/programs/earlychildhood/comprehensivesystems
ECCS grantee plans and models, and other resources to address the five key ECCS components: access to health care and medical homes, social–emotional development and mental health, early care and education, parenting education and family support.

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Network, 2013) or partner with researchers to test promising approaches and build the evidence base.

- **Involve the "Community Voice" in Planning Trauma-Focused Policy Responses.** States and communities can promote system-change projects that acknowledge cultural and community values in order to engage families, build stronger partnerships, and create long-lasting change. Successful community responses to trauma and violence take into account the experiences, history, and cultural practices of the individuals who live there. The ACES work in Iowa and Minnesota, for example, included findings from a statewide survey of residents, and Red Cliff Project LAUNCH relies on traditional tribal activities to engage children, families, and providers. When there is genuine inclusion of "community voice" in planning and service delivery, the system is more meaningful to the participants.
- **Advocate for Needed Services and Supports.** Safe, stable, caring relationships with parents and other adults can shield young children from the effects of toxic stress. However, these relationships are disrupted when parents are unable to provide the nurturing their children need because of their own mental health problems, unemployment, addictions, and homelessness. Policy conversations must therefore consider parents' needs in order to attend to children's needs. This includes expanding the availability of mental health and substance abuse services while also improving access to basic services such as housing, education and job training, transportation, and service coordination.

Conclusion

Recognizing the devastating impact of trauma and violence on infants, toddlers, and families is the first step toward developing more responsive state, community, and tribal policy and strengthening supports and services for vulnerable young children and their families. States, communities, and tribes have the capacity to change the life course of at-risk children if they create a systematic, cross-sector approach to improving community safety while providing needed supports and services. Reducing risk factors and increasing protective factors through community, state, and federal interventions can bring about short- and long-term improvements to the well-being of children, families, and communities.

Julie Cohen, *MSW, is associate director of the ZERO TO THREE Policy Center. Ms. Cohen is the author of numerous publications, including* Nurturing Change: State Strategies for Improving Infant and Early Childhood Mental Health *(2013),* Supporting Infants, Toddlers, and Families Impacted by Caregiver Mental Health Problems, Substance Abuse, and Trauma: A Community Action Guide *(2012), and* A Call to Action on Behalf of Maltreated Infants and Toddlers *(2011). Ms. Cohen worked at Voices for America's Children as a policy and advocacy specialist focused on child welfare and early care and education and also served as a court appointed special advocate (CASA) working with children in the New York City child welfare system.*

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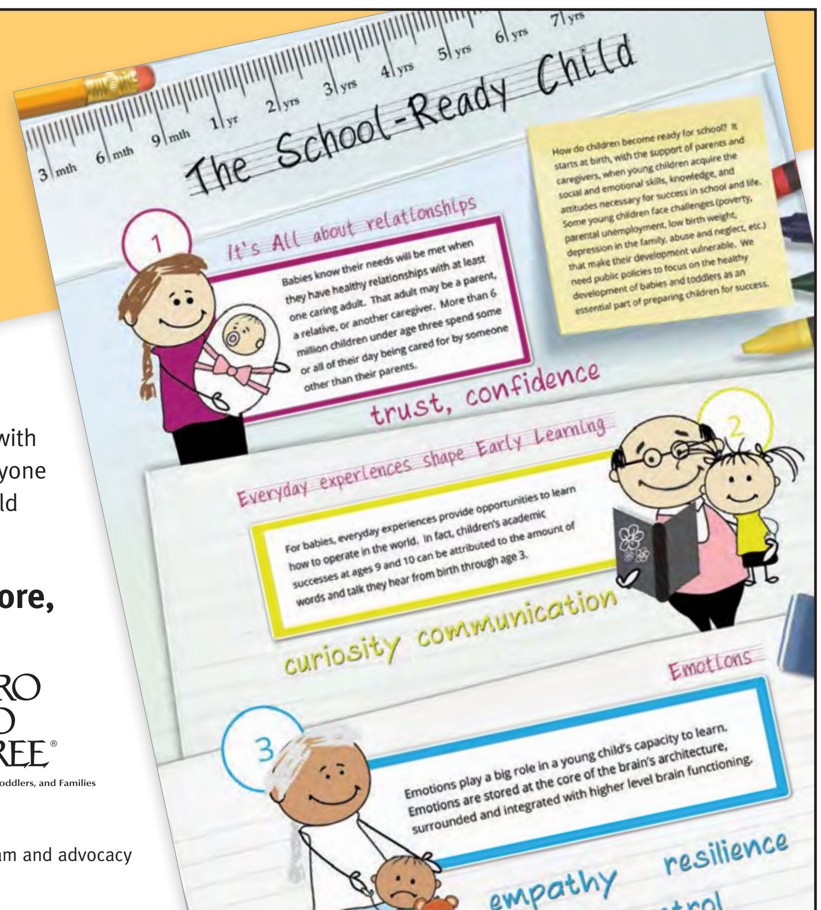

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Trauma-Informed Part C Early Intervention

A Vision, A Challenge, A New Reality

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A convergence of compelling evidence has linked traumatic early childhood adverse experiences with a lifetime trajectory of serious mental and physical health problems. Advances in the understanding of trauma such as the landmark Adverse Childhood Experiences Study (Anda et al., 2004) compel early childhood professionals to re-examine traditional systems and practices and bring a trauma lens to the work with young children and families. Nowhere is the need to rethink services more apparent than in the Part C Early Intervention System (which we will refer to as EI), a federal program designed to serve infants and toddlers with disabilities or delays, or who are at high risk of risk of delay. Federal legislation now requires the child welfare system to refer all infants and toddlers with substantiated abuse or neglect to the EI system for an evaluation of need for EI services. Within the diversity of groups eligible within each state's definition, EI also serves other groups of children—such as low birth weight babies and young children with established disabilities—who are at elevated risk for abuse and neglect (Spencer, Wallace, Sundrum, Bacchus, & Logan, 2006; Sullivan & Knutson, 2000) and infants and toddlers with disabilities who may have experienced medical trauma from repeated hospitalizations and painful procedures.

Although EI providers are well-trained to address developmental disabilities and general developmental delay, they are not typically trained to consider the impact of trauma on development and

Abstract

Federal directives require that any child less than 3 years old with a substantiated case of abuse be referred to the early intervention (EI) system. This article details the need and presents a vision for a trauma-informed EI system. The authors describe two exemplary program models which implement this vision and recommend steps which the field can take to move toward a trauma-informed EI.

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on relationships. For example, intervention for a language delay in a child who has experienced complex trauma calls for a very different approach than a language delay related to cerebral palsy. Although there are models for trauma-informed child welfare, health care, education, mental health, and juvenile justice, there is not yet a model for trauma-informed EI. In this article, we describe the national policies that link the child welfare system to EI and create the need for states to build trauma-informed EI systems. We briefly review the tenets of trauma-informed systems, present a vision for trauma-informed EI, and describe two program models which illustrate what trauma-informed EI can look like in practice. The article concludes with recommendations to the field to infuse a trauma perspective and trauma expertise into EI.

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Early intervention serves infants and toddlers with disabilities who may have experienced medical trauma from repeated hospitalizations and painful procedures.

Policies Supporting Trauma-Informed Early Intervention

Two pieces of federal legislation compel states to address trauma-informed EI services: the Individuals With Disabilities Education Act (IDEA, 2004) Part C Program for Infants and Toddlers With Disabilities and the Child Abuse Prevention and Treatment Act (CAPTA, U.S. Department of Health & Human Services, 2010)

Part C Early Intervention and CAPTA

The original intent and the legislative language of Part C EI provide the basis for a collaborative and comprehensive system of services to eligible infants, toddlers, and their families. Part C requires states to serve children who have established conditions or disabilities (e.g., spina bifida, Down Syndrome), but gives states flexibility in defining the criteria for the amount of "delay" necessary for services. As a result, states differ in the amount of delay necessary for EI eligibility, ranging from 20% to 50% delay in one or more areas (Ringwalt, 2012). States are are encouraged but not required to serve children at "high risk" of substantial delay. Only six states currently serve at-risk children, despite compelling evidence of the likelihood of delay when multiple risk factors are present (Ringwalt, 2012).

Evidence confirms that infants and toddlers in child welfare are at higher risk for developmental delays. National data shows that 38-65% of infants and toddlers encountered by child welfare have delays (Barth et al., 2008) and up to 82% of maltreated infants will have attachment problems (Goldsmith, Oppenheim, & Wanlass, 2004). A national longitudinal study found that 35% of infants and toddlers needed EI services at the time of contact with child welfare (meeting the strict criteria of 2 standard deviations of delay; Casanueva, Cross, & Ringeisen, 2008). This high incidence of developmental delays and the potential benefits of EI for children encountering the child welfare system were so compelling that the federal government amended both CAPTA and IDEA to address this unmet need.

CAPTA now requires that states develop "provisions and procedures for referral of a child under age 3 who is involved in a substantiated case of child abuse or neglect to EI services funded under EI of the Individuals with Disabilities Education Improvement Act" (Sec. 106(b)(2)(A)(xxvi); IDEA, 2004) While the definition of "substantiated case" varies from state to state, it typically means that an incident of child abuse or neglect is believed to have occurred. Part C EI contains parallel language to that included in CAPTA and requires that states ". . . must include a description of state policies and procedures that require the referral for EI services ...of a child under the age of 3 who (A) is involved in a substantiated case of child abuse or neglect, or (B) is identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure (Sec. 637 (a)(6))." CAPTA and EI both require that a child with substantiated abuse or neglect be referred to EI to determine the child's eligibility for EI services; neither federal law requires the child's automatic eligibility for EI. The determination of eligibility for services remains the responsibility of the EI system and follows the dictates of the state's EI eligibility criteria.

Challenges and Successes in Implementing CAPTA Requirements

The parallel requirement in child welfare and EI for referring children with substantiated abuse or neglect for developmental services creates opportunities to strengthen ties between the two programs while presenting challenges to each system. To better understand the challenges from the child welfare perspective, ZERO TO THREE and Child Trends conducted a survey of state child welfare agencies. Data from 46 agencies responding identified the following barriers in implementation: (a) birth parents' lack of familiarity with EI services and lack of training in identifying developmental needs, (b) need and cost of EI services exceeds that available through current funding, (c) EI staff's inability to engage children and families in the child welfare system, and (d) transportation and other access-related issues. The survey found that child welfare agencies are addressing these challenges by: (a) collaborating with EI agencies to implement requirements of federal, state, and local laws (36 states); (b) formal information sharing about each system's policies/procedures (28 states); and (c) clearly delineating the roles/responsibilities of EI and child welfare staff (24 states; Changing the Course for Infants and Toddlers, 2013).

In 2008, a survey of EI state administrators shed light on the experiences of EI staff with referrals of children under the CAPTA requirements (IDEA Infant Toddler Coordinators Association [IITCA], 2008). Thirty states responded to the survey,

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representing 76% of all children served in the EI program. At the time of the survey, 70% of states had an interagency agreement or memorandum of understanding with child protective services regarding CAPTA referrals. Survey results indicated that children less than 3 years old involved in substantiated abuse or neglect are routinely receiving developmental screening; the developmental screening was being conducted primarily by EI (44%), but also by child protective services (37%) and others such as state-funded at-risk, follow-up programs, and medical providers. The impact of CAPTA on the numbers of children in EI tended to vary depending on the state's EI eligibility requirements. States with narrow eligibility criteria reported high ineligibility rates among CAPTA-referrals. Survey results also indicated that from 2007–2008, 21% of state Part C systems experienced an increase in referrals from child welfare and 29% experienced a decrease in referrals. Fifty percent of respondents did not know whether there had been an increase or decrease in referrals from child welfare, demonstrating the need for additional effort in data collection and reporting (IITCA, 2008). It is troubling that because of the pressures on state budgets, EI eligibility requirements are becoming more restrictive at the same time that the infant-toddler population is the fastest-growing segment of the child welfare population. These children are highly vulnerable to delays in social, emotional, and cognitive development and are at high risk for special education placement (Scarborough & McCrae, 2008; Wulczyn, Ernst, & Fisher, 2011) and are able to benefit from EI services.

Both the EI and child welfare systems experienced challenges in the implementation of CAPTA—challenges which heightened shortcomings in each system (IITCA, 2008). CAPTA drew attention to the need for and lack of access to community-based infant and early childhood and adult mental health services. CAPTA also emphasized the need for new skills and training for providers in both systems. EI evaluation teams were not familiar with the signs of traumatic stress in infants and toddlers, nor how a trauma history might affect parental involvement in EI services. Child welfare staff and families were not familiar with EI services, nor with identifying developmental needs of infants and toddlers. CAPTA referrals strained states where EI funding was insufficient to respond to new referrals, changes in data collection and reporting, training needs, and other infrastructure requirements. Questions around consent for EI services and participation in the Individual Family Service Plan process had to be addressed (e.g., biological parents, custodial parents, child protective services; Herman, 2007; IITCA, 2008) and remain unclear in many circumstances.

Federal legislation now requires the child welfare system to refer all infants and toddlers with substantiated abuse or neglect to the EI system for an evaluation of need for EI services.

A focus group study of frontline child welfare and EI professionals in Illinois found many of the same concerns as those articulated at the state agency level: lack of professional preparation to address trauma, absence of trauma screening, limited involvement of biological parents in EI, struggles around eligibility for children without identified disabilities, and funding concerns from fears of flooding the system with referrals of high-risk families (Gilkerson et al., 2012). The focus groups highlighted not only the needs of children who are referred through CAPTA for prior abuse or neglect but also the needs of families and of children who are already in EI for developmental reasons and who experience trauma while in EI (e.g., abuse, neglect, accidents, witnessing violence, and medical trauma).

The study (Gilkerson et al., 2011) found that the potential for retraumatization exists from the EI experience itself for traumatized children when there is a lack of knowledge of a trauma-sensitive approach (e.g., abrupt separation of a child from caregivers to complete an assessment task when that child had recently been removed from the home, asking biological or foster parents to leave the room so the provider can work with the child alone, or routine procedures that can be intrusive such as an oral exam of a child's mouth if conducted without awareness of a child's trauma experience). Barriers to considering trauma were identified: (a) belief that infants and young children are too young to be affected by trauma experiences; (b) reticence of parents to talk about trauma and mental health concerns (and providers reticence to ask) because of the associated stigma and fear their child may be taken away; and (c) lack of preparation and supervision in professionals to address the social–emotional domain in general, not just trauma-related responses and, for some, a belief that addressing this domain was not part of their role. In addition to an absence of appropriate tools or processes for trauma screening, respondents reported that the approved tools for eligibility determination were not adequate for quantifying social–emotional delays, especially those related to attachment issues, trauma, or both.

Collaborative, Integrated Approach to Addressing Trauma in EI

The requirements in EI and CAPTA provide new opportunities for child welfare and EI to work together to infuse developmental perspectives into child welfare and trauma-informed approaches into EI. Identified positive outcomes of the CAPTA requirements include increased attention to the developmental needs of maltreated infants and toddlers, greater dialogue between EI and child welfare lead agencies, increased opportunities for professional development and training across systems, and most important, more children identified who can benefit by receiving EI services (Herman, 2007; Keller-Allen, 2007). The EI system offers infants and toddlers referred through CAPTA a reliable system with predictable responses and timetable for referrals, home-based services easily accessible for families, interventions from a range of disciplines and linkages with other services in the community; and lastly, EI "often goes the extra mile to help a child or family" (Gilkerson et al., 2011).

The U.S. Department of Health and Human Services issued a joint guidance letter intended to "encourage the integrated use of trauma-focused screening, functional assessments and evidence-based practices in child-serving settings for the purpose of improving child well-being" (U.S. Department of Health and Human Services, 2013, p. 1). Issued in partnership with the Administration for Children and Families, Centers for Medicare & Medicaid Services, and Substance Abuse and Mental Health Services Administration, the letter acknowledged the impact of trauma on health and development, affirmed the collaborative approach to effectively address complex trauma, and provided essential financing information to state program directors. The stage was set for a new integration of a trauma-informed approach with the philosophy and practices of EI.

Vision for a Trauma-Informed EI System

The National Child Traumatic Stress Network (NCTSN) defined a trauma-informed child- and family-service system as:

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One in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family. (NCTSN Trauma-Informed Service Systems Working Group, 2012).

NCTSN described the characteristics of trauma-informed systems as:

(1) *routinely screen for trauma exposure and related symptoms;*
(2) *use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms;*
(3) *make resources available to children, families, and providers on trauma exposure, its impact, and treatment;*
(4) *engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma;*
(5) *address parent and caregiver trauma and its impact on the family system;*
(6) *emphasize continuity of care and collaboration across child-service systems; and*
(7) *maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience."* (NCTSN Trauma-Informed Service Systems Working Group, 2012)

Building on these characteristics of a trauma-informed system and the focus group study of EI and child welfare (Gilkerson et al., 2011), Gilkerson (2012) presented a vision for the elements of a trauma-informed EI system. The first two essential elements relate to the philosophy of EI which guides the approach for the all children in EI; the remaining elements are trauma-specific.

FOR ALL CHILDREN IN EI AND THEIR FAMILIES

- **EI Values:** Rests on the values of an individualized, family-centered, relationship-based, child-sensitive, culturally responsive approach for all children in EI.
- **Social–Emotional Competence:** Fully recognizes the social-emotional domain as one of the five developmental areas specified under Part C EI, implements procedures to identify eligibility for services in the social-emotional domain, and provides intervention services to address social-emotional developmental delays.

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Although there are models for trauma-informed child welfare, health care, education, mental health, and juvenile justice, there is not yet a model for trauma-informed early intervention.

FOR CHILDREN EXPOSED TO TRAUMA AND THEIR FAMILIES

- **Unique Needs:** Views children who are impacted by trauma as having unique needs which must be considered at each phase of the EI process. EI recognizes and responds to the special impact of trauma—both interpersonal and medical trauma—on an infant or toddler's development and uses a trauma-sensitive lens and adequately trained professionals to understand (a) risks to the child's development and family relationships and (b) how to intervene to promote developmental growth.
- **Broad Eligibility:** Uses a definition of EI eligibility broad enough to include infants and toddlers with developmental delays associated with trauma exposure and with multiple environmental risks; formal procedures for informed clinical opinion are in place and used to help with eligibility determination.
- **Trauma Screening:** Routinely screens for trauma exposure and related symptoms at intake and throughout the EI process; medical trauma is assessed at intake and again when hospitalizations and painful procedures occur. Providers respect the family boundaries around trauma and seek to create a safe, trusting relationship in which trauma experience can be shared, understood, and considered in the EI process.
- **Priority on Emotional Safety:** Places priority to the child's emotional safety and the need for co-regulating caregivers during all aspects of EI: intake, assessment, and service provision; avoids retraumatizing the child; and helps the child gain or regain competence derailed through trauma.
- **EI Trauma Specialists:** Includes professionals in EI with trauma-specific expertise such as infant mental health specialists with trauma-training; these specialists can provide trauma-informed evidence-based services to infants, toddlers, and families; collaborate with other EI providers to integrate trauma-related and developmental services; and help develop the capacity of other providers to work from a trauma-informed perspective.
- **Trauma Training, Consultation, and Reflective Supervision:** Infuses and sustains a trauma awareness, knowledge, and basic skills in all EI professionals through training, reflective supervision, and consultation; training is not one-time but over time with opportunities for reflective supervision and case consultation; at a minimum, all managers, service coordinators, and providers receive awareness training in trauma and trauma-informed practices; follow-up training, consultation, reflective supervision, or a combination of these are provided by trauma-trained, infant mental health specialists or consultants. Because trauma affects regulation, cognition, and language, special provisions

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are made to ensure that developmental specialists, occupational therapists, and speech and language pathologists receive trauma training and consultation.

- **Involvement of All Caregivers:** Biological parents and foster parents are able to be involved in the child's evaluation and service delivery. Providers receive special training to work with all caregivers.
- **Coordination of EI Services:** Coordinates services between EI disciplines to ensure the smooth integration of services; considers reducing the numbers of professionals involved to provide security and continuity for the child and family; co-treatment between developmental professionals and infant and adult mental health providers is planned and provided; infant mental health provider is available to provide reflective consultation to the developmental professional on cases that are shared.
- **Interagency Agreements:** Implements coordinated, statewide interagency agreements between the child welfare agency and EI lead agency to effectively implement CAPTA requirements; expands these state agency partnerships to include mental and behavioral health, health, and the court system; state level partnerships create funding mechanisms to cover staff development, coordination, and reflective supervision needed for trauma work.
- **Community Partnerships:** Develops innovative partnerships at the community level between EI, mental health, health, and child welfare to provide side-by-side, collaborative services; partners with community-based mental health and social service agencies to engage families in other services to expand the intervention services and address the impact of trauma
- **Secondary Trauma:** Provides ongoing supports and reflective supervision to EI professionals to manage professional and personal stress in working with infants and toddlers with developmental issues who have been affected by trauma and their families and to build their resilience and competency.

Trauma-Informed EI in Practice

In this section, we describe two existing programs which illustrate the vision for trauma-informed EI. The first model, in Baltimore, Maryland, describes the effort of an EI program to infuse a trauma-informed, infant mental health framework into its screening, assessment, and referral practices. The second model, the New Mexico Infant Team approach, exemplifies a comprehensive interagency, transdisciplinary, collaborative model which fully merges EI and mental health in collaboration with child welfare and the court system.

> The original intent and the legislative language of Part C EI provide the basis for a collaborative and comprehensive system of services to eligible infants, toddlers, and their families.

Baltimore Infants and Toddlers Program

Beginning in 2011, Baltimore City Department of Health, the lead agency for EI in Baltimore, has made the integration of EI and early childhood mental health a priority. This priority led to the development of a trauma-informed EI program which is a partnership between Baltimore Infants and Toddlers Program (BITP), an interagency EI program serving more than 900 infants and toddlers in Baltimore City, and the University of Maryland School of Medicine's Taghi Modarressi Center for Infant Study (CIS)/Secure Starts program, an agency with a long history of providing infant mental health training, consultation, and direct services to young children and families. Developed by Tody C. Hairston-Fuller, BITP coordinator of evaluation and assessment, and Jessica Lertora, associate director from CIS, the model integrates trauma screening into the eligibility process for all children referred to EI, including those referred through CAPTA. On the basis of screenings and assessment, referrals are made for infant mental health consultation or treatment depending upon need. A central feature of the Baltimore program is the strong foundation that the EI professionals have in trauma and infant mental health. The EI services are funded by the EI agency; the infant mental health services are funded by EI funds via a contract with the CIS Program.

STAFFING

The BITP program includes the director, service coordinators, and the full array of EI disciplines with the addition of a developmental pediatrician. The coordinator of evaluation and assessment oversees the evaluation process and integrity of referral process. CIS provides a trauma-trained, infant and early childhood mental health consultant who has provided consultation with the EI program in different capacities over the past 5 years. Her role includes providing staff training, participating in the review of the trauma screenings, and providing referral sources and services to the CAPTA-referred EI families who need infant mental health consultation or treatment. She also participates in a special evaluation team which focuses on helping to assess children with specific social–emotional concerns.

Through the partnership with CIS, all service coordinators have been trauma trained. They understand how trauma affects development, can recognize the symptoms of trauma, and are confident with helping families through the referral process. The CIS and the University of Maryland School of Medicine's Department of Child and Adolescent Psychiatry also offers an Early Childhood Mental Health Certificate Program which highlights trauma as a vital part of the core curriculum. All the EI administrative staff and team leaders have received this certification, which allows everyone on the staff to aid the service coordinators around family and child needs and with next steps in referrals when the CIS therapist is not present.

REFERRAL TO SERVICES

Baltimore has a single point of entry for all children referred to EI, inclusive of those in the foster care system. The foster care children referred through CAPTA receive a developmental evaluation using the *Battelle Developmental Inventory, 2nd edition* (Newborg, 2004). If they are eligible for Part C, they receive an *Ages and Stages: Social Emotional Questionnaire* (*ASQ: SE*; Squires, Bricker, & Twombly, 2003) and a six-question trauma screen.

