ZERO TO THREE®

September 2010 Volume 31 No. 1

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

Coping With Trauma and Loss

Building Capacity for Trauma Intervention

Fostering Resilience in High Stress Families

Supporting Combat-Injured Families

Grieving the Death of a Parent During Early Childhood

Also in This Issue:
Infusing Cultural and Linguistic Diversity in Early Childhood Education

THIS ISSUE AND WHY IT MATTERS

Research into the effects of traumatic experience on very young children is a relatively new area of study. Decades ago, adults believed that infants and toddlers were too immature to understand or remember stressful events and therefore immune to the effects of trauma. Today there is a growing knowledge base recognizing that even the youngest infants are affected by the events and experiences in their environment and that trauma and stress can have long-term consequences. However, ZERO TO THREE's recent survey with parents of children from birth through 3 years old revealed that there are still significant gaps in understanding the social and emotional development of very young infants. The survey found, for example, that a significant number of parents believed that infants younger than 6 months of age cannot experience feelings such as fear and anger (Lerner & Ciervo, 2010).

The lack of understanding about how deeply children are affected by their early experiences, along with research demonstrating the biological effects of early trauma, brings a new urgency to meeting the needs of very young children who have been exposed to traumatic events. Trauma and ongoing stress can lead to increased arousal, elevated stress hormones, and other biochemical changes in the body and the brain. During infancy, when circuitry of the brain is rapidly taking shape, early stress and trauma can alter brain development and have long-term effects across physical, mental, and emotional development.

It is difficult to identify the extent to which very young children suffer from traumatic experiences because of their limited ability to verbally express their thoughts and feelings, and because the symptoms of post-traumatic stress are affected by their developmental capacities. Infants and toddlers do not experience or express symptoms of traumatic stress in the same way that adults do. Symptoms of stress may show up in their play, in disruptions in their eating or sleeping routines, in their growth and development, in their relationships with others, and in regressions in their developmental abilities.

The articles in this issue of *Zero to Three* focus on how parents, caregivers, and other professionals can bolster the resilience of young children in the face of stressful and potentially traumatic experiences. The authors explore how different systems of care—doctors and health care providers, child care professionals, the military community, and mental health professionals—can support families who are experiencing difficult life events and create an environment of support and safety for the very young children in their care. Children can and do cope with trauma and stress in the early years and, with the help of sensitive and caring adults, have the opportunity to develop strengths and skills that will empower them to cope with adversity throughout their lives.

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Lerner, C., & Ciervo, L. (2010). Parenting young children today: What the research tells us. *Zero to Three, 30*(4), 4–9.

ZERO TO THREE®
National Center for Infants, Toddlers, and Families

Founded in 1980

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September 2010 Volume 31 No. 1

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Building Capacity for Trauma Intervention Across Child-Serving Systems

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The pervasive impact of trauma on the development of infants, toddlers, and preschool age children has sensitized infant mental health clinicians to the urgent need to identify and treat affected children as early as possible. *Developmental trauma disorder*—newly recognized clinical entity being introduced into the diagnostic nomenclature—speaks to the wider scope of impairments seen in very young children as a result of chronic or severe interpersonal trauma, relative to those seen in similarly affected older children, because of the particularly adverse impact of such events on the developing brain and the many formative capacities that are developing in infancy and early childhood (van der Kolk, 2005). Infants and young children who have been victims of ongoing interpersonal trauma, including neglect; physical or sexual abuse; exposure to family violence or community violence; or the death of parents, siblings, or close family members, show impairment across all domains of development including the capacity for self-regulation, secure attachment, pro-social behavior, attention, and impulse control. Children's language development, cognitive development, and school readiness are all similarly affected (Cook, Blaustein, Spinazzola, & van der Kolk, 2003).

Despite the increased awareness in the field of infant mental health, practitioners working with young children in other systems—including primary pediatric care, early care and education programs, and even those in the child welfare system—still have little awareness of the impact of traumatic events on young children. There are many reasons for this. First, these practitioners—pediatricians, attorneys, judges, caseworkers, and even teachers—have different areas of professional study and tend to function in settings where they are surrounded by others with similar professional training. Thus, there is no exposure to this information in their professional development activities. Second, most practitioners have not experienced the extreme adverse life events that constitute a traumatic experience, nor have their own children, because, by definition, a traumatic event is one that is outside of the range of usual life experiences (American Psychiatric Association, 1980). Thus, there is no experiential frame for understanding children's symptoms as a consequence of trauma. Those who may have had traumatic experiences as children have often developed defenses that permit them to miss symptoms of trauma in the children in their care (Fallot & Harris, 2001).

There are other reasons that trauma goes unidentified by the majority of professionals who interface with young children and their families. Traumatic events such as child maltreatment and domestic violence often

Abstract

Infants most vulnerable to trauma are often the least able to access interventions. Universal child-serving systems, such as primary pediatrics, early care and education, and the child welfare system, can offer a port of entry for millions of children annually for trauma-related supports and services. However, practitioners in these systems have varying levels of professional training and often express discomfort in exploring this topic with families. The co-location of infant mental health clinicians in these systems builds capacity to identify and treat trauma-affected children and builds competencies in extensive networks of professionals. This article describes a range of successful services and supports in these systems.

occur behind closed doors. Parents do not report such events out of fear of the possible repercussions of disclosure or out of a lack of awareness that such events are harmful for young children. Even when parents seek therapeutic services for a young child who is having tantrums, sleep problems, or aggressive behavior, they often do not connect the child's symptoms or problematic behaviors to adverse events that have occurred in their families and thus do not report such events in their description of the presenting problem. Infants and toddlers have limited language capacity and are most often unable to disclose these events themselves. Finally, there is still a widely held belief that infants and toddlers are too young to be aware of events in their surroundings or that they are too young to retain memories of the traumatic event.