TRAUMA SCREENING

The program developers reviewed a range of trauma screeners and chose a two-part screener, adapted from the *Young Child PTSD Screener* (Scheeringa, 2011) for use in the EI evaluation process. The screening assesses the child's exposure to trauma and the trauma impact. To assess trauma exposure, the service coordinator asks the current caregiver (e.g., biological parent, grandparent, foster parent) a series of questions about trauma (e.g., has the child been a witness to violence [inside or outside the house], had a severe adjustment to illnesses, been attacked by an animal, or experienced natural disasters). To assess the impact of trauma on the child, the service coordinator asks the following six questions, each scored on a 3-point scale from none, a little, to a lot.

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1. Does the child have intrusive memories of the trauma? Does s/he bring it up on his/her own?
2. Is your child having more nightmares since the trauma occurred?
3. Does s/he get upset when exposed to reminders of the event (s)?
4. Has s/he had a hard time falling asleep or staying asleep since the trauma?
5. Has your child become more irritable, or had outbursts of anger, or developed extreme temper tantrums since the trauma?
6. Does your child startle more than before the trauma? (For example, if there's a loud noise or someone sneaks up behind him/her, does s/he jump or seem startled?) (Scheeringa, 2011, p.1)

For very young children, the service coordinators review the medical passport from the Department of Social Services and talk with foster parents to understand the child's exposure to trauma and its impact. At this point, the trauma screening is provided only at the initial eligibility; follow-up screening is not currently provided. Providing routine follow-up screening at the 6 month IFSP reviews would ensure that each child is rescreened, avoiding the likelihood of missing a child affected by trauma. Repeated screening would also help uncover how a child's symptoms are affected through developmental gain or regression, in addition to perhaps identifying the possibility of new traumas occurring.

SERVICES PROVIDED

On the basis of the screening scores, the impact of the trauma is categorized in three tiers, each with a different referral response.

- **Tier 1:** Child passes trauma screen and *ASQ: SE* (Squires et al., 2003)—Child receives follow-up service coordination and relevant EI services
- **Tier 2:** Child fails *ASQ: SE* and passes trauma screen—Child may receive up to 6 sessions of consultation visits from a CIS infant mental health therapist and relevant EI services
- **Tier 3:** Child does not pass *ASQ: SE* and has positive endorsement for trauma screen—The child is referred to CIS therapist for infant mental health intervention services, including—but not limited to—mental health consultation (6–8 sessions), or infant mental health treatment (up to 1–2 times/week until the child ages out of EI), or referral to a more intensive mental health intervention or program.

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Although EI providers are well-trained to address developmental disabilities and general developmental delay, they are not typically trained to consider the impact of trauma on development and on relationships.

Information is sought from the EI providers in efforts to attain a fuller picture of the child within the context of the family. However, the EI and infant mental health providers do not interact regularly, but can co-treat if needed.

NICOLE'S STORY

Nicole was a 14-month-old toddler, part of a sibling group who were referred to child welfare for neglect and abandonment. Nicole was in the care of a foster mother who had strong concerns about her inconsolability; Nicole cried endlessly and, after 2 months, she had not shown any connection to her foster mother. Nicole was referred to BITP and found eligible for EI because of delays in adaptive behavior with feeding problems (e.g., she would not take textured solid foods) and social–emotional concerns, as she did not pass the *ASQ: SE* (Squires et al., 2003). The trauma questionnaire was completed by the foster mom, who reported that Nicole had difficulty with sleeping and significant hypersensitivity to noise. These findings cued the EI service coordinator to contact protective services and learn more about Nicole's early birth history as well as the months just prior to placement. Nicole's history revealed significant periods of abandonment, including the children being found alone.

Because Nicole did not pass the *ASQ: SE* (Squires et al., 2003) and had a trauma history with significant symptoms, she was considered a Tier 3 referral. In addition to EI occupational therapy services for oral motor and feeding skills, she received a referral to an intensive feeding clinic which required daily attendance for 6 weeks. A referral to the CIS infant mental health specialist for home-based infant mental health services was made to address the attachment and relationship concerns and to facilitate Nicole's ability to interact with her peers. The foster parent and child were involved in each of the sessions with the infant mental health specialist, who used a Child–Parent Psychotherapy approach (Lierberman & Van Horn, 2008) to this family's needs. Treatment focused on goals which included reducing the child's inconsolability, increasing the foster parent's feelings of effectiveness in caring for Nicole, and psycho-education around the effects that neglect may have had in Nicole's life, all in the context of play and focusing on building the dyadic relationship between caregiver and child. After receiving EI, including infant mental health services for 9 months, Nicole was functioning at her developmental level and was no longer eligible for special education services when she turned 3 years old. Nicole was adopted by her foster mother and has maintained regular visits with her siblings. Follow-up with her adoptive parent after Nicole turned 3 revealed that Nicole continues to attend weekly playgroups at the local library and interacts with her peers with ease. Her mother reports that Nicole is loving, affectionate, and seems to never get enough of "Mommy's Love." It was noted that Nicole does take time to warm up to strangers, but looks to Mom for reassurance that all is well.

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SUCCESS OF THE MODEL

The model provides a universal trauma screening for all children referred to EI. Because all children in foster care are screened, the program ensures the likelihood that no trauma experienced from a substantiated case of abuse or neglect will be unattended. Children receive EI developmental services depending on their individual needs and, as appropriate, they receive infant mental health services or referrals to address attachment relationship and social/emotional/behavioral concerns. This is the CAPTA and IDEA legislation in action. The commitment of the Department of Health has been instrumental in the success of this program, first prioritizing the integration of EI with infant mental health and then standing behind their priority with funding for staff training in infant mental health, trauma screening, and contracting with CIS for infant mental health services to supplement EI. The partnership with CIS has provided EI with the expertise in infant mental health which was integral to implement the Department's vision for integrated services. While the program is funded by the Part C allotment to the state, these funds do not fully cover special projects that are designed to enhance service provision. Special projects, like the trauma screening and follow-up infant mental health home visiting services, are vulnerable to budget cuts when resources tighten and funds are needed to provide basic EI services mandated by law. Again, strong lead agency support is key to the sustainability of the model.

New Mexico Infant Team

New Mexico is one of the six states whose EI eligibility includes an at-risk category. If an infant or toddler does not qualify with the requisite percentage of delays, New Mexico providers have an option to qualify children who are in protective custody for EI through the state's at-risk criteria. Since 2009, New Mexico has implemented an interagency, transdisciplinary, Infant Team model program linking EI with three other state systems: (a) child protection, (b) behavioral (mental) health, and (c) the family courts. The goal of the New Mexico Infant Teams is to provide infants in state custody with a coordinated, trauma-informed, and developmentally based process for assessment, early developmental intervention, and mental health treatment to promote safety, permanency planning, and positive developmental outcomes (Clarke & Harris, 2013). Funding for the Infant Teams is provided by the New Mexico Department of Children, Youth and Families where Child Protection is housed. EI services are funded by the Department of Health through a Memorandum of Agreement that specifies the mutually agreed-upon responsibilities and collaborative protocols for the model.

> After receiving EI, including infant mental health services for 9 months, Nicole was functioning at her developmental level and was no longer eligible for special education services.

Like the Baltimore model, the New Mexico Infant Teams were developed by leaders, Deborah Harris and Jane Clarke, who had extensive experience in EI and infant mental health. Guided by the principles of infant mental health and developmental intervention, the Infant Team model does not infuse one approach into the other; rather, the model conceptualizes the fields of early developmental intervention and infant mental health treatment as two equal parts that together create a sum greater than the individual components.

STAFFING

Although the staffing differs by region, typically the Infant Team includes: (a) a director(s) with a background in infant mental health and early intervention who supervises all aspects of the Infant Team, including providing clinical and reflective supervision, (b) a coordinator who is the liaison with Child Protective Services, (c) infant mental health specialists who provide the infant and parent mental health treatment, and (d) EI providers assigned to the Infant Team: a service coordinator, developmental specialist, and occupational therapist or speech and language pathologist. The EI providers have specialized training and reflective supervision focused on trauma-informed care.

REFERRAL TO SERVICE

Referral to the Infant Team starts with the CAPTA referral from Child Protective Services which goes simultaneously to the Infant Team coordinator and to the EI program. The EI developmental evaluation is put on a fast track and is completed by the Infant Team EI staff within 1 to 2 weeks of the referral. By federal guidelines, EI evaluations can take up to 45 days from referral. The shortened time frame for an evaluation responds to the infant's needs during a stressful period and provides important, timely information to Child Protective Services and the courts during the initial adjudicatory process. Rapid response to the CAPTA referral, prompt development of the IFSP, and immediate initiation of services are critical to address the effects of trauma and essential to trauma-informed EI.

SERVICES OFFERED

The Infant Team provides a braided array of developmental and mental health services including:

- Developmental assessment provided by Infant Team EI providers.
- EI service coordination provided by the Infant Team EI service coordinator, including facilitation of IFSP development with the child protective worker, foster parent(s), biological parent(s) and infant mental health specialist and mid-year/annual IFSP reviews. The service coordinator has an expanded role and is part of the Child Protection and Infant Team meetings, provides input into the monthly court report, and works in tandem with the infant mental health specialist to coordinate developmental services through a trauma-informed lens.
- Parent–child relationship assessment conducted after the EI developmental assessment by Infant Team infant mental health specialists. The assessment includes the *Crowell Parent-Child Interaction Procedure* (Crowell, Feldman, & Ginsberg, 1988), parent perception and reflective functioning interviews such as the *Working Model of the Child Interview* (Zeanah & Benoit, 1995), and other protocols (e.g., Traumatic Events Screening Inventory–Parent Report Revised; Gosh-Ippen et al., 2002; and the *Neurosequential Model of Therapeutics Metrics;* Perry, 2006).
- EI developmental services as outlined in the IFSP are offered by the EI providers and include co-treatment with the infant mental health specialist.
- Parent–child dyadic psychotherapy with the biological parent(s) and child provided by the infant mental health specialist. The IFSP developmental interventions addressing the child's specific needs are incorporated into the dyadic work with primary caregivers as well as provided in separate sessions with the parent, foster parent, and child. Therapeutic supervision of visits may also be included.
- Family Court education and liaison provided by the infant mental health

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specialists; this includes educating the judges about infant's response to trauma, family risk factors, and the current needs of the particular infant in custody (e.g., relationship and interaction patterns, placement recommendations, visitation arrangements, EI services, and medical condition and medical needs). The team provides regular reports to the court and expert witness testimony on behalf of the infant.
- Infant Team liaison with Child Protective Services: The Infant Team works closely with Child Protective Services on treatment plan development and case coordination. The Infant Team coordinator provides regular and comprehensive reports to Child Protective Services in addition to monthly provider meetings (specific to each case) and ongoing contact about status of each case.

The Infant Team meets twice a month for 3 hours to discuss organizational issues, staff and assign cases, and participate in reflective supervision

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Advances in the understanding of trauma compel professionals and policymakers to once again rethink EI policies and practices

TWEETY'S STORY

Tweety was a toddler who came into custody when she was 14 months old. Tweety, a nickname her parents gave her, and her younger sister, who was 4 months old at the time, were removed from their parent's home because of unexplained injuries to the infant. During the initial investigation, the mother disclosed an extensive history of domestic violence and substance abuse by the children's father. The girls were placed in kinship foster care.

During initial visits and assessments, Tweety cried, whined, and grunted continuously, looking down or into space but not making eye contact with the staff or either of her parents, who visited separately. She sucked vigorously on a pacifier much of the time and did not respond to most of the attempts that her parents or other caregivers made to soothe, engage, or distract her. She was so distressed that the initial EI developmental evaluation could not take place and was rescheduled for a later time at the foster home. Tweety's inconsolability and disengagement were difficult for her parents as well as her foster parents and challenged the professionals who attempted to evaluate her. All of the adults—parents, foster parents, grandparents, Infant Team Staff, Child Protective Services staff, Court-Appointed Special Advocate workers, and other involved parties—experienced personal activation regarding the children's situation. Both of these very young girls had experienced trauma in a number of forms and were demonstrating significant signs of distress and dysregulation. How to address and intervene when the adults are also distressed and dysregulated became a focus of the Infant Team staffings for Tweety and her infant sister.

During the EI developmental evaluation, Tweety showed delays in motor, language, and social–emotional and regulatory domains. In the infant mental health interactive evaluation session with her mother, Tweety was not engaged and did not use any language at 17 months old. She did not show particular interest in the toys or activities. She did not look at her mother for much of the procedure, nor did she explore the environment. For most of the session, Tweety was stationary or lay in her mother's lap. When her mother began to talk to the Infant Team staff about her situation and upcoming court appearance, Tweety became very focused on her mother's tearful face and sucked more intensely on her pacifier as she continued to watch her mother. The mother was sharing her sorrow and guilt at not protecting her children from the domestic violence and her fear of future repercussions. When the mother occasionally looked down at Tweety, the little girl covered her face with her blanket or looked away.

The Infant Team's service plan was to integrate social–emotional, relational, and developmental services for Tweety with the therapeutic supervised parent visits and parent–child psychotherapy for Tweety and her caregivers. The services included occupational and speech and language therapy as well as infant mental health. The goals for the work with Tweety's parents were three-fold: (a) help them to see and to acknowledge their children's developmental and emotional challenges, (b) explore and manage their own dysregulation and distress in response, and (c) make behavioral changes in their responses to and support of their daughter's needs. All team members were trained in the advanced Circle of Security or the Circle of Security DVD-P® (2010) and used the terminology and imagery of Circle of Security with the parents to help the parents observe and communicate about their child's needs

Developmental and infant mental health goals were integrated into a treatment plan. The occupational therapist worked closely with the speech–language consultant and the infant mental health supervisor to develop strategies that would help both the parent(s) and the child with their arousal system activation, which was interfering with the parent(s) and child's capacity for mutually responsive and satisfying interactions. The misattunement between the parents and child, in turn, was not supporting Tweety's developmental progress. The next section outlines the kinds of interventions designed to address Tweety's trauma-related dysregulation and to promote attuned interactions between the parent(s) and child. These goals and interventions blend developmental, relational, psychotherapeutic, and body-based approaches.

- Provide Tweety with patterned, repetitive somatic activities to entrain more rhythmic regulation. Tweety's frustration, stress reactivity, inattention, and

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sleep disturbances originate from problems in the brainstem and diencephalon likely due to her ongoing exposure to intense domestic violence and stress. Because cognitive interventions do not change lower areas of the brain, rhythmic interactions through movement and music will provide Tweety with the patterned, repetitive stimulation these brain areas need.

- Tweety may have distorted templates and biases about what nonverbal cues mean. The brain makes new memories only for novel experiences. In order to help Tweety build a sense of safety in her relationship with her father, the team supported her father to create new experiences with Tweety that allowed her to feel safe, confident, and appreciated; build awareness of Tweety's regulatory and emotional needs; and suggest new shared experiences and support the father with pacing, tone of voice, and sharing in play.
- The most effective communication is synchronous verbal and nonverbal, a combination of words connected to affect and matching actions. When words do not match the facial expression, Tweety will trust the facial expression. When Tweety experiences inconsistency between the words, affect, and the actions, she will feel confused. Help her parents understand how to communicate with their eyes, smiles, touch, voices, and the consistency of their actions.
- Help parents to learn how to narrate their actions and become a "play-by-play" announcer, showing her how to put words to Tweety's and their own actions, feelings, and thoughts.
- Novelty activates the stress response and because of Tweety's experiences, even the tiniest little stimulation causes her to have a big reaction. Help her to become less reactive through using smooth movements, clear facial expressions, calm speech, and slow actions to help her to lower her high arousal level.

These intricate interventions are not a simple matter in the best of circumstances and a very complicated order when considering individual histories of trauma and high levels of activation and arousal due to the current traumatic situations (e.g., injuries, removal, court hearings, separations, conflict, and substance abuse and domestic violence issues). For example, the team had a lengthy discussion about Tweety's constant use of her pacifier and about the strong desire on the part of EI team members to discourage the use of the pacifier in order to promote speech development. During reflective supervision, the team was able to discuss their own "presses" around the use of a pacifier as well as the meaning or need for Tweety to use her pacifier as a regulatory tool at this time.

> When a system or program takes the step to become trauma-informed, every component is assessed and potentially modified to include a new trauma lens.

Both of Tweety's parents successfully completed their individual court-ordered programs (domestic violence and substance abuse treatment); they each individually completed the Circle of Security DVD Parenting (2010) and repeated it as co-parents. Both Tweety and her younger sister made significant developmental gains in motor, regulatory, and social–emotional domains. Both girls and were reunified with their parents, who agreed upon a co-parenting plan, and the case was deemed a "wonderful success" by the family court judge.

SUCCESS OF THE MODEL

The Infant Team has received positive recommendations from all parties, including the biological parents, guardian ad litem, children's court attorneys, and Court Appointed Special Advocate. All have stated that since the Infant Team has been involved, the nature of the legal cases has changed and the information regarding the infant's experience and needs are now brought to the forefront during court hearings. Initial evaluation of the model shows fewer no-shows, more involvement with EI services, and in New Mexico more voluntary relinquishments (vs. court-ordered termination of parental rights). The Children, Youth and Families Department has developed a new database to track outcomes which will help the Infant Teams assess progress and challenges. New Mexico now has Infant Teams in four judicial districts. The Children, Youth and Families Department is funding on-going consultation and a community of practice for all of the Infant Teams. EI has recently approved increased hours for collaborative and transdisciplinary consultation, which allows the EI staff to bill for Infant Team meetings and consultation.

IMPLEMENTING THE VISION

Both of the Baltimore and New Mexico programs exemplify the vision for a trauma-informed EI system and the promising outcomes achieved. The programs embrace a relationship-based approach to EI and have complemented the developmental expertise of EI with trauma-informed expertise in infant mental health. EI staff receive training in trauma and reflective supervision to support the integration of the new concepts into practice. Community collaborations play a central role in helping families receive the specialized services needed. Clearly, the leadership from the funding agencies is essential in making trauma-informed EI a reality.

Summary and Recommendations

Just as EI has benefited from major paradigm shifts over the years—from child-centered to family-centered, relationship-based practices; from medical models to natural environments—advances in the understanding of trauma compel professionals and policymakers to once again rethink EI policies and practices. This article has proposed a vision for a trauma-informed EI system-building on the federal policies that link the child welfare system to EI and frameworks around trauma-informed systems. The impressive work of the NCTSN in developing resources for trauma-informed systems and the pioneering work of the New Mexico Infant Team and the BITP provide inspiring examples of what is possible for children and families when trauma is assimilated into EI systems. The wealth of science and promising practices can guide the next steps.

Experience from previous paradigm shifts also provides the wisdom to know that system change is not quick, nor easy; that it has to come from top down and bottom up; and that all aspects of the system must share the vision. When a system or program takes the step to become trauma-informed, every component is assessed and potentially modified to include a new trauma lens. At the program level, professionals can begin by simply asking the question: "Have I considered whether trauma has played a role in the child's development and behavior?"

At the system level, there are also steps that could lead to a more trauma-informed system. Some of these might include:

- NCSTN might develop a work group on trauma and EI, creating a toolkit for a trauma-informed EI system similar to their valuable materials for trauma-informed child welfare systems.
- Council for Exceptional Children Division for Early Childhood might include a trauma perspective in their revision of the *Recommended Practices in Early Intervention/Early Childhood Special Education* (Sandall, Hemmeter, Smith, & McLean, 2005).

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- ZERO TO THREE, in partnership with other national organizations, could provide direction for policy action steps for trauma and EI in a document such as the policy recommendations made in *A Call to Action on Behalf of Maltreated Infants and Toddlers* (American Humane Association, Center for the Study of Social Policy, Child Welfare League of America, Children's Defense Fund, & ZERO TO THREE, 2011).
- The U.S. Department of Education Office of Special Education Programs (the federal agency responsible for Part C), and the U.S. Department of Health and Human Services Administration for Children, Youth and Families (the agency responsible for child welfare policy) might jointly convene key stakeholders from federal and state government, parent advocacy and professional associations, national experts, and interested foundations to identify issues, review relevant data, and identify areas of innovation and joint recommendations for the field related to trauma and EI.
- Federal agencies funding trauma-related projects can specifically include Part C EI in their requests for proposals; training and research initiatives funded by the Office of Special Education Programs could include projects related to early childhood trauma.
- Part C Statewide Training Systems can offer foundational training in trauma for EI service coordinators and providers; they can develop reflective consultation groups for EI providers facilitated by infant mental health specialists with trauma training.
- State Early Intervention Interagency Coordinating Councils can review the vision for Trauma-Informed Part C presented here and begin to assess the needs and opportunities at the local and state levels to move toward a trauma-informed system.

Creating a new vision, a trauma-informed vision, for Part C EI has already begun. Federal legislation, state policies, and program practices are beginning to acknowledge and address child and family development using the knowledge of brain development, the impact of adverse early experiences, and trauma research. We hope that by sharing examples of what trauma-informed care looks like in practice, and by proposing a trauma-informed framework for Part C EI, this vision will become more of a reality for the many infants and toddlers affected by trauma and who could benefit greatly from EI. The need is compelling; the science irrefutable; and the opportunity is at hand to elevate trauma-informed practices into EI systems.

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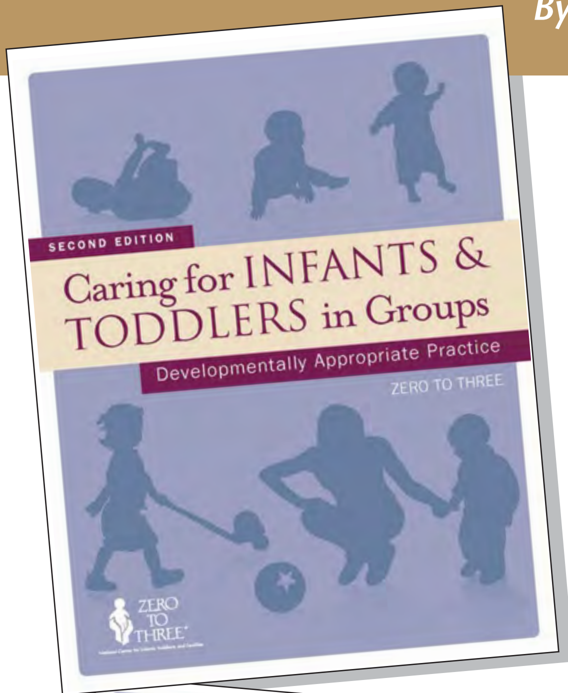

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Young Children and Disasters

Lessons Learned About Resilience and Recovery

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Young children, like older children and adults, are impacted by disasters. For children from birth to 5 years old, how they are affected and react will be closely related to the impact of the disaster on their caregivers, including their caregivers' resilience and the recovery process. Young children and their families are impacted by natural disasters such as hurricanes, earthquakes, tornadoes, wildfires, tsunamis, and flooding. These can result in displacement, loss of homes and personal property, economic hardship, loss of community and social supports, and, at times, injury and death of loved ones. Children can also experience technological disasters, such as oil spills or nuclear disasters, in which additional concerns are paramount and that include compounding factors contributing to uncertainty about the future. Technological disasters can result in multiple layers of destruction to environment, property, marine life, the economy, and communities. Fears about toxic exposure and future health of children add to the many ongoing concerns. For young children who are mainly dependent on others to interpret and mediate their experiences, protection and support are required to encourage resilience and for them to achieve full recovery. At times, providing that protection and support may be challenging because of the chaos that often follows disasters and leads to unpredictability, instability, and lack of routines. The very factors that play a key role in making life stable for young children are disrupted by disasters. Therefore, during and following disasters, young children may become confused, show behavioral and emotional dysregulation, and at times appear numb, unresponsive, and anxious. These reactions may manifest themselves in behaviors such as regression and withdrawal and aggression. However, rather than understanding the normalcy of their reactions, adults may interpret their concerns and anxiety as misbehavior, leading to impatience and even harsh punishment. Therefore, preparation and planning for disasters is crucial for both adults and young children in order to support resilience, that is, the ability to "bounce back" and recover.

The Gulf Coast has been impacted by nine major hurricanes in the past 11 years in addition to devastating Hurricane Katrina and the breach of the levees in 2005. Hurricane Katrina caused much physical destruction including loss of homes, property, toys, pets,

Abstract

For young children, consistency, nurturance, protection, and support are required for both resilience and full recovery. This article reviews relevant literature, developmental issues affecting young children, and factors that influence resilience and recovery including both promotive and protective influences. Focus is also placed on disaster preparedness and implementation of effective interventions for young children following disasters. Disaster response for young children can be much improved with attention to their developmental needs including their increased vulnerability and dependence on caregivers to keep them safe and support their recovery. With better preparation, training, and recognition of potential difficulties, young children can be provided with more support during and in the aftermath of disasters.

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and, for many, extreme heartache, a loss of communities, and separation from extended families. The impact on young children and their families has been both physical and psychological. Mental health issues have continued to affect children, families, and communities because of the magnitude of the destruction and displacement and the slow recovery (Kronenberg et al., 2010; J. D. Osofsky, H. J. Osofsky, Hansel, Reuther, & Callahan, 2013). Five years after Katrina, recovery was interrupted when many of the same areas and communities were impacted by the Deepwater Horizon Oil Spill (Gulf Oil Spill) in April 2010. With disruptions in a way of life, the uncertain impact on communities dependent on fishing and the petrochemical industry in the Gulf, and the risk of subsequent hurricanes, there was an increase at that time in anxiety, concerns, and mental health symptoms for children, families, and communities in this region (H. J. Osofsky, J. D. Osofsky, & Hansel, 2011; J. D. Osofsky, 2011; J. D. Osofsky et al., 2013).

Studies have shown that disasters with a slow recovery, such as Hurricane Katrina, can result in acute and chronic psychological effects (Hansel, Osofsky, Osofsky, & Fredrich, in press; Kessler, Galea, Jones, & Parker, 2006; Kronenberg et al., 2010; Masten & Osofsky, 2010; H. J. Osofsky, J. D. Osofsky, & Hansel, 2011; H. J. Osofsky, J. D. Osofsky, Kronenberg, Brennan, & Hansel, 2009; J. D. Osofsky, & H. J. Osofsky, 2013; J. D. Osofsky et al., 2013; Weems et al., 2007; Weems et al., 2009) that negatively impact the child's normal developmental trajectory (Pynoos, Steinberg, & Piacentini, 1999; Shaw, 2000). Younger children are particularly vulnerable, especially if their parents are traumatized and stressed resulting in their being less emotionally available to their children. Large-scale complex disasters, such as Hurricane Katrina, the Gulf Oil Spill, or the earthquake which triggered a tsunami and Fukushima Daiichi nuclear disaster are of particular importance related to children's development. They not only directly affect the young child and family, but also trigger disturbances across multiple systems, including microsystems, exosystems, and macrosystems in which the lives and development of children and families are interconnected (Bronfenbrenner, 1986; Goldstein, Osofsky, & Lichtveld, 2011; Masten & Obradović, 2008; H. J. Osofsky, Palinkas, & Galloway, 2010; Weems & Overstreet, 2008). For many children of Katrina, their once thriving neighborhoods, grocery stores, and playgrounds were no longer functional, and many children experienced multiple moves and changes in schools as well as parental unemployment (H. J. Osofsky, J. D., Osofsky, Arey, et al., 2011; J. D. Osofsky, H. J. Osofsky, & Harris, 2007; J. D. Osofsky, H. J. Osofsky, Kronenberg, & Hansel, 2010). The families impacted by the Gulf Oil Spill have been threatened with severe economic disruptions as well as threats to family and community identities as they live and thrive by the Gulf of Mexico, work with the petrochemical industry, or both. For example, St. Bernard and Plaquemines Parishes (close to New Orleans), were devastated by Hurricane Katrina, and, in coastal areas of the parishes, have experienced significant long-standing effects from the Gulf Oil Spill. Data from the Exxon-Valdez Oil Spill (Picou & Gill, 1996; Wohlforth, 2010) suggest that the significant vulnerability of children and families persists over time impacting individual, family, and community function. The psychological, social, economic, and ecological consequences of technological disasters can extend for years into the future.

Young children and their families are impacted by natural disasters such as hurricanes, earthquakes, tornadoes, wild fires, tsunamis, and flooding.

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There are concerns about the long-term impact on developmental trajectories for young children exposed to a disaster with slow recovery, especially given the persistent stress on caregivers and lack of social and community supports. The concerns are consistent with an understanding of the impact of disasters with prolonged recovery, or complex disasters with cumulative effects with the cascading effects of disasters (Masten & Cicchetti, 2010). Either of these situations can lead to both acute and chronic psychological effects on children's development (Kessler et al., 2006; La Greca et al., 2013; H. J. Osofsky, J. D. Osofsky, & Hansel, 2011; H. J. Osofsky et al., 2009; Weems et al., 2009; Weems et al, 2007). Such traumatic exposure is likely to have significant impacts on children, especially younger children over decades with possible cross-generational effects.

Research About the Impact of Disasters on Children

The impact of disasters on children depends on a number of different factors including the nature of the disaster, the age and vulnerability of the child, the types of resources available to the child, and family and community supports (Masten, Narayan, Silverman, & Osofsky, in press; Masten & Osofsky, 2010). Because fewer studies have been done with younger children, drawing on outcomes from older children may be helpful and provide background for understanding the potential impact. Child-focused disaster research in general examines post-disaster symptomatology. Few studies have been done with pre-post disaster data for obvious reasons; it is difficult to predict where a disaster might occur. The majority of the literature on hurricanes indicates that exposed children are at a high risk for symptoms of depression, anxiety, and posttraumatic stress (PTSD; Goenjian et al., 2001; Kessler et al., 2006; J. D. Osofsky et al., 2013; J. D. Osofsky et al., 2007; J. D. Osofsky et al., 2010; Weems et al., 2010). Several studies of older children exposed to disasters have documented symptoms of PTSD in children following natural disasters including earthquakes, tsunamis, and hurricanes (Goenjian et al., 2005; John, Russell, &

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During and following disasters, young children may become confused, show behavioral and emotional dysregulation, and at times appear numb, unresponsive, and anxious.

Russell, 2007; Kolaitis et al., 2003; La Greca, Silverman, Vernberg, & Prinstein, 1996; La Greca, Silverman, Lai, & Jaccard, 2010; Lonigan, Shannon, Taylor, Finch, & Sallee, 1994; Piyasil et al., 2007; Pynoos et al., 1993). Many of these studies have also reported increased depressive symptoms in children following natural disasters. Although there is overlap in symptomatology of both PTSD and depression, including anhedonia, sleep difficulties, problems with concentration, irritability, and a restricted range of affect, the research has been clear in demonstrating the distinct presence of each disorder following disasters (Goenjian et al., 2001; Kolaitis et al., 2003; Roussos et al., 2005).

Developmental Considerations for Young Children and Disasters

Overall, research on disasters has shown that the impact on children depends on a number of different factors including the degree of exposure in the immediate aftermath and longer term as well as immediate and longer term responses of others to the disaster. The effects will be related to the nature of the disaster, age and vulnerability of the child and family, proximity of the event, degree of exposure of child and family, as well as the recovery environment with medical, social, economic, and spiritual support (La Greca, Silverman, Vernberg, & Roberts, 2002; Masten & Osofsky, 2010; Norris, Stevens, Pfefferbaum, Wyche, & Pfefferbaum, 2008: Speier, Osofsky, & Osofsky, 2009)

Research indicates that children of all ages are impacted by the stressors associated with disasters and that age-related developmental differences influence responses to disasters. However, variations in symptoms by age may at times be difficult to interpret because both exposure and protection before, during, and after disasters may be very different for young children as compared with older children. Older children may have more abstract and also more realistic fears about the meaning and lasting consequences of traumatic events (Barber, 2009; Dimitry, 2011). With recent research and advances in knowledge about early development, especially the effects of stress and traumatic experiences on brain development, it is important to pay attention to the developmental timing of events. Prenatal and neonatal exposure and traumatic stress should be considered. For example, following 9/11, researchers found differences in infants born to mothers exposed to 9/11 during pregnancy depending on whether the mother developed PTSD (Yehuda et al., 2005). Infants of mothers who had PTSD symptoms had lower cortisol levels than infants whose mothers did not develop PTSD, and cortisol levels for mothers exposed during the third trimester were particularly low. This pattern is consistent with the possibility that prenatal stress exposure alters the biological systems that regulate physiological stress in children. An interesting study of prenatal stress and child outcomes comes from Project Ice Storm, which followed children whose mothers were pregnant during the 1996 ice storm in southwestern Quebec that left more than 3 million individuals without electrical power for as long as 6 weeks during the coldest part of the winter. Children exposed in utero to high levels of prenatal stress exhibited poorer cognitive, linguistic, and play activities compared to non-exposed children at 2 and 5½ years old. Poorer outcomes were associated with exposure during the first and second trimesters of pregnancy. At present, the group is assessing children 11½ years old, including using structural MRIs to complement the physical and developmental measures. The control group is children whose mothers were pregnant the year before the ice storm. Preliminary results have indicated that there is a relationship between children's exposure to high levels of prenatal stress during the first half of pregnancy and lower hippocampal volume at 11½ years old. Hippocampal volume is hypothesized to correlate with intellectual, emotional, and behavioral development. In a promising note, animal studies have indicated that the deleterious effects of prenatal stress can be mitigated by quality neonatal handling, similar to how infants born with mild and moderate prematurity have improved outcomes with quality parental care. This research is important for a developmental understanding of responses to disasters and is also consistent with recent epigenetic models indicating that early childhood experiences can have a significant impact on an individual's gene expression related to maternal stress and its effect on the fetus, with potentially lifelong health effects (Hertzman, 2012; Yehuda & Bierer, 2009).

Factors That Affect Resilience and Recovery After Disasters

Large magnitude and complex disasters often trigger a sequence of catastrophic events that increase the probability of more significant cumulative disaster dose effects. For example, Hurricane Katrina in 2005 was compounded by the breaching of the levees and the flooding that followed. The Gulf Oil Spill in 2010, involving the Deepwater Horizon Rig which was not capped for months while large amounts of oil compounded by dispersants flowed into the Gulf, increased the anxiety and uncertainty of a population of children and families still recovering from Hurricane Katrina resulting in increased psychological, economic, and ecological strain. The earthquake and subsequent tsunami in Japan in 2011 were compounded by the meltdown of the Daiichi nuclear power plant resulting in a "level 7" (highest level) nuclear disaster with uncertain spread of radiation for distances far removed from the plant. The cumulative and cascading effects of these complex disasters result in issues that place children and families at risk, and they mandate consideration related to recovery.

Recent theoretical research has focused on examining patterns of resilience and recovery as they relate to developmental

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theories and trajectories for children. Important factors that support resilience in preparation for and following disasters include promotive and protective influences (Bonanno, 2004; Bonanno & Mancini, 2008; Layne et al., 2009; Masten & Obradović, 2008). Masten, Narayan, Silverman, and Osofsky (in press) described two important factors for understanding the effects of disasters on children: (a) *promotive factors* predicting better outcomes at all levels of risk or adversity; and (b) *protective factors* that are more important when risk or adversity is high. The impact of disasters and developmental issues that follow are influenced by the nature and severity of the exposure, the importance of pre- and post-disaster context for understanding disaster response and recovery, protective factors for positive recovery, and possibly by the role of age and gender (Masten & Osofsky, 2010). Adding complexity to an understanding of outcomes following disasters, Pynoos (1993) emphasized factors that contribute to poor long-term outcomes following disasters including extended periods of high cumulative adversity related to breakdown of infrastructure, ongoing economic consequences, family stress, loss of life and property, and other aspects of slow recovery.

While parents play a key protective role for children of all ages related to preparedness, safety, communication, and role-modeling adaptive behaviors, parents are particularly important for younger children who are more vulnerable and dependent on their caregivers. Parents need education and information in order to carry out their caring roles most effectively to ensure the protection of children during and following disasters. Further, the characteristics of the young child need to be taken into consideration. A recent study by Kithakye and colleagues (2010), which also included pre-disaster adjustment, found that self-regulation skills in preschoolers were associated with prosocial behavior in general and had a moderating effect on the impact of exposure severity on prosocial outcomes. Masten (2007) also found that self-regulation skills can support a protective role for children.

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Hurricane Katrina caused much physical destruction including loss of homes, property, toys, pets, and, for many, extreme heartache, a loss of communities, and separation from extended families.

Disaster Preparedness Including Understanding of Prior Adversities

An important part of disaster preparedness for young children must involve parents and caregivers to effectively plan and carry out the roles of protection, communication, and safeguarding children under very difficult circumstances. It is important to remember the additional risk factors for children related to prior traumatic experiences and losses that play a key role in how young children (or children and adults of any age) will react to and cope with disasters. Children with prior difficulties and those who have experienced previous trauma or loss, and continue to experience post-disaster trauma and adversities, are at higher risk for mental health problems than those without these compounding difficulties (Bowlby, 1973; Laor et al., 1997; J. D. Osofsky, 2004; Pynoos, 1993; Pynoos, Steinberg, & Goenjian, 1996; Vogel & Venberg, 1993).

For children with multiple adversities, experiencing a disaster and the post-disaster environment may lead to different outcomes related to these multiple adversities (Felitti, 2009; Klasen et al., 2010; Kronenberg et al., 2010; Pynoos, 1993). The co-occurrence of trauma and poverty can lead to increased vulnerability for children of all ages, particularly for young children. These issues are significant following disasters and were illustrated poignantly for children and families in the Gulf South in the aftermath of Hurricane Katrina for whom symptom severity was very high and decreased only slightly in the years following the disaster (Kronenberg et al., 2010; J. D. Osofsky et al., 2007). In a study of tsunami survivors in Sri Lanka, Fernando, Miller, and Berger (2010) discussed the role of daily stressors related to outcomes and coping in addition to the actual exposure to a disaster. While much of this work has been done with older children, there are important implications for younger children because more stress in families will impact younger children significantly. Becker-Blease, Turner, and Finkelhor (2010) provided data on prevalence and incidence of exposure to disasters in a nationally representative sample in the United States for children ranging from 2 to 17 years old. The data indicated that about 14% of children and adolescents reported experiencing some type of traumatic event in their lifetime with about 4% having experienced such an event in the last year. A recent study by Chemtob and colleagues (2010) highlighted the importance of the emotional state of parents and their availability to their children after a disaster, showing that the preschool children of parents who had more symptoms of PTSD and other mental health problems following the 9/11 terrorist attack had more difficulties. Consistent with developmental theory, children who are not protected at the time of the disaster by supportive caregivers may be more vulnerable to the effects of the disaster.

As a result of the evacuation and displacement following Hurricane Katrina, some young children were separated from their parents and experienced other disruptions in their primary relationships, family, child care, and other support systems. Although there are few circumstances other than disasters that cause such a massive disruption in the lives of young children, history has shown (Bowlby, 1973; Burlingham & Freud, 1942) that in times of stress, attachment behaviors are activated with young children who turn to their caregivers for comfort and security. During World War II, during the London Blitz, Burlingham and Freud observed young children being cared for at a residential nursery. Children who were separated from their caregivers showed regressive behaviors, aggression, and withdrawn and

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The earthquake and subsequent tsunami in Japan in 2011 were compounded by the meltdown of the Daiichi nuclear power plan resulting in a "level 7" (highest level) nuclear disaster with uncertain spread of radiation for distances far removed from the plant.

depressed behaviors. In 2003, Foster, Davies, and Steele studied the long-term effects of children's separation from caregivers during the London Blitz. They found that 60 years later, adults who were separated from their parents as children, when compared to those who lived in London with their parents during the war and did not evacuate, were at increased risk for an insecure attachment style and were more likely to report low levels of psychological well-being. These results are consistent with the recent Adverse Childhood Experiences Study (Felitti, 2002; Felitti & Anda, 2008). During Hurricane Katrina, children were confronted by multiple stressors including the primary stressors of the storm, such as witnessing the devastation and destruction and sustaining injuries, and inability for some to access their primary attachment figures or other supports such as their pets, familiar toys, and schools in order to cope. When young children lack secure caregiving relationships, they are at risk for less optimal social and cognitive outcomes (O'Connor & McCartney, 2007; Rydell, Bohlin, & Thorell, 2005).

Effective Interventions for Young Children After Disasters

Consistent with important interventions for young children in general, those who are impacted by disasters will benefit from: (a) support for the parents and caregivers including efforts to reduce individual and family stress; (b) supporting child, parent, and family functioning; and (c) helping parents and caregivers communicate with their young children related to the changes in their lives. In helping young children, it is important to recognize the importance of the family environment, supports for the family in the community, attachment relationships, establishing safety, routines, and some sense of normalcy in the young child's life. Parental guidance can be important when intervening with young children following disasters by supporting the adults' understanding that a young child's behavior has "meaning" and the importance of learning more about the relationship between emotions and behaviors. In fact, data from screenings done in collaboration with schools in areas heavily impacted by Hurricane Katrina indicated that many parents, when given an opportunity, recognized the need for additional support and asked for guidance and counseling for their young children (Kronenberg et al., 2010; J. D. Osofsky, 2011). An interesting example of interventions with young children following a disaster was experienced by the Louisiana State University Mental Health Trauma Team, in November 2005 when, together with volunteers from the Substance Abuse and Mental Health Services Administration, they established a child care center on the cruise ship that housed first responders and their families, 80% of whom had lost their homes during Hurricane Katrina and were living on the boat while they continued to do their work in New Orleans. The child care center was needed for young children of first responders, some of whom had to go to work, and of others who needed some respite from being with the children all day. The first game that the children wanted to play, which was repeated day after day, was "hurricane." It was very difficult for the parents to observe and join in their children's play, involving repeated reenactment of experiences during the hurricane. Education and support for the parents was needed to help them accept that their children's behavior was a normal part of working through their traumatic experiences. Further, the therapists had to be mindful of the nature of repetitive traumatic play and—over time, together with their parents—help the young children understand their new life experiences after the hurricane that included much displacement and loss, many new adjustments, and hopes for the future. This example illustrates children playing out traumatic experiences and how difficult it can be for parents to see and experience this play. At the same time period, a young father expressed concern about how to explain to his 2–year-old that their house was destroyed and they would not be able to move back. When asked what he said, he replied, "I said to my son 'It's a little bit like when your toy broke and we had to get a new one. In this case, our house is broken and we'll have to get a new one; however, we will all be together in the new house.' "

In order to elucidate some of the issues further, the following case illustration is based on work done with a young child, who experienced multiple disasters, by clinicians from Louisiana State University Health Sciences Center Department of Psychiatry as part of the Mental and Behavioral Health Capacity Project, which is part of the Gulf Region Health Outreach Program.

Susie's Story

Susie was a 5-year-old girl living in rural Louisiana. She was referred for school-based psychotherapy by her school counselor because of repeated behavior problems that were severe enough that her teacher felt she could not handle Susie on her own. Before the referral, she would often ask other teachers or staff to help her with the behavioral outbursts. When Susie was upset, she would become aggressive toward her classmates and her teacher, and would occasionally throw small objects such as books. Susie was also having difficulty with her school work because she had difficulty concentrating and paying attention in class and was often out of the classroom because of her behavior. She was labeled as a "bad child" in the school setting. The teacher did not feel she could help Susie with her problems.

Details about the family history that were obtained during an interview with Susie's

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parents are relevant to understanding the effects of disasters on young children. Susie was born within a year of Hurricane Katrina. Her family lost their home and had to evacuate from their community while the mother was pregnant, leading to much disruption not only during the pregnancy but also during the first few years of Susie's life. The family moved from their hometown and stayed with several sets of relatives for months at a time. The family was later separated geographically for several months when the father was able to move back to the community before the rest of the family was. Susie's mother felt overwhelmed and dispirited during that time. Susie younger sister had been born while the family was temporarily living in another community. Given the many needs of this family and the disruptions in their lives, the parents described that they were often preoccupied and focusing on the needs of the younger sister. In the second meeting, the clinicians learned of further adversities in the family's lives including significant substance abuse by Susie's father before she was born.

At the time of referral Susie's mother was a homemaker caring for Susie's younger sister. Her father worked in the oil industry. Since the Gulf Oil Spill 2 years earlier, her father was having difficulty finding work. With additional stress on the family including significant financial problems, her father again increased drinking and her mother described escalating marital conflict. On two occasions, Susie witnessed her father hitting her mother during an argument. These conflicts were never discussed directly with Susie because her mother did not know what to say. Following the early disruptions in her life and the more recent stresses, Susie had increasing difficulty regulating her behaviors and her emotions.

The evaluation and treatment took place in a private office in the school setting. The therapist described Susie as a neatly dressed and likeable 5 year old who interacted easily with the therapist but was easily distractible when anxious. The therapist was able to engage the mother, the teacher, and the school in a team approach to try to help Susie. Infant mental health training helped the therapist understand Susie's dysregulated behaviors and consider the effects of the multiple traumatic experiences she had encountered in her short life. The therapist also worked with the teacher, helping her to understand what might be contributing to Susie's disruptive behaviors so the teacher could become more empathic and also develop better strategies and interventions to deal the behaviors in the classroom. Together they were able to find ways to address and reduce the behavior escalation; for example the teacher learned to intervene earlier and give Susie more individual attention in situations in which Susie was more likely to act out. Susie's mother engaged in weekly Child Parent Psychotherapy (CPP; Lieberman & Van Horn, 2005) sessions—an intervention for young children from birth to 5 years old who have experienced at least one traumatic event—with Susie and the therapist at the school. The primary goal of CPP is to support and strengthen the relationship between a child and his parent (or caregiver) in order to restore the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning. In CPP, Susie's mother learned the importance of establishing safety for Susie, and she came to understand how the multiple disruptions, family stresses, and conflict influenced Susie's behavior problems at school. As her empathy increased, she developed the ability to talk with Susie about the family disruptions and difficulties in ways that were age appropriate. CPP also helped to strengthen the relationship between Susie and her mother; Susie clearly felt more secure, trusted her mother more, and was able to turn to her when she was distressed. Appropriate and sensitive interventions from the teacher and reassurance from her mother helped to calm Susie's fears so that she verbalized worrying less about her mother's safety while at school. The therapeutic interventions together with mother and child helped to improve Susie's behavior in the classroom so that her teacher could handle most situations. Over time, Susie no longer needed to be disciplined as often and sent out of the class. The emotion and behavior regulation that Susie was able to learn through the intensive CPP helped to establish a safe place with her mother, which allowed her to behave and learn more effectively in the classroom, engage more with her peers, and, over time, develop a better relationship with her teacher.

Conclusion

Disasters of all kinds occur far too frequently, be they hurricanes, typhoons, earthquakes, fires, flooding, or many others. The potential for young children being impacted is great because, even with preparedness, it is not often possible to anticipate when a disaster may occur. When a disaster occurs, not only is the child impacted, but parents or caregivers, whose roles include keeping the child safe and providing protection and nurturance, are also affected and often traumatized. Further, with displacement there is disruption and loss of property, sometimes lives, and certainly routines that are so helpful for the stability and positive growth of young children. Young children in particular can be profoundly impacted by disasters because they lack the cognitive and emotional maturity and skills to cope that are present in older children. In addition, young children are more reliant on parents and other caregivers to support their development and meet their needs. In coping with disasters, parents and caregivers may not have the physical or emotional resources available to be able to meet the young child's needs. Disaster response can be much improved with more attention to the developmental needs of children of different ages, with particular attention to younger children

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Parents need education and information in order to carry out their caring roles most effectively to ensure the protection of children during and following disasters.

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who are more vulnerable and dependent on adults. With better preparation, training, and recognition of potential difficulties, young children can be provided with more support during and in the aftermath of disasters.

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Do You Work With a Young Child Who Has Been Exposed to

Violence, Neglect, or Disaster?

Hope and Healing

A Caregiver's Guide to Helping Young Children Affected by Trauma

KATHLEEN FITZGERALD RICE and BETSY McALISTER GROVES

Millions of children each year become victims of maltreatment, witness the abuse of a parent or caregiver, or suffer from some form of trauma. Research suggests that early childhood professionals can play a significant part in helping those children recover from the effects of those experiences.

Hope and Healing is a guide for early childhood professionals who care for children in a variety of early care and education settings. The authors define trauma, help readers recognize its effects on young children, and offer practical information to those working with traumatized children and their families. *2005. 60 pages. Paperback.*

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"Stronger Than the Storm"

Keeping Infants and Young Children in Mind During the Response to Superstorm Sandy

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Abstract
Superstorm Sandy hit the coast of New Jersey with deadly force causing hundreds of miles of coastline damage, loss of homes, property and road damage, and power outages throughout the region. Despite the state's strong disaster response network, most programs and responders have little background in supporting the needs of infants and very young children in the wake of natural disasters. Likewise, support for early child care centers and family care providers needed to become a greater priority in targeting response. The Center for Autism and Early Childhood Mental Health at Montclair State University and the New Jersey Association for Infant Mental Health took the lead in convening key stakeholders throughout New Jersey and Early Head Start/Head Start to provide awareness building, training, and referrals targeting very young children. This article outlines the need for a special focus on infants and young children after a disaster and the efforts in New Jersey to engage messaging around the needs of infants, toddlers, and their caregivers in the face of the storm.

Imagine the sounds of winds howling, the deafening sounds of strong rain hitting the roof and windows, then suddenly everything goes dark and cold as the power has been lost. Parents maneuvering through the house with flashlights and candles. The pounding of police and emergency responders at the door telling families to leave their homes. The panicked look on parents' faces as they try to pack up children, pets, and belongings, rushing to get to shelter before the roads all close. The overwhelming feeling of fear and worry about what will happen next.

Now imagine a week later, families still in temporary shelter at local schools or with family or friends—needing to assess their damage, contact insurers and the Federal Emergency Management Agency (FEMA), and possibly get back to work—but without the child care supports they had been accustomed to because so many centers or providers have also been impacted by the damage. The fear and uncertainty experienced during the storm itself remain, now accompanied by growing frustration—some of which is triggered by the demands of a dependent and frightened young child or a baby who cries at the strangeness of it all—the faces, sounds, smells, disruptions in routines, or changes in the way that Mommy talks, holds, and looks. Those centers which have not withstood severe damage are trying to accommodate more children and families whom they do not know and who are in "crisis" mode. Families and child care providers are operating at intense levels of emotion and survival.

What About the Babies?

The descriptions above capture the effects that many experienced through Superstorm Sandy. While emergency preparedness and response protocols, search and rescue, and search and recovery operations have been developed and rehearsed, as Selma Fraiberg often asked, "What about the babies?" Considering the examples shared above, it is important to look at how exposure to high levels of stress or trauma can affect families with infants and young children and can affect the systems of care designed to support families such as early child care and education, medical and hospital providers, and other social service and support networks. It is important to understand that Sandy and the disaster events experienced surrounding that storm encompassed not only hurricane and hurricane-force winds and flooding, but also an earthquake and a nor'easter bringing snow and more rain. What might seem like a single

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Reacting in stress or crisis response, parents may become frozen or paralyzed in their attempts to protect their young.

event was a series of multiple natural disaster events which the state of New Jersey is still recovering from a year after its onset. More than 350,000 homes were lost or damaged, and the infants, children, and families who lived there were changed. Consider the impact of these events through the eyes of young children and their caregivers.

For most, the arrival of a baby stirs a natural drive to protect. In his book, *The Motherhood Constellation*, Daniel Stern (1995) referred to the "life growth" theme which details the parents' sense of obligation and responsibility for ensuring the life, safety, and growth of their baby. Consider then, how a natural disaster like a hurricane or superstorm could impact on the experience of the life-growth theme. Reacting in stress or crisis response, parents may become frozen or paralyzed in their attempts to protect their young or respond aggressively in their need to provide safety and protection. Parents who themselves have been significantly stressed or traumatized by their own losses or experiences may not be as capable of investing in their parental life-growth theme as they are operating in personal survival mode themselves. The ability to remain responsive and attuned during and after a disaster may be compromised.

Similarly, babies and young children may experience difficulties in regulation, display developmental regressions, and engage in more intense and security-seeking attachment-promoting behaviors such as gazing lovingly at the parent, cuddling, or smiling. Their stress levels may be too high and they may alternatively be clingy or rejecting of touch, sleepy or sleepless, demanding attention, or seemingly uninterested in others. Daniel Siegel (1999) noted that babies come into this world wired to form relationships. In fact, one of the critical developmental tasks for infants and young children is to develop secure relationships—to seek proximity to one who can provide a safe haven in times of distress and a secure base from which to explore (Bowlby, 1969). Consider how the drama and the trauma of a superstorm like Sandy could impact the attachment process itself. Consider how the anxiety, depression, or anger of the parent or other significant caregivers might impact on the child's perception of whether they should approach or withdraw, of whether they feel safe and valued or weak and vulnerable. The experience of disaster and trauma can diminish or destroy the young child's belief in a safe world. This article examines what New Jersey families and providers experienced in the course of Sandy.

The Course and Impact of Sandy Across New Jersey

Hurricane Sandy hit New Jersey on October 29, 2012, with the point of greatest impact along the eastern seaboard. In the eight counties that were most seriously affected by the storm, the percentage of the population that was younger than 5 years old ranged from 4.8-6.9%. Sandy curved north-northwest and made landfall near Brigantine, New Jersey, just northeast of Atlantic City, as "Post-Tropical Cyclone Sandy" a superstorm with hurricane-force winds. In her path she left thousands homeless and millions without power. The storm caused upwards of $30 billion in economic losses to businesses. Hundreds of child care centers were closed from days to months. Other facilities both at the shore and in inland communities were without power or sustained water or had other damage due to high winds and fallen trees. Families who desperately needed to have safe, accessible child care during this very dangerous and trying time were often without resources and forced to face home repairs, maintaining work schedules, and coping with no electricity with little support in caring for their young children.

It was not only the shore communities that were affected. Inland communities, especially northern counties like Hudson County near the mouth of the Hudson were also greatly affected. Hoboken, a mile-square, densely populated city west of New York City, was flooded by the storm surge through the New York Bay into the Hudson River. Half of Jersey City, New Jersey's second largest city, lost power, while large sections of the city's downtown, including City Hall and the Jersey City Medical Center, were flooded and evacuated. By late night October 30, an estimated 20,000 people were stranded in Hoboken, surrounded by water. In Weehawken, a small community north of Hoboken along the Hudson, the downtown neighborhood known as the Shades incurred severe damage, with nearly every resident forced to temporarily relocate. The newly renovated, state-of-the-art Head Start Center in Hoboken sustained major damage and was forced to close.

On October 31, New Jersey Governor Chris Christie welcomed President Obama to set eyes on the areas along the Jersey shore and signed an executive order postponing Halloween until November 5th, 2012, for the first time in our recent history. This decision was made to promote safety and support fun for children in the midst of the horrific events. The media captured many reports and images of the damaged shore communities. Mantoloking, an small but affluent community located along the Barnegat Peninsula, just north of the storm's contact, suffered a severe "wash over" which included the creation of two new, temporary inlets with many oceanfront homes completely removed from their foundations and destroyed. More than 50 homes were demolished, representing 10% of the community's housing. Fires, possibly fueled by natural gas, destroyed about 14 homes on October 29 in Mantoloking and restarted in the early morning hours of October 31. The Belmar boardwalk was demolished along with Perth Amboy's marina and waterfront. Much of the Casino Pier in Seaside Heights and nearby Fun Town Pier in Seaside Park collapsed into the ocean as they were unable to withstand the intensity of the waves—the iconic image of the destroyed rollercoaster sinking in the waters off the shoreline became a symbol of Sandy and how most of the rides residents went on as children were destroyed…washing away the tangible pieces of shared childhood memories. In the seaside communities on Long Beach Island the storm surge deposited up to 4 feet of sand on island streets, making them impassable. The storm washed away an old section of the world-famous Atlantic City Boardwalk and left most of the city's emptied streets under water. Ortley Beach was declared "Ground Zero" due to the astonishing amount of devastation.

Further north and west of the shore, damage also struck through rising water tables, river and stream flooding, and damage due to high winds. In the early morning of October 30, there was up to 5 feet of water in the streets of Moonachie and Little Ferry—very small communities prone to flooding. Sayreville, a community along the Raritan River, faced rising flood waters from the storm surge

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entering Raritan Bay, which forced the evacuation and rescue of dozens of residents by the Sayreville water rescue team. The Oyster Creek Nuclear Generating Station in Lacey Township was placed on alert when storm waters around the plant rose 6 feet above normal. Sustained winds in Morristown, located in north central New Jersey, peaked at 40 mph with gusts to 67 mph. Wind speeds reached 88 mph in Montclair, 80 mph in Clifton, 78 mph in Newark, 74 mph in Point Pleasant, and 61 mph in Basking Ridge. Gusts along Long Beach Island peaked between 75–90 mph. The rail operations center of New Jersey Transit was flooded by 8 feet of water, and floodwater damaged at least 65 locomotive engines and 257 rail cars.

If that damage was not enough—adding to already frayed nerves and worries, downed trees and power outages followed and a magnitude 2.0 earthquake struck at 1:19 a.m. November 5, centered in Ringwood, in the northwest corner of New Jersey. Immediately after Sandy made landfall, forecasters were already discussing the possibility of a nor'easter, directly impacting New Jersey during the following week so in preparation for that storm, residents in coastal areas were evacuated once again due to the threat of high winds, flooding, and a storm surge of up to 3 feet. The nor'easter hit New Jersey on November 7, a little more than a week after Sandy's landfall. Much of the state experienced wet snow which weighed down power lines and caused tree limbs to snap, adding to the already existing power outages throughout the state.

When the storms ended and the winds calmed, residents were faced with the daunting task of recouping losses—physical and emotional; and rebuilding—homes, families, and communities. Those efforts, which continue 1 year later, are emotionally draining, physically exhausting, and psychologically daunting. They take their toll not only on those most directly impacted by damage and trauma but on all who surround those persons and communities and on the helpers and responders themselves.

Photo: ©iStockphoto.com/Aneese

Superstorm Sandy left thousands homeless and damaged or destroyed nearly 350,000 homes in New Jersey, and the infants, children and families who lived there were changed.

Disaster Response for Infants and Young Children

Infants and young children communicate stress and trauma principally through pre-verbal and nonverbal channels such as affect, gestures, alterations in body states and self-regulation, play, altered sleep and feeding patterns, exaggerated expressions of emotions, somatic issues, separation issues and anxiety, and regressions (Levine & Kline, 2007). They may show hyper arousal—high startle responses, have trouble focusing as they are attending to all stimuli scanning for danger—or become hypo-aroused—shutting down and shutting out sights and sounds around them or appearing nonresponsive. As noted earlier, in the face of real or perceived danger they can become clingy and experience great anxiety, exhibiting highly intense protests when separating from a valued parent or caregiver. On the flip side, some children, not being sure who to trust, become indiscriminate in their attentions and affections with all adults whether familiar or unfamiliar. They may show signs of re-experiencing the trauma through play re-enactments or through reoccurring nightmares, distress around reminders of the event, or preoccupation with aspects of the event (see box Effects of Exposure to Disaster in Children). Magical thinking often gives added power to their frightening memories or experiences (Levine & Kline, 2007). Imagine how the world looks and feels to young children who are either in these states of hyper- or hypo-arousal or have changing relationships with parents and caregivers during an intensely challenging time. Imagine how difficult it is for parents and caregivers to "read" their young child's cues and respond to often challenging or "rejecting" behaviors while they too are under stress.

In looking to support families impacted by Sandy, it is important to reflect on the lessons learned from Hurricanes Katrina and Rita on the Gulf Coast. After the hurricanes struck, much was done to examine lessons learned about flood risks and evacuation preparations. Subsequent to those disasters, protocols and legislation around the safe response, even to pets and animals, were created. School and community responses were tightened but there was little exploration into the needs of infants and young children and their families in the aftermath of the hurricanes. Organizations such as ZERO TO THREE, Save the Children, Brazelton Touchpoints Center, the National Traumatic Stress Network, National Association for the Education of the Young Child, Sesame Workshop, the

Effects of Exposure to Disaster in Children

Common effects experienced by children who have been through a disaster or trauma include the following:

- Compromised feelings of safety and increased feelings of danger
- Diminished belief in the capacity of the adult world to protect
- Diminished sense of trust and security in self and others
- Increased cognitive preoccupation and interference with capacity for learning and information processing
- Interference with capacity for emotional regulation, modulation of alertness, and arousal and self-calming
- Disruptions of biological and psychological routines of sleeping and eating
- Increased risk for social and behavioral difficulties

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The experience of disaster and trauma can diminish or destroy the young child's belief in a safe world.

Fred Rogers Company (formerly Family Communications, Inc.), and others published various guidelines and resources after the storms, often consistent with previous responses to the impact of the traumas of violence and terror (such as the Oklahoma City bombings or 9/11) on young children.

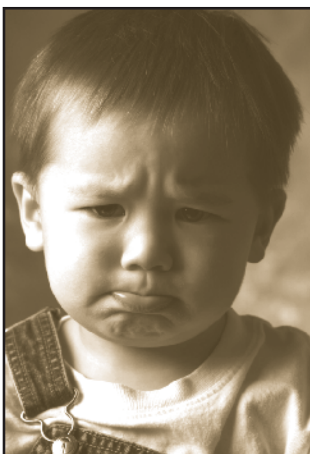
What do researchers know about the impact of natural disasters on young children and on community systems serving infants, toddlers, and their families? They know that infants and children are indeed affected by traumatic situations and that trauma can impact their self-regulation and learning capacities. This impact is related to how trauma affects the underlying brain systems, particularly the limbic system, and with the effects of activating the hypothalamic-pituitary-adrenal system (Perry & Szalavitz, 2006; Siegel, 2010). Trauma can interfere with social responding and with the building and maintenance of relationships (Lieberman, Harris, Osofsky & Osofsky, 2010). So much for the idea that "He is only a baby, it doesn't really affect him." Infants and children are not saved from adverse effects by their immaturity. In fact, it is their immaturity and dependence on the adults in their lives that pose both great risks and great opportunities to help them.

Lessons learned from Hurricane Katrina and the impact of disasters and post-disaster recovery revealed that young children are a particularly vulnerable group because their response is so dependent on immature central nervous system functioning and is mediated by the responses of parents and other adults in their environment (Osofsky, 2011). Large-scale disasters with a slow recovery period, such as hurricanes, affect not only the individual but also multiple systems in which children develop (Masten & Obradović, 2008, as cited in Osofsky, 2011). Neighborhoods, playgrounds, child care facilities, and favorite stores and destinations are changed for many of the families with young children. While there has been significant research in how natural disasters impact school-aged and adolescent children, there is a paucity of studies about infants, toddlers, and young children affected by disasters.

The National Child Traumatic Stress Network in a 2007 Service Systems Brief advocated for the creation of trauma-informed systems of care. For very young children it is critical to recognize the importance of the family environment; supports for the family in the community; and attachment relationships which provide safety, routine, and a sense of normality (Osofsky, 2011). The next section will reflect efforts in New Jersey to provide such key supports and to develop a disaster response informed by the unique needs of infants, children, and their caregivers. Such knowledge about early childhood development and family supports will help the response system craft a more effective, tailored response to the families and communities of care.

Efforts to Build a Collaborative Response

The language used is important, and part of the effort to mobilize responses guided by knowledge and principles of infant mental health was to develop a clear position about "messaging" regarding infants and young children. This included an adherence to a simple rule: those of us working on these efforts never said "young children" but always "infants and young children." Soon after the storm hit the coastline, this messaging principle became a responsibility of all who participated in the mobilization effort described here. This practice was rooted in the belief that when the public thinks about early childhood, most consider "P–3"—preschool to grade 3 (8 years old)—but rarely does the public consider pregnancy and children from birth to 3 years old. By distinguishing "infancy"



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Helping Infants and Young Children When Disaster Occurs

1. **Be there and be calm:** Ask children what they know and what they have heard. Listen to the child's story, follow the child's lead, and be reassuring about the ways that you the adults will take care of them. Use simple language and correct any misunderstood accounts. Tell a child what they need to know, not all that you know. For example, **say something like**, "The winds blew some trees down and the water from the oceans and rivers caused flooding in some places. Some people were hurt and some houses were damaged. The emergency crews, police, and firefighters are working hard to take care of all the people who need help. You are safe here and we will take care of you."
2. **Wait to see how the child reacts and respond accordingly**: Ask the child, "Do you think we can help in some way?" Encourage acts of caring, such as donating items to a food pantry, clothing to a shelter, or money to a charity that will help families affected by the disaster. Explain to them what will happen next as this will help them feel more able to anticipate the future and feel more secure and protected. Practice these conversations with other adults.
3. **Give permission for many different feelings:** Infants experience the basic emotions of sad, mad, glad, and worried. As children grow, their emotional experience and expression grows to feel the basic six emotions: sad, mad, glad, excited, scared, and frustrated. Avoid imposing meanings or interpretations on children, but allow them to feel what they feel. Often children will explain their feelings through their body states. Consider asking "where" do they feel as well as "how" do they feel.
4. **Share your feelings:** It is okay and important for children to know that the adults in their lives have the same feelings when bad things happen. Let children know you feel these feelings and that you are there for them. It is important, however, that you remain in control. Monitor your own emotion and tone of voice. Pay attention to your gestures, affect, and voice because children pay special attention to these ways of communicating. You can help children feel safer and calmer when your behaviors convey these feelings. If your own reaction is difficult to manage, enlist another adult to help you.
5. **Limit repeat exposure to images and reports of the events:** When children do see images or reports of tragedies, Fred Rogers of *Mr. Rogers Neighborhood* suggested that we help them "look for all the people who are helping." Couple the sad tragedy with the comforting presence of others who are helping and taking care of others.
6. **Remember the 3R's of safety: Relationships, Routines and Restoration:** Both children and adults tend to need the basic "R's" of safety for comfort and reassurance at times of uncertainty. Highlight relationships with familiar and consistent caregivers, family, and friends. Protect and increase routines that are familiar and normalizing such as play time, going to school, reading books, and other patterned activities. Remember the body and the importance of restoration, including appropriate sleeping and eating patterns, and time-limited regressive behaviors to previously used ways of feeling better, i.e. hugs and physical touch, sensory-based "soothies" like a blanket, stuffed animal, or pacifier, and expression of emotion like crying, clinging, whining, or wailing.
7. **Intervene with the developmental age and stage of the child in mind:** Infants require comfort, familiar attachment figures, holding, protection, and restoration of order. As language and imagination grow, toddlers and very young children need simple words, repeated reassurances, acceptance of time-limited regression, constant monitoring and love. At each developmental period, the availability and empathic response of a caring, familiar adult begins the process of remediation.
8. **Intervene with the particular learning style and temperament of the child in mind:** Children with autism and other special needs may process information—gestures, pictures, and language—in different ways. Often a "4L's" strategy may help: Less Language and Longer Latency. This means that you can use fewer words and wait longer for a reply. Ask the child what they were thinking and feeling and even draw pictures or tell stories. Use your own facial expressions, voice, and words to reflect and "tune in" to their emotions. If helpful, use pictures or drawings to identify and label different feelings. Be prepared for misunderstandings and misinterpretations, and keep clarifying and reassuring the child that you will be sure they are safe.
9. **Provide structure and communicate safety:** Uncertainty is the province of adulthood. While we as adults may feel unsure of the possibility of future tragedies, we must always let children know that we will take care of them and protect them. Children thrive when provided structure and safety.
10. **Recognize that there are some feelings that we can only share and cannot fix:** Children need us to be there with and for them at such times. It's OK not to have an answer, and to be with the children in their sadness and confusion. If the status of a child's parent or relative is unknown, reassure the child that you will stay with him/her and that you will be sure to contact someone they know who can come to be with them. If a child's parent or relative is missing and may have died, let the child know that you will be sure that someone from their family or another close person comes to take care of them. Let them know that you care for them, hold and hug them if they will let you, and tell them that you are sad with them.
11. **Remember to take care of yourself:** If the adults in a child's life are overwhelmed, overstressed, and overtired, it will be more difficult to be safe, secure, and stable for the child. Pay attention to the "ABC's" of self-care: awareness, balance, and connection, and enlist other adults to help you process what has happened and support you in your support of the child.

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as a separate developmental period—before language—the clarity of why special knowledge and consideration were needed became clear.

On November 1, 2 days after the storm hit, the Center for Autism and Early Childhood Mental Health (CAECMH) issued a blast email to a large network of state stakeholders, containing a set of guidelines regarding ways to help and support the infants, young children, and their families affected by the storm. The box Helping Infants and Young Children When Disaster Occurs presents a modified version of that document.

This practice of communicating guidelines regarding the needs of infants, children, and their caregivers had also been done after the tragedy in Aurora, Colorado. It was clear that the "messaging" around the devastation of the storm, and its impact on infants and children, was more widely understood because the CAECMH had become a source of information and support in the earlier tragedy, as well as the subsequent devastating events at the Sandy Hill School in Connecticut and the Boston marathon.

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The response to Superstorm Sandy reflected both the need to educate all about the unique needs of the youngest and to engage in a "messaging" effort that ensured infants, toddlers, and children are considered carefully.

Invitation to Infant and Young Children Community

Dear Friends,

I hope you are safe and well and were not terribly affected by Hurricane Sandy. Sadly, significant portions of the eastern shoreline, notably along the New Jersey coast were devastated, and many families are facing unbearable losses. Another major storm is predicted for this week, increasing stress, fear and authentic risks of destruction to already overwhelming events.

We are planning a meeting for all infant and early childhood mental health and care/education specialists right after the annual meeting of the NJAIMH. The purpose of the meeting will be to discuss ways to address the needs of infants, children, their families and care providers in the wake of Hurricane Sandy. The meeting will he held on Friday, November 9 from 2 to 4 pm at Montclair State University, at University Hall Room 1020.

With the assistance of our university Office of Government Relations, I am contacting our Governor's Office and the state Office of Emergency Management to determine what if any plans have been developed to address the needs of infants and children affected by this disaster and to coordinate any plans we begin to formulate. I have also reached out to ZERO TO THREE, and am in the process of reaching out to other state governmental and aid organizations to be sure we coordinate our plans. I have also been told of a program in the NJ Department of Human Services, "New Jersey Hope": http://www.state.nj.us/humanservices/dmhs/disaster/

I am attaching an information sheet and providing you with two links to useful resources:

1. This is a resource that can help talk with children about the hurricane: http://www.7-dippity.com/docs/After_The_Storm_(2008_Internet_Edition).pdf
2. This sheet contains ways to help children with autism and other special needs: http://aeiou.org.au/files/fact_sheet_-_coping_with_natural_disaster.pdf

We are all needed and we will try to identify needs and coordinate links with those of us who can provide support. Our neighbors' lives have been devastated. We will speak about strategies and programs that might be of help to the infancy and early childhood communities, particularly with regard to the emotional well-being and responses to the traumatic events, of infants, children and their families and those who care for and assist them.

Mobilization and Professional Development

On November 5, less than 1 week after the storm, an "Invitation to Meeting to Discuss Infants, Children, and Hurricane Sandy" was issued to a large network of infant, young child, and family stakeholders; to all state departments; and to local and national organizations. The text of this invitation is provided in the box Invitation to Infant and Young Children Community. The response was overwhelming! More than 50 infant and child care specialists responded to the call in person and another 20 colleagues participated through teleconference, representing all key state, federal, and relief agencies, including: representatives of the New Jersey Department of Children and Families, who began coordinating the state's response to the storm; the state Departments of Human Services, Health, and Education; representatives from the state Traumatic Loss Coalitions; representatives from FEMA and the state emergency management authorities and from the American Red Cross, Save the Children, ZERO TO THREE, Administration for Children and Families/Office of Head Start, New Jersey Chapter of the American Academy of Pediatrics, New Jersey Association for Infant Mental Health, New Jersey Chapter of the National Association for the Education of Young Children, the Coalition of Infant/Toddler Educators, the New Jersey Child Care Resource and Referral Agencies, state Head Start and Early Head Start Programs, National Technical Assistance Center for Children's Mental Health at Georgetown University, and others. Professionals from pediatrics, nursing, education, mental health, occupational therapy, speech and language pathology, infant–pediatric massage, childbirth education, higher education, and allied disciplines participated. The meeting was held on November 9, 2012, hosted by CAECMH, College of Education and Human Services at Montclair State University, and the New Jersey Association for Infant Mental Health.

Four reasons were identified for this gathering:

1. **Rally the troops!** Inform them about the impact of the hurricane and the particular way the devastation can affect infants, children, and families.
2. **Inform participants about the developmental, emotional, and behavioral consequences** of such disasters on infants, children, and families.
3. **Identify specialists to create a registry of individuals who are able and willing to work with other state-organized efforts in the counties identified by FEMA** as deeply affected by the storm. These efforts could include working with

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disaster relief teams, and be deployed in infant and child/education provider centers and family care provider homes.

4. Invite all to attend **two 3-hour training events** on November 14 and December 8, provided by the CAECMH to all the identified "infant and early childhood specialists" where the consequences of the disaster; strategies for consultation; support for infants, children, families, and providers; and ways to "help the helper" will be examined.

This meeting set the stage of a mobilization of personnel and resources. More than 100 professionals attended the free 3-hour workshop, offered twice on November 14 and December 8, which included a detailed presentation and material review, and during which they were invited to be part of a registry that would include (a) all participants who wished to make themselves available to provide material from this workshop to families and (b) community groups who wished to learn more about the impact of the storm and ways to respond to the needs of infants, toddlers, young children, and their families. Participants were asked to provide contact information, professional discipline, geographical area, and language(s) spoken. More than 70 participants joined the registry. All those who joined were told that they would be provided with a full 190-slide PowerPoint presentation used during the workshop along with references and supportive materials, if they agreed to the following conditions:

1. Presenters must include the first three slides in all presentations. (These slides listed the authors and developers of the material).
2. Only those who participated in the November 14 and December 8 presentations offered by the CAECMH are authorized to use any of the slides in the presentation.
3. Slides can be deleted (except the first three) and added, but those which are added must be attributed to the presenter or presenter's organization.
4. No slides can be copied and used in other presentations unless prior authorization is given by the CAECMH.
5. No fee can be charged to any participant who attends a presentation given by the authorized presenter using these slides.

These requirements ensured the preservation of the quality and fidelity of the material, and they and also ensured that, at this time of need, the information would be offered for the benefit of all without cost or burden. This was a "pay it forward" policy: Each participant received the information and materials at no cost, and they were asked to provide support to others at no cost.

In early November, under the leadership of Allison Blake, Commissioner of the New Jersey Department of Children and Families in collaboration with other state-level partners, a Superstorm Sandy New Jersey State Led Child Task Force was created to ensure that all resources and relief efforts were shared and coordinated. Deputy commissioner Jeff Guenzel led the task force and began by stating, "At times like this, another disaster would be that well-meaning people try to help, and wind up duplicating efforts and competing with each other!" (personal communication, November 2012). This was an extraordinarily critical principle, and "all" were "invited to the table," including the CAECMH director representing the needs of infants, toddlers, children, and families. A "Sandbox" sub-committee was created to attend specifically to the needs of infants, toddlers, and young children. Members including representatives from the New Jersey Association for Infant Mental Health, Save the Children, the New Jersey Chapter of the American Academy of Pediatrics, and state and federal agencies. For the months of November and December, the State Led Task Force met weekly to review data on impact and recovery, share resources and service programs, disseminate grant-funding opportunities, and discuss intervention strategies.

In December 2012, the state Child Care Resource and Referral Agencies were provided with a form to distribute regarding requests for presentations from members of the workshop registry. The form allowed respondents to request any or all of following services:

- Workshop to your staff about understanding the impact of the disaster on infants and children, and strategies to help.
- A parent workshop or meeting with parents to discuss how infants and children might respond to trauma and how to help them.
- A meeting with a community group, business, faith-based community, or another sponsoring organization wishing to learn about infants, children, and their special needs during this critical time.
- Other consultation or service. Please specify (subject to availability of volunteer).

Respondents also gave information on when they wanted services, a location, and a description of the expected audience (e.g., professional discipline, parents, community members, mixed). This form, however, appeared less important than the presence of registry participants in their target communities. We did not develop a data system to track how many presentations occurred, something that could be done in the future, but some registry participants informed the Center at Montclair State University when presentations were made, and a conservative estimate is that 10–20 presentations were made. We believe that estimate does not represent all agency staff who did a quick "turn-around" of the presentation to their own infant and child care staff.

It was also our belief, not dissimilar from what occurred following the devastation of 9/11, that the need for safety and stability are priorities immediately following a disaster, and while our message of how infants and young children must be attuned to, is most important quickly after trauma occurs, we recognize that the effects on families continue, and the need to address mental health concerns will continue to emerge. In March 2013, the New Jersey Disaster Response Crisis Counseling (DRCC) responders met from throughout the state for a DRCC Retreat in the Aftermath of Sandy. Nearly 200 participants reflected on their experiences in responding to families, and a special workshop was offered around responding to infants and young children. Participants were reminded that they have a responsibility to make choices to care for themselves in a preventive, proactive way. To do this work and feel the vulnerability every single day is complex and wonderful and daunting. In addition to the opportunity for reflection, this forum provided new information about the continuing needs of families in the state for ongoing support in the wake of disaster.

Moving Forward Stronger and More Informed

As New Jersey approached the first anniversary of Sandy, and sensitive to the ongoing needs of families, particularly to those of infants and young children, the New Jersey Department of Children and Families, in partnership with CAECMH, committed $720,000 from October 2013 through June 2015, targeted at professional development of staff in infant and early childhood mental health and targeted to the now 10 counties designated as those most affected by Superstorm Sandy. The goal is to provide a wide range of staff with knowledge and practice about (a) infant and child mental health, (b) ways to respond to trauma, (c) how to support families, and (d) how to engage in reflective practices and self-care. Among the identified goals for these staff who work with infants and children from birth to 8 years old are the creation of 500 personnel who will meet the Levels I and II of the newly adopted New Jersey Association for Infant Mental

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Health Competency Guidelines and Endorsement system. The Endorsement, as one of 17 states in league with the Michigan Association for Infant Mental Health, was funded through the New Jersey Council for Young Children, under their Infancy and Early Childhood Mental Health strategic plan.

Collectively, infant and early childhood mental health are "on the table" and the response to Superstorm Sandy reflected both the need to educate all about the unique needs of the youngest and to engage in a "messaging" effort that ensured, now and in the future, that infants, toddlers, and children are considered carefully. That we always keep "Babies in mind."

Gerard Costa, *PhD, DIR-C®, IMH-E® IV, is the founding director of the Center for Autism and Early Childhood Mental Health at Montclair State University. He is a clinical assistant professor in the Department of Psychiatry at Rutgers University-New Jersey Medical School, and serves a trustee, DIR (Developmental, Individual difference, Relationship-based model), and graduate school faculty of Interdisciplinary Council on Developmental and Learning Disorders. He serves as a consultant to ZERO TO THREE and was on a team of ZTT specialists that provided support to the child care community in the wake of Hurricanes Katrina and Rita. He sits on several nonprofit boards and the BUILD NJ Committee. He received his doctorate in developmental psychology from Temple University and is a gubernatorial appointment to the New Jersey Council for Young Children, where he heads the Infancy and Early Childhood Mental Health committee. He served on the New Jersey State Led Child Task Force and headed the "Sandbox" committee focusing in the needs of infants and toddlers after Superstorm Sandy.*

Kathleen Mulrooney, *MA, LPC, IMH-E® IV, holds a master of arts degree in clinical psychology and is a licensed professional counselor in New Jersey with a specialty in infant and early childhood mental health. She served as assistant director for Military Family Projects for ZERO TO THREE and consulted with ZERO TO THREE in efforts to respond to the Gulf Region one year after Hurricanes Katrina and Rita. She has been part of the New Jersey Disaster Response Crisis Counselor network since its inception and has responded to natural disasters, school and community violence, and post 9/11 responses. She trains other DRCC counselors through workshops focused on impact of trauma and disaster on infants and young children and their families as well as children with special needs and disaster response. She is currently with the Center for Autism and Early Childhood Mental Health where she serves as project coordinator of the New Jersey Autism Center of Excellence Coordinating Center at Montclair State University, overseeing nine clinical research sites in the state.*

Nicci Spinazzola, *EdS, LMFT, LPC, ACS, NJ-DRCC, is a licensed marriage and family therapist, licensed professional counselor, approved clinical supervisor and NJ-Disaster Response crisis counselor. She maintains a private practice in Morristown, New Jersey, specializing in adolescent and family treatment related to trauma and loss. She was a member of the New Jersey Governor's Council on Youth Suicide Prevention. She has been involved as the Traumatic Loss Coordinator in charge of countywide crisis intervention, crisis response, and training in the schools and community. She is currently the clinical director of the Richard Hall Community Mental Health Center, and is an instructor in the Continuing Education Program for Rutgers University in the School of Social Work. She has designed and implemented programs to meet the needs of families, schools, and community organizations, speaking extensively on the topics of disaster response, managing sudden and traumatic loss, resiliency, suicide prevention, intervention and postvention, self-care and other related topics. She provides training for local universities, school systems, social service and public safety agencies.*

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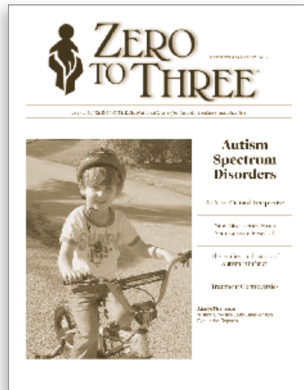

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Babies, Toddlers and the Media
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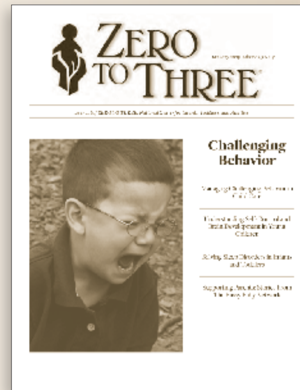

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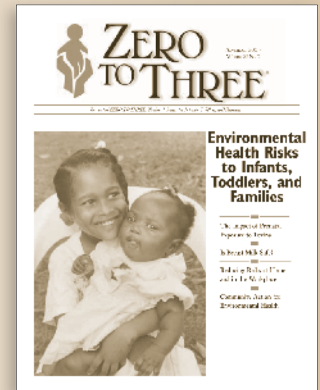

Environmental Health Risks to Infants, Toddlers, and Families
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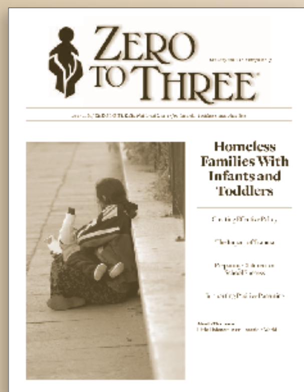

Homeless Families With Infants and Toddlers
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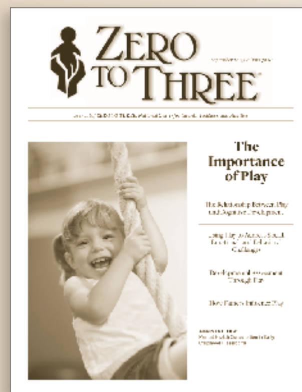
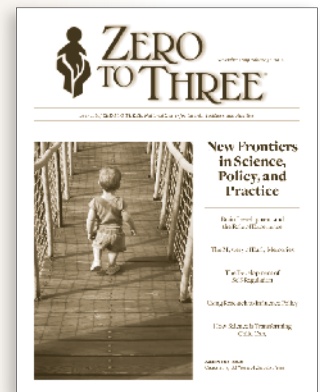


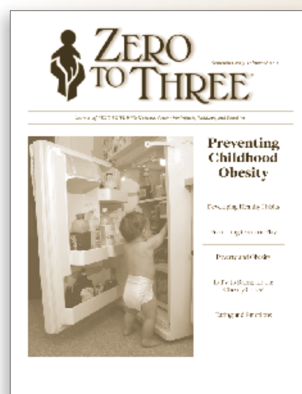
The Importance of Play
Item No.: 409-OLB

Infants, Toddlers, and Teen Parents
Item No.: 337-OLB



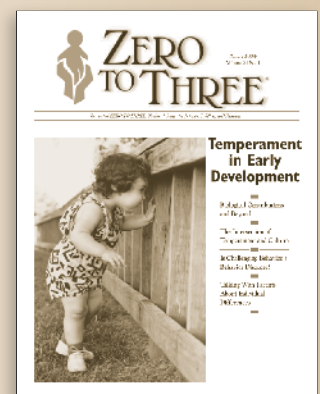
New Frontiers in Research, Policy, and Practice
Item No.: 411-OLB

Postpartum Mental Health
Item No.: 407-OLB



Preventing Childhood Obesity
Item No.: 387-OLB

Reflective Supervision: What Is It and Why Do It?
Item No.: 390-OLB



Temperament in Early Development
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Stepping Stones

Relationships, Resiliency, and Reflective Practice

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What is the meaning of "accomplishment?" Merriam-Webster (n.d.) says "the successful completion of something; the act of accomplishing something; a quality or ability equipping one for society." Synonyms for the word are: completion, execution, consummation, and proficiency. Antonyms include: failure. I agree with Webster, almost entirely. But for me personally, I believe that failure is part of accomplishment. The way that I see it is failure is a determination builder. It helps to develop willpower and tolerance, which are things that are essential for reaching your goals and desires. I, honestly, never pictured myself here today before you at my graduation. The truth is the only graduation that I have had was from elementary school. I did not finish high school or go to prom. Regretfully, these are milestones that I missed. I call them failures. I had my first child at 14 years old. I stepped into Hirsch Metropolitan High School with a protruding belly, low self-esteem, and even lower tolerance.

I went for a couple of months and eventually found more and more reasons why I should not return. The second semester, I was on and off; I would attend for a week and not return the following week. I did this until, eventually, I did not go back. I call this, too, a failure.

Soon to follow my first child were my two sons. At the age of 19 I had three children: Kierria, Alex, and Larry. I call them my "three little Blessings." I also call them an accomplishment. Amazingly, this family that I created depended on me for food, clothing, shelter, and all of the love I had—and love that I did not even know that I had. Home was not the happiest place for me as a teenager so at age 18, I left. I did not have a job or an education so I lived with whoever would let me, eventually ending up in an abusive relationship, which led to me living in an abandoned home in the middle of winter—no heat, no water, no food, no lights, and no one to count on. One night I sat in bed looking down at my children, snuggled up under me to keep warm. At that moment, my eyes filled with tears and my heart was in overwhelming pain. At that point, I realized that I had to be the most selfish person alive. My children did not deserve this and neither did I. I packed up the little we had and went to a shelter.

Being there took a lot of tolerance. I often thought about giving up. I prayed to God for a miracle. On October 18th my miracle came in the form of five modern angels—Kathy, Kim, Sylvia, Gabriela, and Michelle. I call them the "Dynamite Five." They are the dream team, the FACT team. Through all of my difficult times struggling to stay afloat, the FACT team did not leave my side. They encouraged me and they supported me. They made me believe in myself and reminded me of all of the potential that I had. I met with the FACT team every week, and I stayed determined to do whatever it took to get my family where we needed to be. They gave me someone to talk to. When I say someone to talk to, I mean someone who would actually listen. I started looking for a job and enrolled in GED classes. I always knew that education was a major part of my life and it would be essential for me to be able to raise my children and

Abstract
This article describes the story of resilience of a mother who achieved multiple successes despite challenges that included child abuse and homelessness. The factors that contributed to her success included consistent support from a team of staff of the Family Assertive Community Treatment (FACT) Program. This agency serves mothers from 18 to 25 years old who have a mental health or substance use disorder (or both), and a history of chronic, often multigenerational homelessness. One of the team members recounts the journey they experienced together in the formal helping relationship. The authors discuss the important role of reflective supervision and how a cadre of nurturing and committed relationships created the context for resilience and growth in the face of toxic stress.

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help them when they went to school. It was hard, but I found a job and received my GED soon after. I call this, too, an accomplishment. Now, today, nearly 3 years later, I am so happy. I have all of the tools that I need to keep a job, a roof over my family's head. My determination is stronger than ever and so is my tolerance and self-esteem. I am confident in myself and my decisions I make regarding my family, my ability to succeed, and my ability as a mother. The FACT team helped me to deal with trauma from past relationships, family, and friends. They helped me find something that I had lost so long ago—love for myself. Once I was able to love me, accept myself, and my failures, it allowed me to accept and love someone else. Next month I will be getting married and I am happier now than I ever imagined. So, I ask you again, "What is the meaning of accomplishment?" It is the ability to succeed, to never give up and to accept your failures as stepping-stones to your success. (Keanna Murphy, graduation speech, October 24, 2011.)

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Young children and their parents thrive in healthy connected relationships.

A Story of Resilience

Young children thrive in healthy connected relationships. Their parents also require nurturing relationships for their growth and well-being. Research has established that the quality of parent–child attachment is critical to the healthy growth and development of young children (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969/1982). Findings from research on attachment suggest that common toxic stressors in a parent's environment may interfere with her ability to respond in a warm and sensitive manner to her young child (National Scientific Council on the Developing Child, 2004). Stress related to poverty, battling domestic violence, or an unpaid cell phone bill, may lead to a parent who is slow to respond to the cries of a young child. A parent worried that the rent is due, the water is about to be shut off, or she is about to lose their job is at high risk to respond in a less than sensitive manner to a child's pleas for food. Highly stressed parents with poor coping skills or ability to regulate their emotions place the child at higher risk for child maltreatment (Dentzer, 2013; Salloum & Lewis, 2010). Despite researchers' deep understanding of the factors that foster resilience in children, they know less about the factors that foster the resilience of parents who face difficult circumstances.

This article highlights the beautiful story of resilience of one young mother who began parenthood at 14 years old and the critical role of the relationships she formed with a caring team of agency practitioners. Keanna Murphy has chosen to use her real name in this article to tell her story, stating "I want others to know they can overcome hardships." The general principles of a cultural–relational approach explain the factors that nurture resilience and success in families with young children in the face of toxic stress. We specifically examine how a set of professional relationships, forming a nurturing "community," contributed to the resilience of one stressed and embattled mother. The article concludes with a discussion on the role of reflective practice and supervision as part of nurturing professional relationships that serve as a context for growth and resilience for families with young children.

Stress and Coping in Families at Risk

Toxic stress refers specifically to the cumulative stress experienced by an individual from multiple sources such as early trauma, low socioeconomic status, or an impoverished environment. Risk factors are all associated with chronic stress, creating what is now known as toxic stress within parents (Dentzer, 2013; Shonkoff, 2010). High levels of stress are associated with negative health outcomes including heart disease and high blood pressure. Intergenerational poverty, incarceration, foster care, unemployment or under employment, and low literacy rates are both an outcome and cause of toxic stress. One subset of parents fall into a category termed *disconnected* (Golden, McDaniel, Loprest, & Stanczyk, 2013). This term refers to low-income parents (often limited to single mothers) who are not working and are not receiving cash public assistance. Golden and colleagues reported that in 2009 approximately 20% of low-income single mothers, representing approximately 1.2 million families in the United States, were disconnected at any point in time. They highlight that this group of mothers often face challenges that include the above barriers in addition to limited education, responsibility for an infant or for an ill or disabled child or family member, criminal records, or lack of citizenship.

Resilience

The concept of resilience has been studied in those children who succeeded in the face of adverse and traumatic circumstances such as chronic child abuse, domestic violence, war, or natural disasters such as the flooding of New Orleans after Hurricane Katrina (Lewis & Ippen, 2004; Salloum & Lewis, 2010). *Resilience* refers to a dynamic process of positive adaptation within the context of significant adversity (Luthar, Cicchetti, & Becker 2000). In their review of the development of the construct of resilience, the authors stressed that "it is imperative that researchers study resilience as a process and not a personality trait" (p. 546). Further, they argued that resilience is multidimensional in nature. They presented evidence that a portion of at-risk children experiencing similar environments of adversity of child maltreatment showed positive academic resilience. These findings are consistent with the early work identifying resilient responses in children living in difficult circumstances (Werner, 1988).

The *relational–cultural theory* provides an overarching theoretical framework to understand how resilience may be nurtured in parents (Comstock & Qin, 2005). Attachment

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Attachment and relational–cultural theories, as well as evidence from decades of research, emphasize that human health, growth, and courage develop within a context of relationships.

and relational–cultural theories, as well as evidence from decades of research, emphasize that human health, growth, and courage develop within a context of relationships (Bowlby, 1969/1982; Comstock & Qin, 2005; Easterbrooks, Charduri, Bartlett, & Copeland, 2011; National Scientific Council on the Developing Child, 2004). A parent's individual strength is also derived from strength in relationships. Comstock and Qin (2005) argued that it is the "process of creating mutual empathy and mutual empowerment" (p. 26) that allows individuals to become increasingly relationally complex, rather than more individual and autonomous over their life span. The concept of mutual empathy has to do with the experience of mutual responsiveness and influence. Thus, human growth is achieved through the enhancement of each individual's "capacity to create, build, sustain and deepen connection as a lifelong goal. The experience of feeling alive and valued comes to us when we feel we have been heard and have impacted another" (p. 26). These relational concepts are of particular significance to understanding Ms. Murphy's journey as she faced the toxic stress of the discouragement of chronic poverty, homelessness, unemployment, and domestic violence.

A Mother's Story

Below is a portion of a transcript of Ms. Murphy's exit interview with Susan Reyna Guerrero, president and CEO of Beacon Therapeutic Diagnostic and Treatment Center, a community mental health agency serving the south side of Chicago (see box The Beacon Therapeutic Diagnostic and Treatment Center). Upon graduation from the program, Ms. Murphy, the commencement speaker, described the adversity and stressors she faced.

Susan—Tell me a little about yourself. How did you get involved with the Family Assertive Community Treatment (FACT) program?

Keanna—I joined the FACT program in October 2008. I had my first child very young. I was just graduating from the eighth grade. I attended Hirsch Metropolitan High School but I did not stay for long. Being 14 years old and a freshman in high school, it really affected my self-esteem. I attended school for a couple of months, maybe the first semester. I did not go back to high school in the second semester. I did not graduate high school. Home was not really the happiest place for me as a teenager growing up. A lot of the issues at home kind of started because I had a child so young. I left home when I did not feel really comfortable at being home. At that point I would stay with friends and family. It finally came to the point where I did not have anywhere to go. I went to a shelter. That is how I was introduced to the FACT program.

Susan—Monday when you gave your commencement speech, I think what was so apparent was the profound love for your children. You have three children. I am going to put a picture of them because when you look into their faces (and this is shortly after you received your diploma, gift, and shook your hand) you can see the tremendous amount of love that they have. Understanding the challenges that you faced in your life and where you are today, it is truly a success story. And, this is something that you should be so overwhelmingly proud of. It is something that we are overwhelmingly proud of. I know that you have been through some really challenging times and I would be interested in finding out what are some of the things that FACT did for you? There is a team of five. Did you get to know all of them? What did they all do for you?

Keanna—I interacted, closely, with all five of them. I was able to open up and felt that I had someone to count on, someone to trust. At a point, they became to me more than just a counselor or a therapist or a case manager; they became like family to me. It got to the point that if I had a problem, I was not really close with many of my family members, so I would call the FACT team. They were my form of escape; they were my shoulder to cry on. They were the people that I looked to when I needed help or when I needed someone to tell me that everything would be okay. They gave me that confidence. They gave me that sense of belonging and the fact that somebody loved me.

Susan—That is really profound because when I see the team and the way that they look at you, it is with a tremendous amount of respect and believing in you and believing in your capacity to be a wonderful mom, which is what you are. What services did you actually get from the FACT team? Did you get a

The Beacon Therapeutic Diagnostic and Treatment Center

Beacon Therapeutic was started in 1968 by a group of parents who were looking to find a better educational program for their children. Since then the agency has grown into a multisite, multiservice organization focused on children and families. The services they offer include:

- An intensive outpatient program for children and adolescents who require structured treatment to help them either move into or remain in their local public school
- Homeless outreach services including mobile mental health services
- The Children's Health Insurance Program
- An Early Head Start program that works with low-income expectant parents and children from birth to 3 years old and their families
- A day school program for children with emotional, behavioral, or learning needs that exceed their local school's capacity

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housing program? Were you able to get housing through them?

Keanna—Yes. The FACT team helped me to find housing, really good housing. It is a home that my children and I were very comfortable with, someplace that we could actually call home. It was not somewhere we slept on the floor or on a couch at someone's house. It was ours. It gave us the "okay" to say that this was our home; this was our house. That was really important to me and my children. They also did questionnaires, they would come and check up on my kids to make sure that my kids were developing properly at the ages that they were and that they were reaching the necessary milestones that they were supposed to reach at certain ages. They also kept me informed on how my children were supposed to develop. It gave my children the chance to interact and have fun. They would play with my kids and joke around. My kids looked forward to the visits as much as I did.

Susan—How often was the team going into your house to visit you?

Keanna—They would rotate, and I would see someone from the FACT team every week.

Susan—Were they there for an hour or a couple of hours?

Keanna—Actually, it came to the point that it was not like a home visit, it was like my "aunt" was coming over to see us. We would talk for so long and the conversations were so in depth that we would lose track of time. Kathy or one of the other ladies from the FACT program would come over and we would just talk, and it seemed like time would just fly. They would look up and say, "Wow, we have been here for 3 hours."

Susan—Oh, wow!

Keanna—Yes. It was really important to me, and my children looked forward to it.

Susan—You described from 2008 until now, 3 years is a long time. You have accomplished so much in those 3 years. You got your GED. How hard was that for you when you left school at such a young age and then going back to try to learn something? How did the FACT team help you with that? How did you accomplish that goal?

Keanna—They offered so much encouragement. Before I got pregnant with my first child, I loved school. I was really into school. I was on the cheerleading team, the pom pom team. I was president of the debate team. I was president of the student council. I was involved in a lot of extracurricular activities because I felt, at that time, that I belonged. When I got pregnant and went to high school, it was like I felt shunned. I felt kind of detached from the rest of my peers. I lost interest in school because I felt like I was not able to relate to it any more. I told the FACT team that I wanted to go back and get my GED; they pushed me and offered the encouragement and the support that I needed to be able to work, to be able to be a mom, come home to my children, and still be able to find the time to study to complete my GED training.

Photo: © Bill Koechling

Since 1968, Beacon Therapeutic Diagnostic and Treatment Center has served homeless and at-risk mothers, fathers, and children in the Chicago metropolitan area.

Susan—That is remarkable because I think that it is hard for anyone to try and do school work. But, you are trying to do school work with little children. One thing that you said in your commencement speech was that failures are part of life, and you used those failures to succeed. Clearly that is what you have done. Where are you now, 3 years later? You were in a homeless shelter when you first enrolled in Beacon, in the FACT project. Where are you now? Do you have a home?

Keanna—I have a beautiful home. I have three happy, growing, intelligent children.

Susan—In your speech you mentioned that at one point you had to do better for your children. That is what motivated to take the next step. You have three kids now, a beautiful home; you have your GED, where do you see yourself? What is your future when you talk about a destiny?

Keanna—[sharing a photo] That is my fiancé, Phillip . . . next month we are getting married. I plan to go back to school; I want to go to college. I want to get my master's or an associate degree. I have not really pinpointed it yet, but I am really interested in some form of communication, maybe television or radio. I have heard from a lot of people that I have the ability to touch others. I also believe that my story is something that I want to share with other people. Maybe it is something that would encourage other people to never give up. I would like to be a small part of someone else's accomplishment or someone else's success story because of something that I said or something that I shared about my hardship. I plan to go back to school and pursue whatever it is that I need.

Susan—I am fully confident that you will do it. All of our moms were very eloquent and able to describe their successes. What was so moving was to be able to understand the inner strength that the moms have and that you have. That is what makes you a success. What would you suggest for other people who are trying to help other young women in your same situation?

Keanna—One of the things in the beginning that made me kind of hesitant was the fear of being judged; the fear that someone would be there but were not actually listening to me. I would say to anyone who is trying to help someone, just listen to them. Do not be judgmental. When a person feels that they are being judged, they feel that they cannot open up and will build a wall that will not let you get through to them. If you can't get through to them to try to help them realize the potential that they have, they may never find it or it may take too long to find it. Just be someone for them to talk to; just listen to us.

Susan—What would you say are some of the most powerful things that occurred to you along your journey in the last 3 years? What are some significant things that you feel most proud about?

Keanna—I feel very proud of the fact that I got my GED. That was a tremendous accomplishment for me because when I first left high school, I did not see myself going back. I am very proud of that. I have a

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The purpose of reflective practice is to explore feelings and clarify thoughts about the work so team members can see their work more clearly.

stronger tolerance for things now. My determination is stronger than ever. I realize my potential, which is something that I lost sight of. I realize how much love I have for myself. This was something that I also lost. I am excited to see what is in store for me. I am ready for it!

Susan—One of the things that FACT is looking at is when we talk about the moms who graduated, how do we continue to support them? One of the moms was saying that she wished that she was not graduating because she does not want to leave. I spoke with Kathy, the project director, and they are trying to get something like an alumni group. It sounds as if you are talking about trying to help someone else, and I think that there is, clearly, a place for you to do that [helping other young moms]. You are still very young, yourself, and you are trying to maneuver all of the kids and all of the situations and I think that that is something that we look forward to you participating in—being able to help other moms.

The FACT Program

The FACT program focuses on the relationship between the caregiver and the child and on the impact of homelessness and trauma on the participant and their children. The FACT program targets young moms from 18 to 25 years old who have one child 5 years old or younger. These mothers are homeless or at risk of being homeless. They have a diagnosis of some sort of mental health issue or substance use issue or some type of domestic violence exposure. Many also have a history of foster care or State of Illinois Department of Children and Family Services involvement or are coming from an environment where there are limited resources.

FACT uses a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness who do not readily benefit from clinic-based services. The FACT team focuses on the hardest to serve mothers (18-25 years old) who meet the criteria listed above. Almost half of the participants who have worked with FACT have been involved in the child welfare system. FACT interventions are evidenced-based and are grounded in Beacon's philosophy of care which incorporates trauma-informed care and uses harm reduction principles, reflective practice, and strength-based models of relationship building to promote community stability and family functioning while respecting and affirming diversity (Beacon Therapeutic, 2013; Lieberman, 2007).

A Practitioner's Perspective on a Resilient Mother

One of the first participants that FACT worked with was Keanna Murphy. Ms. Murphy is also one of the most resourceful participants that FACT has worked with. The struggles that she went through and the outlook that she has on life are truly inspiring. It has been said that it takes a village, and the story of Ms. Murphy and the FACT team really embodies that proverb.

When Ms. Murphy first came into contact with the FACT team in 2008 she had been living in a shelter. She had come into contact with so many other programs that were unable to provide the support that she needed that she seemed discouraged. She was in need of someone to listen to her, to support her, and to educate her on the resources and services that were available to her and her children. From the beginning, Ms. Murphy was open to the team and always made sure that she was using all of the resources and meeting with staff on a regular basis. She met with the housing specialist, the case manager, the therapists, and the children specialists and talked to each team member about her goals. Her main goal was always to provide for her children to make sure that they had all that they needed. She was focused on being a good mother, making sure that her children were safe and that she protected them in every way that she knew how.

Ms. Murphy is strong and resilient, and she was open to the possibility that the team would work with her where she was at, at her own pace, on her own terms. She would talk about what she wanted, and the team would listen and provide the resources and the supports that she needed. Each time the team met with Ms. Murphy she began to build trust with the team and she would talk more about the barriers that she had in her life. She began to tell more of her story and to talk more in detail about her life and the path that she had been down.

Eventually Ms. Murphy found suitable housing and her children had a home. Staff members began to help her cook, budget, and manage a household. The team used every chance to work with her on her needs and the needs she had for her children. Ms. Murphy still remains in contact with FACT, she remains in a housing unit, and she still has her children in her care and is providing for them. She maintains a job and her children are in school or in care when she is at work. She still struggles from time to time and has learned how to use her supports when she encounters one of life's barriers. However, now she has the confidence and the tools to be successful on her life journey.

Reflections From a Team Member

The most important aspect in the work that was done with Ms. Murphy was how the team was able to build a cohesive support system that was unconditional and was built on real pure trust. Trust in knowing that the hard things needed to be talked about, trust in knowing that honest truth may hurt, and trust in knowing that what needed to be said would be said. Knowing that trust isn't given, it is earned over time, is important. Learning that over time Ms. Murphy was going to open up and share what she was comfortable sharing was important. I learned that always being thankful for her honesty, whether it was immediate or if she waited to share until a bit later,

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was important. I also learned that there is a correlation between trust and the amount of time that it takes for someone to share. It is a simple correlation; the more trust, the shorter the time it takes to share. As trust was growing, when significant events happened, the less time it took for her to share and the more she was trusting the relationship. In return, Ms. Murphy was able to talk to the team about what she needed from the team and she was also able to talk to the team about what she didn't need as well. There were times that Ms. Murphy needed more support, and she was able to ask the team for it. There were also times when Ms. Murphy may have needed space and the team was also able to do that for her as well. For her to be able to tell the team honestly what was happening in her life helped her to be able to get through the hard times and celebrate the good times and to always focus on her priority of being a good parent.

The Role of Reflective Practice and Supervision

Just as the families in programs like FACT need support, all staff, supervisors, and managers involved with these families also need support. As the families struggle, the team members feel their struggles. Team members feel because they care. They worry about the parents. They worry about whether the children will be safe. The unrelenting stress associated with families confronting ongoing problems is exhausting for those of who work with them. This stress has been called compassion fatigue (Lipsky & Burk, 2009). If practitioners don't learn how to cope effectively with the stress, it can lead to burnout. Self-care is a form of support that is essential for helping professionals.

Steven Covey's concept of "Circle of Concern" versus "Circle of Influence" provides a window into effective coping (Covey, 1990). The Circle of Concern includes those things the team worries about over which they have no control. The Circle of Influence represents the issues team members can affect that fall within their role. Intense feelings are the erasers of role boundaries. The stress associated with caring causes team members to focus their attention on the Circle of Concern and neglect the Circle of Influence. Team members put their efforts into areas over which they have no control and hence feel ineffective. Team members try even harder to affect what they cannot change, and feel more ineffective. This is the cycle that leads to burnout. Maintaining role boundaries is the foundation of effective practice. How do team members do this? How do they cope with the stress?

There are many examples of conventional wisdom that recognize this problem and offer coping strategies: For example, "When you are in a hole, stop digging" and the Alcoholics Anonymous Serenity Prayer "God grant me the serenity to accept the things I cannot change (Circle of Concern), the courage to change the things I can (Circle of Influence), and the wisdom to know the difference." This wisdom comes in the form of reflective practice.

Since Fenichel's (1992) seminal publication of *Learning Through Supervision and Mentorship*, there has been increasing awareness of the importance of integrating reflective practice into infant, toddler, and early childhood programs (Bernstein & Edwards, 2012; Gilkerson, 2004; Heffron & Murch, 2010). Reflective practice provides support to the staff, supervisors, and managers who regularly provide services to families. One of the authors (VB) has facilitated a reflective practice group with the FACT program since its inception. (See box Reflective Group Structure for a description of the group process.) It is important to note that, for reflective practice to be the most effective, management must commit to it. Providing resources for reflective practice were written into the original FACT program grant proposal, and once the grant ended, the agency continued to support reflective practice.

The stress that leads to intense feelings distorts understanding by blurring the perception of what is actually happening in the work. The purpose of reflective practice is to explore feelings and clarify thoughts about the work so team members can see their work more clearly (R. Borden, personal communication, April 2013). Through the supportive relationships of clinical supervisors and peers, team members can share feelings and in the process of sharing them, the feelings become less intense. One of the tenets of relational-cultural theory—the experience of the relationship, of being listened to and empathized with—allows the team to become more objective in their understanding of their work (Comstock & Qin, 2005). They are less reactive and consumed by what is happening in the moment (Munro, 1999). Through the relational support of others, they are able to answer the questions: What is going on in my work when I'm feeling stressed or ineffective? What is going on in my work when I am feeling good or effective? How do I understand this difference?

A Strengths-Based Approach

A principle of effective practice is that one must identify and build on what is working (i.e., build on strengths; Lieberman, 2007). However, one can only build on what is working if those positive moments are not hidden by intensely negative feelings. Practitioners need reflective practice to see their work from a different perspective, one that includes positive experiences and helps to identify what is working well. In the 5 years that the reflective supervision group met, feedback from the FACT team has generally been positive. One participant said, "It is so helpful to slow down, take a breath, and think in depth about the work."

Learn More

Interview
Listen to the full interview with Keanna Murphy by Susan Reyna Guerrero, president and CEO of Beacon Therapeutic Diagnostic and Treatment Center.
http://blip.tv/beacon-therapeutic/keanna-fact-program-success-story-5679056

Reflective Supervision Resources

A Practical Guide to Reflective Supervision
S. S. Heller & L. Gilkerson (2009)
Washington, DC: ZERO TO THREE

Look, Listen, & Learn: Reflective Supervision and Relationship-Based Work
R. Parlakian (2001)
Washington, DC: ZERO TO THREE

Reflective Supervision: Stories From the Field
R. Parlakian (2002)
Washington, DC: ZERO TO THREE

Reflective Practice Enhances Public Health Nurse Implementation of Nurse Family Partnership
R. J. Beam, R. A. O'Brien, & M. Neal. (2010). Public Health Nursing, *27*(2), *131139.*

On-line Resources

Reflective Supervision: A Tool for Relationship-Based EHS Services (Technical Assistance Paper No. 13)
Early Head Start National Resource Center at ZERO TO THREE. (2010). Washington, DC: U.S. Department of Health and Human Services.
http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/Early%20Head%20Start/supervision/supervision/AToolforRelati.htm

Victor Bernstein Website
https://webshare.uchicago.edu/xythoswfs/webview/fileManager?stk=&entryName=%2Fusers%2Fvbernste%2FPublic&msgStatus=
Dr. Bernstein offers a list of resources for reflective practice. If this link is inaccessible, email vbernste@uchicgao.edu for a "ticket" link.

Finding The Words, Finding the Ways: Exploring Reflective Supervision and Facilitation—DVD and Training Manual
M. C. Heffron & T. Murch (2012)
www.wested.org/resources/finding-the-words-finding-the-ways-exploring-reflective-supervision-and-facilitation/?doing_wp_cron=1379525786.2199580669403076171875

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Reflective Group Structure

The following structure was created for reflective supervision with the Family Assertive Community Treatment (FACT) team by Victor Bernstein in 2010. The agenda was intentionally made to be flexible to provide a framework to begin each session but from which the members could deviate depending on the needs of the group that day.

1. Centering ourselves—readiness to be present. Begin with the "478" breathing exercise (inhale through the nose for 4 seconds, hold your breath for 7 seconds, exhale slowly through the mouth for 8 seconds). Repeat 4–5 times.
2. Check in with ourselves—optional sharing of where each participant is at.
3. Emphasize the need to include a focus on what has been enjoyable, positive, or effective in the work to keep a balance.
4. Sharing stories of effective practice—especially things that have improved over the past month.
5. Updates (if staff choose to do so) on families that have recently been discussed.
6. Identify stories of the family work to share and reflect on. One where there may be a struggle and one family where things are on track. It is important to keep a balance.
7. Debrief—what was discussed today that staff want to carry into their work in the upcoming month?

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Conclusion

The concept of "parental self-efficacy" refers to a parent's belief in his ability to effectively manage the multiple demands, tasks, and situations of parenthood (Sanders & Woolley, 2005). Through a team of therapeutic relationships, Ms. Murphy was able to reconnect with unconscious benevolent figures (Lieberman, Padrón, Van Horn, & Harris, 2005) and aspects of her early experiences. Despite the multitude of adverse circumstances faced by this mother, she had strengths that formed the foundation of her resilience. Ms. Murphy's experience with the Beacon FACT program enhanced her sense of self-efficacy.

Early intervention and support programs such as The Nurse–Family Partnership home visiting and Early Head Start have demonstrated effectiveness in preventing and strengthening at-risk families with many beneficial outcomes for children (Boris et al., 2006). However, challenges that have yet to be addressed include ways of engaging parents and ways for programs to overcome system barriers to the participation of their clients in services that specifically address their mental health (Golden et al., 2013; Ghosh-Ippen & Lewis, 2011). The FACT program was able to engage Ms. Murphy through a number of relationship-based practices that contributed to her resilience. The FACT team was responsive, warm, and provided a consistent context for growth in their relationship with her. Ms. Murphy followed her own unique pattern of failure and growth. They followed the lead of Ms. Murphy's expressed needs, not a mandatory, cookie cutter, treatment protocol. Similarly, the FACT team received the regular, warm, and supportive services for their professional growth through reflective supervision.

Ms. Murphy stated that the FACT agency provided "stepping stones" for her to succeed. In Ms. Murphy's words, it was her nurturing relationships with a "dream team" from the FACT agency that was central to her resilience. At the completion of service, Beacon Therapeutic hosted a live TV call-in show with Ms. Murphy as an example of one of the FACT project's many success stories. Ms. Murphy's response to a caller offers inspiration for other parents facing similar challenges:

Caller—You have a fascinating story. What advice would you give to someone who was maybe in your shoes 5 years ago? What would you tell them to do now?

Keanna—What I would tell them to do now is to, basically, believe in yourself. Never stop loving yourself; never feel that because you have made a mistake or because you did not make a right decision that does not make you capable of succeeding—that you are unable to accomplish because you made a mistake. Never give up on your dreams! Never give up on your desires! You can do whatever it is that you choose to do—whatever is in your heart! Whatever you feel your destiny is, just go for it. Do not stray from your path, because everybody has one.

Victor J. Bernstein, *PhD, teaches in the Family Support Program in the School of Social Service Administration at the University of Chicago. His principal interest is in using reflective practice to strengthen relationships in parallel: the trainer–trainee, supervisor–staff, and parent–child relationships in order to improve the developmental outcomes in children born at risk. He provides reflective consultation to program managers, supervisors, and staff from a variety of family support, Early Head Start, early intervention birth-to-3, special education, child welfare, and drug treatment programs.*

Marva L. Lewis, *PhD, is an associate professor at Tulane University with a doctorate in sociocultural psychology. Her past clinical experience includes work psychotherapist on an interdisciplinary team working with high risk infants placed in foster care in Colorado and Louisiana and work as a child protection social worker. Her scholarship focuses on the hair-combing task as a context for research, assessment, and intervention with caregivers and young children.*

Kathy Daniher, *MA, LCPC, is the director of Homeless Outreach Services at Beacon Therapeutic. She utilizes a strengths-based trauma-informed approach in providing clinical services to young children, adolescents, and families. She also uses the principles of harm reduction and reflective practice. She provides trainings to agencies that are interested in incorporating harm reduction, strengths-based, and trauma-informed practices into their work.*

Keanna Murphy, *was a participant in the FACT program at Beacon Therapeutic Diagnostic and Treatment Center in Chicago, IL from 2008 until her graduation in 2011. She was the commencement speaker at her graduation ceremony on October 24, 2011. She is a wife and mother of three children.*

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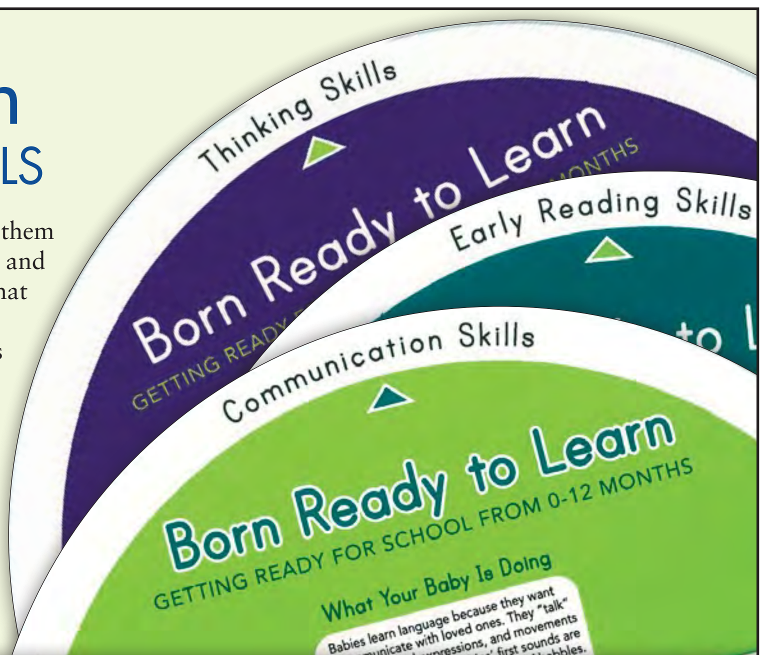

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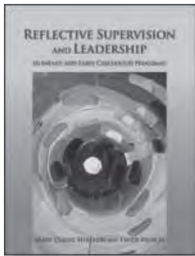

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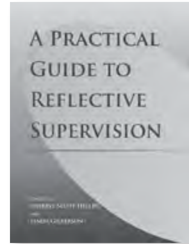

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Parenting Interventions in Early Head Start

The Buffering Toxic Stress Consortium

CONSORTIUM PRINCIPAL INVESTIGATORS*

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Research during the past decade has provided increasingly compelling evidence about the detrimental effects of early adversity on lifetime health and well-being (Odjers & Jaffee, 2013). Some researchers have posited that the multiple and chronic stressors associated with poverty help to account for the gap in school performance between children from low-income families and their more advantaged peers (Blair, Granger et al., 2011; Shonkoff, Boyce, & McEwen, 2009). Among these stressors are child maltreatment and domestic violence, which often occur in contexts of financial insecurity, dangerous neighborhoods, and under-resourced communities (Jaffee & Maikovich-Fong, 2011). At the same time, the developmental plasticity that makes early adversity so influential for health and well-being also enhances the importance of early preventive interventions. Parenting interventions are especially crucial as parents are a critical buffer against early adversity. The Buffering Toxic Stress Consortium was created by the Office of Planning, Research and Evaluation within the Administration for Children and Families (ACF) to test preventive interventions for low-income families facing toxic stress as conceptualized by Shonkoff et al. (2009). Each promising preventive intervention directly targets parenting. In this article we review the concept of toxic stress, discuss the rationale for the development of the Buffering Toxic Stress Consortium, and provide an overview of the six Buffering Toxic Stress intervention research studies.

Abstract

The Buffering Toxic Stress Consortium was created by the Office of Planning, Research and Evaluation within the Administration for Children and Families to test preventive interventions for Early Head Start families facing toxic stress, as conceptualized by Shonkoff, Boyce, and McEwen in their influential 2009 article. Because relationships between children and their primary caregivers are believed to be the most important buffer for children facing high stress, each promising preventive intervention targets parenting. Consortium projects aim to validate empirical assessments of toxic stress, test the value added of supplemental parenting services, and assess implementation and long-term sustainability of these services.

* AUTHOR NOTE: *Consortium Principal Investigators are, in alphabetical order, Lisa Berlin, University of Maryland; Clancy Blair, New York University; Misty Boyd, Cherokee Nation; John N. Constantino, Washington University; Rena A. Hallam, University of Delaware; Myae Han, University of Delaware; Jason T. Hustedt, University of Delaware; Brenda Jones Harden, University of Maryland; C. Cybele Raver, New York University; Michelle Sarche, University of Colorado Anschutz Medical Campus; Jennifer A. Vu, University of Delaware; and Sarah Enos Watamura, University of Denver.*

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Parents are a critical buffer against early adversity.

Toxic Stress and the Hypothalamic-Pituitary-Adrenal-Axis

Reviewing decades of empirical work, Shonkoff et al. (2009) provided a heuristic framework in which they identified three types of stress in early childhood: positive, tolerable, and toxic. *Toxic stress* is defined as "strong, frequent, and/or prolonged activation of the body's stress-response systems in the absence of the buffering protection of adult support" (Shonkoff et al., 2009, p. 5). In this framework, the difference between tolerable and toxic stress lies primarily in the availability of a supportive adult, in that "*Tolerable stress* refers to a physiological state that could potentially disrupt brain architecture ... but is buffered by supportive relationships that facilitate adaptive coping" (Shonkoff et al., 2009, p. 4). This framework integrates work from animal models and human studies that together highlight the critical role of primary caregivers early in life for shaping neurobiological systems that (a) regulate stress, (b) attend to and recognize danger, (c) allocate metabolic resources, and (d) influence growth and learning potential.

The toxic stress framework emphasizes the HPA axis—a complex system with interactions among the hypothalamus, the pituitary gland, and the adrenal glands—which produces cortisol (a steroid hormone involved in metabolism, management of stress and challenge, and regulation of other key body systems) as one final common pathway through which toxic stress gets "under the skin" to compromise well-being (Gunnar & Vazquez, 2006). Although activation of the HPA-axis is highly adaptive for the individual facing acute threat, chronic activation of this stress system results in damage throughout the body. With chronic stress, systems for managing stress become overused and this overuse can directly result in fat deposit around the midline (Thakore, Richards, Reznek, Martin, & Dinan, 1997), a dampened immune system (Fan et al., 2009), increasing sensitivity to stress (Schuder, 2005), and possible changes in thoughts and behavior (Shirtcliff & Essex, 2008; Whiteford, Peabody, Csernansky, Warner, & Berger, 1987). Together these changes appear to increase risk for a number of chronic physical health conditions (e.g., heart disease, diabetes), and psychological problems (e.g., depression, anxiety). Ultimately this sort of chronic stress can reduce both quality of life and life expectancy (Brown, Varghese, & McEwen, 2004; Seeman, Singer, Rowe, Horwitz, & McEwen, 1997).

Importance of the Caregiver–Child Relationship

Both animal and human research emphasizes the importance of supportive and sensitive relationships with adults. Studies of infant–parent attachment, in particular, have established associations between an infant's attachment security and multiple aspects of early and later development, including higher quality social skills and peer relationships and fewer behavior and mental health problems from preschool through adolescence (Berlin, Cassidy, & Appleyard, 2008). Moreover, early child–caregiver relationships may serve as a buffer against the overactivation of the HPA-axis and can protect the developing system from the potentially harmful effects of toxic stress (Cirulli, & Alleva, 2003; Gunnar & Donzella, 2002; Luthar & Brown, 2007; Shonkoff et al., 2009). Inherent in the concept of developmental plasticity is the idea that there are sensitive periods in children's early years when preventive measures in interventions can have a more profound effect on children's development. If children do not receive development-promoting experiences during these sensitive periods, it may be more difficult to restore normal functioning later (Fox, Levitt, & Nelson, 2010; National Scientific Council on the Developing Child, 2010). For example, studies have shown that securely attached children do not demonstrate elevated cortisol reactivity in stressful situations whereas insecurely attached children have difficulty using their parents' presence to prevent cortisol increases in similar situations (Loman, Gunnar, & the Early Experience, Stress, and Neurobehavioral Development Center, 2010).

Interventions targeting the child–parent relationship, specifically to encourage more sensitive and responsive parental behaviors, have demonstrated positive effects on increasing supportive parenting behaviors and on counteracting cortisol hyperactivity (Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008). This discovery emphasizes the role that caregiving can play in lifelong health, as well as the importance of parenting interventions during early childhood. Members of the Buffering Toxic Stress Consortium (see description on p. 75) have selected different parenting interventions aimed at enhancing the child–caregiver relationship with the hope that improved parental buffering may then reduce the effects of toxic stress.

Preventive Interventions and Early Head Start (EHS)

The past 20 years have witnessed the proliferation of EHS and other publicly funded programs designed to promote early child development in at-risk families (National Research Council & Institute of Medicine, 2000; Shonkoff & Richter, 2013). Supporting early child–parent relationships is a prominent goal of such programs. Program evaluations have demonstrated important benefits for children and families, including enhanced parent–child relationships. Specifically, the Early Head Start Research and Evaluation Project (EHSREP) randomized trial of 3,000 low-income families revealed numerous, if modest, program effects on children's cognition, language, and behavior problems at 3 years old (Administration for Children & Families [ACF], 2002; Love et al., 2005).

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In regard to parenting behavior, compared to randomly assigned control participants, EHS mothers were observed to be more supportive (i.e., sensitive, positive, and cognitively stimulating) toward their children, who, similarly, were observed to be more engaged with their mothers. Moreover, EHS children received fewer spankings than did control children, and they were reported by their mothers to be less aggressive. Data from the EHSREP have also revealed that enhancing parenting among EHS families is an important mechanism for improving participant children's school readiness (Chazan-Cohen et al., 2009).

EHS and similar programs are broad-based in terms of the populations they serve, and no program is equally effective for all participants. Several analyses have begun to illuminate subgroups for which EHS is more and less efficacious (Raikes, Vogel, & Love, 2013). For example, analysis of the full EHSREP sample indicated smaller program effects for those children whose mothers were classified as "high risk" (ACF, 2002) based on an array of sociodemographic factors. Researchers have also examined the moderating role of baseline maternal depression, attachment style, or both. In the EHSREP, program impacts on child–parent interaction were greater when mothers initially reported higher levels of depressive symptoms than when mothers reported lower levels (ACF, 2002). In a study of participants from six sites of the EHSREP, findings suggested more positive program effects for mothers with less initial self-reported attachment avoidance or attachment anxiety (Berlin et al., 2011).

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Studies of infant–parent attachment have established associations between an infant's attachment security and multiple aspects of early and later development.

The Buffering Toxic Stress Consortium

In light of Shonkoff and colleagues' (2009) toxic stress framework and the existing research on EHS, in 2011 the Office of Planning, Research, and Evaluation called for research proposals to test promising interventions aimed at mitigating the effects of toxic stress among the highest risk children enrolled in EHS. The funded projects are known collectively as the Buffering Toxic Stress Consortium. The Consortium is a group of scholars from six sites across the nation, each addressing the following common core elements in partnership with local EHS programs: (a) validating proposed risk factors as indicators of toxic stress; (b) testing the value added to EHS of supplemental parenting services; and (c) carefully assessing the implementation and long-term sustainability of the supplemental interventions. Each of these pilot projects has a unique focus and thus individual methods and measures. However, the Consortium has also worked to create a common set of measures across all six sites, including required assessment of the hormone cortisol (see Apprendix A), as well as additional common measures as appropriate across smaller subsets of sites (see Appendix B). Each site's chosen supplemental intervention(s) is(are) described (see Appendix C).

ACF anticipates three benefits of conducting a series of connected pilot studies. First, because EHS is designed as a program with heavy community and family involvement and does not insist on a one-size-fits-all model, the Consortium projects were similarly allowed to be responsive to differing community needs. The sites selected by ACF differ in a number of ways including racial and ethnic composition, population density of their surrounding areas, and the ways EHS services are delivered. Second, because several interventions are tested simultaneously, though not comparatively, the Consortium serves as a set of demonstration projects to launch future, more comprehensive examinations of promising approaches. Third, because a core aim is to build the knowledge base on how parenting protects children from adversity, the Consortium will contribute to the empirical validation of the construct of toxic stress through a variety of measurement approaches used by a diverse group of scholars. To best support creative and generative validation for future work, individual sites will use both site-specific measures and those that are appropriate across all study locations and samples. This approach also allows families enrolled in study sites to receive interventions their EHS programs feel are complementary to services already provided, which is consistent with ACF's strong service- and family-oriented mission. Thus, results from this research will help build a cumulative knowledge base regarding the role EHS can play in promoting parenting practices that buffer children from toxic stress.

Details for Each Individual Study Site

The following section provides a brief overview of the research approaches being used by each of the six Consortium grantees.

New York University

The New York University (NYU) project is entitled "The ABC Intervention in EHS Programs." The NYU team is led by principal investigator Clancy Blair and co-principal investigator C. Cybele Raver, in collaboration with Susan Landry, director of the Children's Learning Institute at the University of Texas Houston. On the basis of Blair and colleagues' previous studies linking poverty, caregiving quality, child cortisol levels, and executive functioning (Blair, 2010; Blair & Raver, 2012), the NYU team is pursuing three aims: (a) determining the extent to which multiple forms of disadvantage serve as multiple forms of toxic stress where concomitant disruptions in parenting quality may mediate some of the effect of extreme disadvantage on stress physiology biomarkers in young children; (b) examining the conditions under which Landry's Play and Learning Strategies (PALS)

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parenting intervention can be implemented with a high level of fidelity with home visitors and families enrolled in EHS programs; and (c) using a randomized, controlled design to test whether PALS (for those EHS-enrolled families randomly assigned to the treatment group) is associated with measurable benefits in parenting, child stress physiology biomarkers, and higher levels of toddler attention and emotion regulation (relative to families randomly assigned to the control group).

The sample which is being enrolled in NYU's ABC PALS project is primarily composed of low-income, Latina mothers and their children from 18 to 36 months old, where families are recruited, served, and engaged as research participants through a productive and sustained partnership with three EHS grantees in New York City. Each program currently conducts home-based services with highly economically disadvantaged families in neighborhoods of concentrated poverty, with a well-trained, stable home-visiting workforce, and supportive administrative leadership. Families are assessed along multiple dimensions of (a) exposure to a host of material, psychosocial, and neighborhood stressors; (b) attendance and engagement in a range of services offered by the ABC PALS program collaborating partners as well as by other community-based organizations in the city; (c) quality of parent–child interaction; (d) child stress physiology; and (e) child self-regulatory outcomes. Assessments occur at pre-test (T1) 2 to 6 weeks prior to engagement in the ABC PALS intervention condition or control "care as usual" and at short-term (T2, or 6 months after enrollment and immediately after the completion of the 14-week intervention) and longer-term (T3 post-test assessments 12 months after enrollment) intervals.

To evaluate the efficacy of the intervention, all parent–child interaction and child outcome data will be analyzed using an intent-to-treat model. In so doing, this longitudinal, experimental design will allow the NYU team to estimate the causal impact of the ABC PALS intervention on (a) parenting practices that may buffer children from toxic stress and (b) on aspects of children's reactivity and regulation in the context of poverty that are potentially indicative of physiological and behavioral markers of toxic stress. This design also offers the NYU team the opportunity for extensive measurement and modeling of young children's exposure to toxic stress and of ways that caregiving may be compromised in those conditions of extreme economic and environmental adversity.

> Although activation of the HPA-axis is highly adaptive for the individual facing acute threat, chronic activation of this stress system results in damage throughout the body.

University of Colorado

The University of Colorado Anschutz Medical Campus (CU-AMC) project is entitled "Evaluation of Parent Child Interaction Therapy and the Emotional Availability Intervention: Mitigating Toxic Stress Among American Indian Children in Early Head Start." The CU-AMC team is led by principal investigators Michelle Sarche and Misty Boyd, with co-investigators Dolores BigFoot and Beverly Funderburk (University of Oklahoma Health Sciences Center), Zeynep Biringen (Colorado State University), and Bob Emde, Mark Laudenslager, and Nancy Whitesell (CU-AMC). Parent Child Interaction Therapy (PCIT) and Mindfulness-Based Emotional Availability Intervention (MEAI) were selected to increase parenting practices that may buffer children from family and environmental stress.

PCIT is a short-term, evidence-based intervention that has shown clear effects in decreasing a broad range of behavioral, social, and family problems among children 2-6 years old (Eyberg, 1988) by focusing on changing parent–child interaction patterns through live coaching. The first of two phases is Child Directed Interaction, during which parents are taught to follow the child's lead in play using specific skills such as praise and running descriptions. Once mastery is obtained, the second phase, Parent-Directed Interaction, begins. In Parent-Directed Interaction parents are taught behavioral management techniques. Treatment duration averages 15 sessions and is guided by assessment of the parent's mastery of targeted skills and the child's behavior falling within the normal range (Neary & Eyberg, 2002). PCIT draws from social learning theory (Patterson, 1975; Sansbury & Wahler, 1992) and attachment theory to encourage a balance of nurturance and structure in the parent–child relationship. PCIT has been adapted for American Indian families by Drs. BigFoot and Funderburk (BigFoot & Funderburk, 2011).

MEAI will be tested as an augmentation to PCIT, occurring between the child's first and second year prior to the initiation of PCIT and before PCIT is age-appropriate. MEAI focuses on parenting practices and teaches parent stress management and exercises to remain in the moment, and it is hypothesized to enhance emotional availability in the mother-child relationship— a protective factor in children's development (Thomas & Zimmer Gembeck, 2011). The intervention (Biringen, 2008) is a step-by-step, manualized 4-session group-format program provided by MEAI-trained instructor(s). Each session begins and ends with mindfulness exercises designed to prepare the parent's biology for optimal interactions with the child, including 3-minute breathing, body scan, and other embodiment exercises (Segal, Williams, & Teasdale, 2002). Additional sessions focus on learning about and practicing the skills to promote attachment and emotional availability, by reviewing instructional videos, role model videos, as well as videos of the group members. Between sessions, parents complete questions and activities in a parent workbook and practice mindfulness with their children in everyday activities (Biringen, 2008).

The CU-AMC site represents a partnership with an American Indian EHS program serving more than 200 children between 6 weeks and 3 years old and their families in a center-based program. All parents of children 10-24 months old at the time of study enrollment will be invited to participate in a multiple baseline approach using longitudinal growth-modeling statistical procedures to test the effects of PCIT alone or PCIT with an MEAI enhancement on three main outcomes: emotional availability, externalizing behavior among children, and hair cortisol among parents and children. Three baseline (pre-intervention) assessments will be conducted: at study enrollment, 3 months post-enrollment, and 6 months post-enrollment. At 6 months post-study enrollment (after the third baseline assessment), parents will be randomly assigned to MEAI or no MEAI; at 12 months post-study enrollment, all parents and children will be invited to receive PCIT. Post-intervention enrollment assessments will be conducted at 12-, 18-, and 24-months post *study* enrollment. A total of 6 assessments will be conducted for each participant (3 pre-intervention and 3 post-intervention).

The CU-AMC site includes added measures of parental substance use and substance use among adults in the child's home, food and resource insecurity, demographic composition of the home, perceived socioeconomic standing, parent and child physical health (including prenatally), child social–emotional development and behavior, parent–child relationship, parent history of trauma (including American Indian historical trauma), and hair cortisol.

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University of Delaware

The University of Delaware (UD) project is entitled "Starting at Home: Incorporating a Parent-Child Interaction Intervention Into EHS Home Visiting." The UD team is led by principal investigator Jason Hustedt, with co-principal investigators Rena Hallam, Myae Han, and Jennifer Vu, and in collaboration with Douglas Granger (Institute for Interdisciplinary Salivary Bioscience Research at the Arizona State University) and Roger Mills-Koonce (University of North Carolina). The selected intervention is Promoting First Relationships (PFR; Kelly, Zuckerman, Sandoval, & Buehlman, 2008; Maher, Kelly, & Scarpa, 2008; Spieker, Oxford, Kelly, Nelson, & Fleming, 2012) and PFR researchers at the University of Washington will also provide support for this project. PFR is aimed at training community-based service providers to work with caregivers so they are more effective in meeting their children's social–emotional needs. This focus on community providers is particularly relevant to the UD project goal of integrating a parent–child intervention as a component of EHS home visits.

The PFR model uses a relational perspective on early social–emotional development, whereby emotional health is achieved through attachment (a nurturing caregiver–child relationship), development of self, and emotion regulation (Kelly et al., 2008). PFR is a manualized intervention with 10 sessions. EHS home visitors reach fidelity after a training process focusing on consultation strategies used when serving families. When implementing the PFR intervention, home visitors videotape approximately 20 minutes of interactions within the mother–child dyad during sessions 1, 3, 5, 7, and 9. During alternate weeks, home visitors review the entire video clip from the previous week together with the mother and provide feedback based on identified strengths. The PFR intervention focuses on promoting five qualities in parents when interacting with their children: (a) offering love and attention every day, (b) responding with empathy and understanding, (c) providing comfort when upset, (d) offering a predictable world, and (e) promoting play and exploration (Kelly et al., 2008). The UD study will compare families receiving a "business as usual" approach at the EHS partnering agency, which follows the curriculum from Parents as Teachers (PAT; Drotar, Robinson, Jeavons, & Lester Kirchner, 2009), with families receiving the PFR intervention in addition to PAT.

A unique feature of this study is that the population to be served is enrolled in an EHS program operated by UD, and PFR will be implemented by current home visitors from the EHS program. This program includes multiple home- and center-based sites. It is expected that the UD study will enroll up to 200 families in a treatment group receiving the 10–session PFR intervention and up to 100 families in a wait-list control group. In the control group, data will be collected as families receive the PAT curriculum without receiving the intervention during a period of approximately 12 weeks (the anticipated average participation time for treatment group families). On the basis of program data from the UD sites, the anticipated sample will be approximately 45% African American, 35% of Hispanic or Latino origin, and 15% White. The majority of families who are of Hispanic or Latino origin in this population speak Spanish as their primary language. Children will be between 6 and 34 months old upon entry into the UD study.

In addition to using the common Consortium measures, this study will also gather data about potential family protective factors, including social support as well as available family and neighborhood resources, and will examine child language. In addition, an initial validation study will be conducted at the outset of the project to explore risk and stress levels within the local EHS population. This project includes a focus on coaching and professional development among home visitors as well as an emphasis on sustainability at the EHS partner program after the conclusion of the research study.

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Studies have shown that securely attached children do not demonstrate elevated cortisol reactivity in stressful situations.

University of Denver

The University of Denver (DU) project is entitled "A Microsocial Video-Coaching Intervention for Toxically Stressed Early Head Start Families." The DU team is led by principal investigator Sarah Watamura, in collaboration with co-investigators Philip Fisher, at the University of Oregon, and Amanda Moreno, at the Erikson Institute. Dr. Fisher is responsible for all aspects of the intervention design, training and clinical supervision of intervention coaches, and implementation support. The intervention selected by Dr. Fisher is called Filming Interactions to Nurture Development (FIND), and has been developed by Dr. Fisher and colleagues working from the popular European intervention, Marte Meo (Wirtberg, Petitt, & Axberg, 2012). FIND is a strengths-based intervention that focuses on parent–child interactions that may directly activate the powerful physiologic underpinnings of securely bonded relationships. The core attachment bond in turn supports the child's health, well-being, growth and learning, in part by signaling to the child that this adult is available to buffer them from threats (Fisher & Kim, 2007). The intervention consists of 10 sessions which could be administered by trained EHS home visitors or outside coaches. In this project the DU team is using community therapists as coaches. For sessions 1, 3, 5, 7, and 9, the FIND coach videotapes the parent and child in regular daily

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routines (e.g., mealtimes, playtime; approximately 10 minutes) and then edits the clips to very short examples of positive microsocial interactions. In the weeks that follow the in-home videotaping (i.e., sessions 2, 4, etc.), coaches meet with parents to share the edited clips from the in-home videos. By building on positive microsocial exchanges, five basic elements of developmentally supportive parenting are enhanced, namely (a) sharing the child's focus, (b) supporting and encouraging, (c) naming, (d) back and forth, and (e) handling beginnings and endings of interactions. The FIND intervention will be tested both alone and in conjunction with 5-hours of parent-focused therapy or life-coaching as jointly determined by the parent and coach, referred to as Parent-Focused Support (PFS).

The population served by the DU team includes 360 families. Of these, approximately 90% are anticipated to be minority race or ethnicity, 80% of Hispanic ethnicity, and as many as 60% are expected to be immigrant families. At the time of initial recruitment, children will be 6–34 months old, and enrolled in one of 3 types of EHS programs: center-based, home-visitation, or a combined program. The study design entails first conducting a screening study to validate the toxic stress identifiers with 360 families. Half of these families are then selected for the intervention study, administered a pre-intervention assessment, and randomized into one of three groups (control, FIND, and FIND+PFS). Each control family's study duration is yoked to an intervention family. Following the intervention window (approximately 12–20 weeks), families will be administered a post-intervention assessment. Finally, 3 months following the post assessment, families are given a final assessment.

The DU site includes additional potential risk and protective factors, additional family background characteristics, and salivary cortisol collected both diurnally and in response to a challenge from both mothers and children. Salivary alpha-amylase is also collected across the challenge paradigm as an indicator of sympathetic nervous system activity (which produces the "flight or fight" response). Because of the DU study's focus on recent immigrant families, the study also includes measures of acculturation and immigration-specific stressors. For all families, the study includes objective and diary measures of sleep and sleep concerns, as well as measures of neighborhood safety, parenting efficacy, and both parent and child cognitive assessments.

University of Maryland

The University of Maryland (UMD) project, "Partners for Parenting" is co-led by Lisa Berlin (School of Social Work/Baltimore) and Brenda Jones Harden (Institute for Child Study/College Park). Scholarly collaborators include Mary Dozier (University of Delaware), Douglas Granger (Institute for Interdisciplinary Salivary Bioscience Research at the Arizona State University) and Roger Mills-Koonce and Cathi Propper (University of North Carolina). EHS program partners include four EHS programs in the greater Washington, DC, area that serve predominantly new immigrant Latino families. Together this team is implementing and evaluating Dozier's Attachment and Biobehavioral Catch-up (ABC) program provided supplementally to EHS children at relatively high risk for toxic stress. For this project, ABC providers are trained external consultants who coordinate carefully with EHS staff to provide additional services for a limited time.

> Because EHS is designed as a program with heavy community and family involvement and does not insist on a one-size-fits-all model, the Consortium projects were similarly allowed to be responsive to differing community needs.

The ABC program, developed by Mary Dozier, is strongly grounded in attachment theory and research, manualized, and supported by two randomized trials (Bernard et al., 2012; Dozier et al., 2009). The ABC program consists of 10 home-based sessions delivered by a trained parenting coach. Each session includes both the mother and her child together, addresses a specific topic, and includes at least some review of video-recorded mother–infant interaction from the previous session. Although brief, the ABC program is also intensive, providing explicit parenting coaching in reference to three specific behavioral targets: (a) nurturance, (b) following the child's lead, and (c) non-frightening caregiving behavior. In the context of ongoing dyadic interaction, ABC parenting coaches are trained to provide frequent "in-the-moment" comments about how maternal and child behaviors relate to each intervention target. These ongoing comments typically highlight areas of maternal or relational strength. They also aim to illustrate the effects of particular parenting behaviors on specific child behaviors and developmental outcomes. These in-the-moment comments intensively scaffold and encourage mothers and help to increase their most supportive parenting behaviors. Two sessions are devoted to the topic of "overriding" one's own history or non-nurturing instincts. As mothers begin to consider the connections between how they were parented and how they do and do not want to parent their own children, they become more aware of how they can override automatically elicited insensitive parenting behaviors. Thus, the ABC program simultaneously promotes supportive parenting behaviors and reduces modifiable risks for less supportive parenting. As sensitive, supportive parenting behaviors increase, they help to buffer children from external stressors. The parenting coaches' overall fidelity and specific commenting are monitored closely in weekly supervision provided in part by Dr. Dozier and her staff.

The population targeted by the UMD team consists of 270 adult (18 years or older) biological mothers of 6- to 18-month-old infants who have been receiving home-based EHS services for at least 3 months and who are not receiving supplemental early intervention (federal Part C) services. Upon completing a baseline psychosocial interview and observational assessment, a dyad is classified as high risk for toxic stress if they demonstrate or report any one of four indicators of potentially compromised parenting (i.e., observed parental harshness, child abuse or neglect, clinically elevated parenting stress, or self-reported attachment insecurity). High-risk dyads are randomly assigned to receive either ABC or the Book-of-the-Week program (90 dyads in each group). "Book-of-the-Week" refers to an extremely light "intervention" that is provided to control families for ethical reasons and to promote research engagement. Thus, the randomized evaluation focuses on higher-risk families only, comparing treatment (EHS + ABC) to control (EHS + Book-of-the-Week) dyads on key outcomes of observed parenting behavior and infant stress regulation. A third group (90 dyads) consists of a non-randomly assigned comparison group of lower-risk EHS dyads who are also provided the Book-of-the-Week program. The validation study will compare higher- and lower-risk EHS dyads' parenting behavior and stress regulation. Outcomes for all three groups will be assessed shortly after the completion of each program.

In addition to Consortium-wide assessments, the UMD study includes site-specific measures such as mothers' self-reports of attachment style and childhood trauma, mothers' reports of their child's exposure to trauma, and neighborhood collective efficacy. Supplemental outcome

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assessments will include maternal cortisol and both maternal and child heart rate collected during a free-play interaction and in response to two emotionally arousing activities.

Washington University

Washington University will implement the Incredible Years Toddler Basic Parenting Program (IYT), a group-based program for enhancing parenting skills and parent–child relationships, focusing on children between 12 and 36 months old. IYT is based on the Incredible Years Preschool and School Age Basic Parenting Programs, which, in multiple randomized controlled trials, have resulted in substantial reductions in symptoms of clinical-level disruptive behavior problems in children (e.g., conduct disorder) earning the highest scientific rating—1—from the California Evidence Based Clearinghouse for Child Welfare. Less is known about the impact of the more recently manualized program for toddlers; however beneficial effects of Incredible Years were recently reported in a large Head Start sample, irrespective of whether parents self-reported abuse or neglect of their children (Hurlburt, Nguyen, Reid, Webster-Stratton, & Zhang, 2013). IY has demonstrated efficacy in key outcome areas related to buffering toxic stress; increasing positive and nurturing parenting, reducing harsh, coercive and negative parenting; and increasing child positive behaviors, social competence, and school readiness (National Registry of Evidence Based Programs and Practices, 2007). The IYT program emphasizes child-directed play, emotion "coaching," praise and encouragement, and the management of common early childhood tasks such as dressing, compliance, sharing, eating, going to bed, toilet training, and gentle animal care. Parents are taught the importance of self-control and how to use calm-down strategies and positive self-talk (The Incredible Years Inc., 2013).

This project's sample is drawn from Youth In Need (YIN), a large EHS provider with headquarters in St. Louis, Missouri. A diverse region is served, including both urban inner-city (St. Louis), suburban (e.g., St. Charles County) and rural (mid-Missouri) populations. Targeted enrollment is a minimum of 110 experimental (IYT) participants and 55 control (treatment as usual) participants who are participating in the home-based EHS program. In the experimental condition, families with children 12–36 months old will still receive usual weekly home visits from YIN but the bi-weekly socialization group component will be supplemented by an adaptation of the IYT Program for a 6-month period (12 sessions). After completion of IYT, families will resume socialization groups as currently provided by YIN. IYT will be administered by group leaders from the Washington University School of Medicine who have been trained and research-certified in the IYT curriculum. YIN family educators will attend the group meetings, are provided written materials that summarize the lesson plans, and are encouraged to reinforce the principles of IYT training when they meet with the families in their homes.

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As sensitive, supportive parenting behaviors increase, they help to buffer children from external stressors.

A range of measures will be used to capture five general constructs: (a) sensitive-responsive caregiving by the parent, (b) the child's capacity for emotion regulation, (c) stress biomarkers including hair and salivary cortisol, (d) history and occurrence of officially reported child maltreatment, and (e) child behavioral outcome. Preliminary work on a pilot population has indicated that the intervention is well-received by parents and family educators and that it enhances participation in socialization groups. Pilot work in collaboration with the CU-AMC site has also indicated that cortisol levels can be feasibly assayed in hair, saliva, and urine in this population of children. Families in both the intervention and control groups will be asked to provide informed consent for administrative data from the State of Missouri to be accessed by the investigative team in order to complement the survey and biological data with official-report data on child abuse and neglect.

Conclusions and Timeline

The Buffering Toxic Stress Consortium projects were funded for the 5-year period of September 2011 through September 2016. In the first funding year, the Consortium focused on the selection and development of cross-site measures and refinement of individual site intervention and research plans. All sites have now begun collecting data and providing services to families in preventive interventions. Preliminary common site results are expected to become available beginning in 2015.

Although data will not be available for some time, initial field reports of the projects are promising. The collaborations between researchers and practitioners in the six sites have allowed targeted families to receive a supplemental parenting intervention in the context of ongoing EHS services. In this vein, the Buffering Toxic Stress Consortium is supporting a major goal of Head Start programs as articulated in the Head Start Parent Engagement Framework—to promote positive parent–child relationships (Administration for Children and Families, 2012). This collaborative work between researchers and EHS practitioners has the potential to make a substantial contribution to what is known about toxic stress in young children and about the interventions that may buffer children against the negative developmental outcomes emanating from early adverse experiences.

Buffering Toxic Stress Consortium Principal Investigators:

Lisa Berlin, *PhD, is an associate professor at the University of Maryland School of Social Work. Dr. Berlin is particularly interested in leveraging attachment theory, research, and*

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attachment-based intervention to support at-risk families with infants and young children. She conducts both evaluation research and descriptive studies designed to inform prevention and intervention services.

Clancy Blair, *PhD, is a professor in the Department of Applied Psychology at New York University. Clancy Blair is a developmental psychologist who studies self-regulation in young children. His primary interest concerns executive functions and the ways in which these aspects of cognition are important for school readiness and early school achievement. His federally funded research includes the development and evaluation of preschool and elementary school curricula designed to promote executive functions as a means of preventing school failure.*

Misty L. Boyd, *PhD, is a licensed clinical psychologist with a tribal behavioral health program, where she has worked for 20 years to bring effective, culturally resonant services to American Indian children and their families. In addition to providing clinical services, she has focused on developing child-serving programs and infrastructure to deliver best practices for child and family wellness.*

John N. Constantino, *MD, is the Blanche F. Ittleson Professor of Psychiatry and Pediatrics, and director of the Division of Child Psychiatry at Washington University in St. Louis. His efforts in the Buffering Toxic Stress Consortium are in close collaboration with colleagues at the Center for Violence and Injury Prevention at the Brown School of Social Work at Washington University: Melissa Jonson-Reid, PhD, Brett Drake, PhD, Patricia Kohl, PhD, and Laura Pons, MSW. Dr. Constantino's scientific contributions involve the development of effective methods for engaging stressed urban families in interventions to prevent child maltreatment and to promote infants' earliest social attachments. He has also developed quantitative methods for measuring inherited aspects of social development in childhood.*

Rena Hallam, *PhD, is an associate professor in the Department of Human Development and Family Studies and serves as the associate director of the Delaware Institute for Excellence in Early Childhood at the University of Delaware. In this role, she studies and implements quality improvement efforts designed to enhance early care and education environments. Prior to her research position, Rena served as project coordinator for an Early Head Start program.*

Myae Han, *PhD, is an associate professor in the Department of Human Development and Family Studies at the University of Delaware. Dr. Han's areas of research are early childhood education, early literacy, and play. She has been teaching undergraduate and graduate courses and has been a co-director of four federal grants including Early Reading First projects as well as the Buffering Toxic Stress Consortium. She has worked with children from low-income families and has delivered numerous trainings and workshops to early childhood teachers. She serves as a president for The Association for the Study of Play and the Literacy Development in Young Children Special Interest Group at the International Reading Association.*

Jason Hustedt, *PhD, is an assistant professor in the Department of Human Development and Family Studies and research director of the Delaware Institute for Excellence in Early Childhood at the University of Delaware. Dr. Hustedt's research focuses on parent–child interactions in low-income families, school readiness and the outcomes associated with early childhood programs, and state and federal early childhood policy. In addition to the Buffering Toxic Stress study, he has led evaluations of statewide pre-K initiatives in Arkansas and New Mexico and a kindergarten readiness study in Delaware. He has also written and presented extensively on state pre-K policies.*

Brenda Jones Harden, *PhD, is an associate professor in the Department of Human Development at the University of Maryland College Park. Her research examines the developmental and mental health needs of young children at environmental risk, and the risk and protective factors that influence their outcomes. A particular focus is preventing maladaptive outcomes in these populations through early childhood intervention programs, such as early care and education, home visiting services, and infant mental health interventions.*

C. Cybele Raver, *PhD, is a professor in the Department of Applied Psychology at New York University. Raver examines the mechanisms that support children's self-regulation in the contexts of poverty and social policy. Raver and her research team currently conduct federally funded RCT intervention studies as well as longitudinal studies on programs and practices that support low-income children's school readiness.*

Michelle Sarche, *PhD, is a clinical psychologist and associate professor in the Centers for American Indian and Alaska Native Health at the University of Colorado Anschutz Medical Campus, Colorado School of Public Health, Department of Community and Behavioral Health. Dr. Sarche has worked with American Indian tribal communities for nearly 20 years to better understand the challenges to, and supports for, health across the lifespan. Her work has focused on parenting, early care environments such as Head Start and Early Head Start, and children's early development. Her current projects include serving as associate director of the Tribal Early Childhood Research Center, co-directing the Native Children's Research Exchange, and leading a project to understand the relationship between stress and early development among American Indian children and their parents.*

Jennifer Vu, *PhD, is an assistant professor in the Department of Human Development and Family Studies at the University of Delaware. Her research interests focus on young children's affiliative relationships and on professional development and early child care quality. Dr. Vu also currently sits on the advisory board for an Early Head Start program and is the faculty advisor for the University of Delaware's student chapter of the National Association for the Education of Young Children.*

Sarah Enos Watamura, *PhD, is associate professor of psychology and director of the Child Health and Development Laboratory at the University of Denver. Dr. Watamura has long-standing research interests in children's physiologic regulation, their development within caregiving contexts, and relations between physiologic regulation and developing physical and psychological stress.*

Aleta L. Meyer, *PhD, is the senior social science research analyst in the Division of Family Strengthening within the Office of Planning Research and Evaluation at the Administration for Children and Families (ACF). Aleta Meyer's areas of responsibility at ACF include the translation of research on toxic stress to ACF programs, evaluation of home visiting for American Indian/Alaska Native communities, youth development, and prevention. The focus of her research has been to translate theory and empirical research across multiple health outcomes into effective and feasible prevention programs. With Thomas Gullotta, she co-edited the volume* Physical Activity Across the Lifespan: Prevention and Treatment for Health and Well-Being (2012).

Christine K. Fortunato, *PhD, is the Society for Research in Child Development/American Association for the Advancement of Science Executive Branch Policy Fellow in the Division of Child and Family Development within the Office of Planning Research and Evaluation at the Administration for Children and Families (ACF). Christine Fortunato's areas of primary responsibility at ACF include the translation of research on toxic stress to ACF programs, investigation of promising social–emotional enhancements in Head Start programs, and integration of new methodologies into research designs on best practices in coaching within Head Start. Her research has focused on how neurophysiological stress responsivity and adverse parenting across early childhood influences externalizing problems and comorbid anxiety.*

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Appendix A. Common Constructs and Measures Assessed Across Sites

The Buffering Toxic Stress Consortium identified common measures across sites at baseline to address the overarching developmental questions: (a) What risk factors do children and their families served by Early Head Start face?; (b) How do these risk factors influence children's social, emotional, and behavioral well-being?; and (c) How does parenting buffer or exacerbate the relationship between these risk factors and children's well-being? The common measures will include information on demographic, household, and neighborhood characteristics; caregiver mental health; children's social, emotional, and behavioral characteristics; sleep quality; caregiver–child interactions; and hypothalamic-pituitary-adrenal axis (HPA-axis) activity. Spanish versions of all measures are available and will be used when Spanish is the primary language spoken within the family.

Construct	Measure or Variables	Data Source	Reference(s)
Demographic, Household,& Neighborhood Characteristics			
Age	Age of Caregiver, Child, & Siblings	Caregiver-report	
Ethnicity, Race, & Language	Ethnicity, Race, and Primary Language Spoken of Caregiver(s) & Child	Caregiver-report	U.S. Department of Health and Human Services, 2011
Household Economic (In)Sufficiency	Socioeconomic status, Poverty, & Financial Hardship (Caregiver Employment Status, Household Income, and Education)	Caregiver-report	Raver, Blair, Willoughby, and Family Life Project Key Investigators, 2013
	Grid of Household Members (Crowding and Adult Mobility)	Caregiver-report	Blair, Raver et al., 2011
Neighborhood Characteristics (e.g., Safety, Noise-level)	Windshield Survey	Observer-rated	Conduct Problems Prevention Research Group, 1992
Caregiver Mental Health			
Perceived Stress	Parent Stress Index (PSI)–Short Form	Caregiver-report	Reitman, Currier, and Stickle, 2002
Depression	Center for Epidemiological Depression Scale–Revised (CESD-R)	Caregiver-report	Radloff, 1977
Anxiety	Generalized Anxiety Disorder 7-item	Caregiver-report	Spitzer, Kroenke, Williams, and Lowe, 2006
Substance Use	MIHOPE Family Baseline Survey	Caregiver-report	U.S. Department of Health and Human Services, 2012
Child Social, Emotional, and Behavioral Characteristics			
Social–Emotional Problems & Competencies	Brief Infant-Toddler Social and Emotional Assessment (BITSEA)	Caregiver-report	Briggs-Gowan and Carter, 2007; Briggs-Gowan, Carter, Irwin, Wachtel, and Cicchetti, 2004
Behavioral Characteristics	Infant Behavior Record (IBR) 3	Observer-rated	Gartstein and Rothbart, 2003
Behavioral & Emotional Problems	Preschool Child Behavior Checklist (CBCL)–1.5 to 5 year version	Caregiver-report	Achenbach and Rescorla, 2000; Achenbach and Ruffle, 2000
Behavioral Characteristics / Temperament	Early Childhood Behavior Questionnaire (ECBQ)	Caregiver-report	Putnam, Gartstein, and Rothbart, 2006
Behavioral Characteristics / Temperament	Infant Behavior Questionnaire (IBQ)	Caregiver-report	Gartstein and Rothbart, 2003; Rothbart, 1981
Sleep Habits & Quality			
Sleep Duration, Timing, & Quality	One-time Assessment of Sleep of Caregiver & Child	Caregiver-report	Developed for the Buffering Toxic Stress studies
Caregiver-Child Interactions			
Caregiver and Child Interactions	Three Bag Task	Observer-rated	Brady-Smith, O'Brien, Berlin, and Ware, 1999
HPA-axis Activity			
Cortisol Assessments	Diurnal Salivary Cortisol	Biomarker	Kirschbaum and Hellhammer, 1994; Schwartz, Granger, Susman, Gunnar, and Laird, 1998
	Cortisol Reactivity and Recovery During Emotion- and Stress-Inducing Tasks	Biomarker	Kirschbaum and Hellhammer, 1994; Schwartz et al., 1998
	Hair Cortisol	Biomarker	Russell, Koren, Rieder, and Van Uum, 2012

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Appendix B. Consortium Collaboration: Constructs and Measures Across 2-5 Sites

Construct	Measure or Variables	Data Source	Sites	Reference(s)
Prenatal, Caregiver, & Child Physical Health				
Prenatal and Perinatal Health	Prenatal and Perinatal Health - Mother and Target Child	Caregiver-report	CU-AMC	
Child Physical Health	Child Health Questionnaire	Caregiver-report	DU, NYU, WashU	Developed for the BTS studies
Child Behavioral Characteristics				
Behavioral Reactivity to a Challenging Task	Mask Task (LABTAB)	Observer-rated	DU, NYU, UMD	Goldsmith and Rothbart, 1996
Caregiver-Child Interactions				
Caregiver and Child Interaction	Three Bag Task	Observer-rated	DU, NYU, UD, UMD, WashU	NICHD ECCRN, 1997; Fuligni, Han, and Brooks-Gunn, 2004
	IT - Home Observation of the Environment (HOME)	Observer-rated	DU, UMD	
Biomarkers of Stress				
Children's Diurnal Pattern of HPA-axis Activity	Children's Salivary Cortisol Across the Day	Biomarker	DU, NYU, UD, WashU	Kirschbaum and Hellhammer, 1994; Schwartz, Granger, Susman, Gunnar, and Laird, 1998
Children's HPA-axis Reactivity	Children's Salivary Cortisol During a Challenging Task	Biomarker	DU, NYU	Kirschbaum and Hellhammer, 1994; Schwartz et al., 1998
Chronic HPA-axis Activity	Hair Cortisol	Biomarker	DU, CU-AMC, Wash U	Russell, Koren, Rieder, and Van Uum, 2012
Caregiver's Diurnal Pattern of HPA-axis Activity	Caregiver's Salivary Diurnal Cortisol Across the Day	Biomarker	DU, NYU	Kirschbaum and Hellhammer, 1994; Schwartz et al., 1998
Autonomic Nervous System Activity	Children's Salivary Alpha Amylase Before a Challenging Task	Biomarker	DU, NYU, UMD	Nater and Rohleder, 2009
Caregiver and Child Adverse Experiences and Trauma				
Caregiver History of Adverse Experiences	Adverse Child Experience (ACE)–Short Form Health Questionnaire	Caregiver-Report	DU, CU-AMC	Felliti et al., 1998
	Childhood Trauma Questionnaire (Bernstein CTQ)	Caregiver-Report	UMD, WashU	Bernstein Ahluvalia, Pogge, and Handelsman, 1997; Bernstein et al., 2003
Maternal Attachment Security	Experiences in Close Relationships - Short Form	Caregiver-Report	UD, UMD	Fraley, Waller, and Brennan, 2000; Sibley and Liu, 2004
Target Child Trauma	Traumatic Event Screening Inventory for Children (TESI)	Caregiver-Report	UMD, WashU	Ghosh-Ippen et al., 2002
Inter-partner and Family Violence	Hurts, Insults, Threatens, & Screams (HITS)	Caregiver-Report	UMD, WashU	Sherin, Sinacore, Li, Zitter, and Shakil, 1998

Note: DU = University of Denver; NYU = New York University; CU-AMC = University of Colorado Anschutz Medical Campus; UD = University of Delaware; UMD = University of Maryland; WashU = Washington University in St. Louis; HPA = hypothalamic-pituitary-adrenal.

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Appendix C. Interventions Implemented by the Buffering Toxic Stress Consortium

Intervention Title	Site	Overarching Goal	Theoretical Orientation	Target Population	Duration	Delivery Format	Key Features
Play and Learning Strategies (PALS); Landry, Smith, and Swank, 2006	New York University	To promote parent–child bond and stimulate early development	Responsive parenting literature	Families with children 5 months to 1 year old (infant curriculum) and children 18 months to 3 years old (toddler curriculum)	10 sessions (infant); 12 sessions (toddler)	Parent–child dyad; parent group	Review of videotape examples; guided practice opportunities
Parent Child Interaction Therapy (PCIT); Eyberg, 1998	University of Colorado Anschutz Medical Campus	Modify parent–child interaction patterns	Social learning theory	Families with children 2 to 6 years old	10-16 sessions	Parent–child dyad	Live coaching; Parent-Directed (PDI) and Child-Directed (CDI) Interventions; adapted for American Indian population
Mindfulness-Based Emotional Availability Intervention (MEAI); Birigen, 2008		Enhance mothers' attachment security and emotional availability	Attachment theory		4 sessions	Parent group	Mindfulness and embodiment exercises; reviewing videotapes of positive parent–child interaction
Promoting First Relationships (PFR); Kelly, Zuckerman, Sandoval, and Buehlman, 2008	University of Delaware	Promote infant emotional health	Attachment theory	Families with children birth to 3 years old	10 sessions	Parent–child dyad	Videotaped parent–child interactions; feedback to parents; focus on 5 parenting qualities: offering daily love and attention; responding with empathy and understanding; providing comfort when upset; offering a predictable world; and promoting play and exploration
Filming Interactions to Nurture Development (FIND); Fisher, 2012	University of Denver	Promote positive relationships and developmentally supportive parenting	Attachment theory	Families with children	10 sessions	Parent–child dyad	Videotaped positive microsocial interactions; feedback to parents; emphasis on 5 elements of developmentally supportive parenting—sharing the focus of attention, supporting and encouraging, naming, back and forth, and handling beginnings and endings of interactions
Attachment and Biobehavioral Catchup (ABC); Dozier et al., 2009	University of Maryland	Promote attachment Security	Attachment theory	Families with infants and toddlers	10 sessions	Parent–child dyad	Videotaped interactions; feedback to parents; live coaching through "in-the-moment" comments; focus on 3 behavioral targets—nurturance, following child's lead, and nonfrightening caregiving behavior
Incredible Years Parenting Program (IYT); Webster-Stratton, Reinke, and Herman, 2011	Washington University	Promote positive parenting	Social learning theory	Families with children birth to 12 months old (babies program), 1-3 years old (toddlers program), 3-6 years old (preschool program)	6 sessions (babies), 8 sessions (toddlers), 4 sessions (preschool) + 4 advanced sessions	Parent group	Emphasis on child-directed play, emotion "coaching," praise and encouragement, management of common early childhood tasks, and parental self-control

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Jargon Buster

Given the multidisciplinary nature of our work with infants, toddlers, and families, we often come across words or acronyms that are new or unfamiliar to us. To enhance your reading experience of this issue of *Zero to Three*, we offer a glossary of selected technical words or terms used by the contributing authors in this issue. Please note that these definitions specifically address how these terms are used by the authors in their articles and are not intended to be formal or authoritative definitions.

Phrase	*What it means*
Colorism	The term "colorism" refers to the valuing of a light skin color over darker skin tones. The emotional experience of this unconscious social hierarchy of skin color variation may have a significant psychological impact on parent–child relationships. [Find it in Lewis, Noroña, McConnico, & Thomas, page 11]
Dose-Response Relationship	In the context of trauma, the relationship refers to the association between adversity and impairment, so that the more categories of adversity are experienced, the more severe and broad-ranging are the associated impairments. [Find it in Lieberman & Soler, page 4]
Historical Trauma	Historical trauma refers to the cumulative psychological effect of group trauma experiences across generations. Historical traumas have occurred in groups across the globe, in numerous cultures and ethnic groups since recorded history. [Find it in Lewis et al., page 11].
The hypothalamic-pituitary-adrenal (HPA) axis	The HPA axis refers to complex interactions among the hypothalamus, the pituitary gland, and the adrenal glands and plays a role in the response to stress. [Find it in Consortium Principle Investigators, Meyer, & Fortuanto, page 73]
IDEA Part C	The Individuals With Disabilities Education Act (IDEA) Part C Program for Infants and Toddlers With Disabilities is a federal program for a collaborative and comprehensive system of services to eligible infants, toddlers, and their families. IDEA Part C requires states to serve children who have established conditions or disabilities (e.g., spina bifida, Down Syndrome), but gives states flexibility in defining the criteria for the amount of "delay" necessary for services. [Find it in Gilkerson et al., page 34]
Pre-Removal Conferences	Pre-removal conferences bring child welfare workers together with the family, informal supports such as family members, formal supports such as medical providers or child care providers, and a trained facilitator. During a pre-removal conference, participants discuss how the removal and subsequent placement will occur and set up supports designed to meet the safety, mental, physical, and educational needs of the children. Through this process, a plan is created for a less traumatic removal for all parties involved. [Find it in Cohen, Oser, & Quigley, page 24].

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