Consequently, young children who have been affected by trauma are often overlooked, considered difficult children, or misdiagnosed. It is not uncommon to find traumatized young children who have been diagnosed as having attention deficit disorder, oppositional defiant disorder, disruptive behavior disorder, or even pervasive developmental disorder. Intervention plans often address the wrong problem; in some cases very young children are even placed on psychotropic medications (Gleason et al., 2007).

In response to these circumstances, and to the large number of traumatized children referred to the Early Childhood Center (ECC), a therapy program for infants, toddlers, and preschool age children at the Albert Einstein College of Medicine in the Bronx, New York, staff have developed outreach projects that place infant and early childhood mental health clinicians in other child-serving systems, including primary pediatric care clinics, preschools and child care centers, foster agencies, and the Bronx Family Court. These projects have been well received by practitioners in these systems and are successful in providing a safety net for children who may otherwise not have been identified or treated. Although urgent need persists for specialized centers and trained clinicians to provide high-quality, relationship- and evidence-based therapeutic interventions for traumatized infants, toddlers, and their caregivers, such resources are still in short supply. Further, it is often the case that the most stressed families are the least likely to access, engage in, or follow through with therapeutic services. Therefore, other systems where children and families receive services may offer the best, if not the only available, port of entry for trauma-related supports and services. The co-location of infant mental health clinicians in these systems, and the collaboration that is inherent to this model, has the additional benefit of expanding competencies to professionals in other disciplines.


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Primary pediatric care, as the most universally accessed service system for infants and toddlers, has the unique capacity to provide a safety net for children.

Primary Pediatric Care

Primary pediatric care is an important and logical place to screen for, and address, trauma exposure in infants and toddlers. The pediatrician is the first, and often the only, professional who sees the infant and young child on a regular basis. Frequency of visits to the pediatrician in the child's first 3 years permits the pediatrician to establish rapport with parents, observe the child's behavior and coping skills, and observe the infant–parent relationship. Parents typically trust their pediatricians and express an interest in receiving advice and information about child development from them (Taaffe Young, Davis, & Schoen, 1996). However, few pediatric practices routinely screen for social–emotional concerns or trauma. Often, even when there is a concern about problems in the parent–child relationship or the child's home environment, there is reticence on the part of pediatricians to inquire about these because of a lack of comfort with psychosocial issues, time constraints, or concern about inadequate resources in the practice or community for follow-up (Williams, Parnes, Klinepeter, Pulley, & Meschan Foy, 2005). Yet, primary pediatric care, as the most universally accessed service system for infants and toddlers, has the unique capacity to provide a safety net for children.

For the past several years, ECC has collaborated with the Comprehensive Family Care Center, a Federally Qualified Community Health Center affiliated with Montefiore Medical Center that annually serves approximately 3,000 children from birth to 3 years old and is also a training site for pediatric residents. In this project, a doctoral level, bilingual infant mental health clinician, referred to as an infant–toddler specialist (ITS), is co-located in the pediatric clinic to address the developmental and mental health needs of children up to 3 years old. The ITS provides universal screening, on-site consultation to pediatric providers and families, short-term infant–parent interventions, and provider education (Briggs, Racine, & Chinitz, 2007).

All children are screened for social–emotional concerns at well-child visit from 6 months to 3 years of age using the *Ages & Stages Questionnaire: Social Emotional* (Squires, Bricker, & Twombly, 2002). For any concern indicated on this screening, or otherwise raised by the parent, the ITS may either join the visit or offer a separate appointment to see the parent and child. Consultation with the ITS is also available for provider concerns about a child, a parent, or a parent–child interaction. Follow-up is immediate and may consist of more comprehensive assessment, parent education and guidance, short-term intervention in the clinic or in the family's home, or a combination of these. If a child or dyad requires more long-term therapy, a referral is made to the ECC. The ITS also makes referrals to other services, such as domestic

Photo: Janet McCracken Stivers

Providers in early care and education programs report they are seeing growing numbers of children with severe behavioral problems.

violence services or mental health services for the parent.

Provider education is a critical component of this collaboration. Through consultation with the ITS, pediatricians learn to identify infant mental health concerns, observe how these are assessed, and develop competence in addressing such concerns themselves. A more formal training component, developed for pediatric residents and medical students, includes conferences on attachment, the impact of stress and trauma on brain development, and clinical applications in high-risk populations. The result is a cadre of trained health professionals who can recognize the warning signs for social–emotional concerns in infants and toddlers, including symptoms of trauma, and can thereby intervene effectively and preventively with families.

Tamika brought her children Benjamin, 2½ years old, and his sister Jasmine, 5 years old, to the Comprehensive Family Care Center for all their medical care. At Benjamin's well-child visit, she completed a 30-month Ages & Stage: Social Emotional Questionnaire *(Squires et al., 2002). Benjamin's score was sub-clinical, meaning the score, itself, did not flag a concern. Tamika did note, in answer to one of the open-ended questions, that Benjamin had been difficult to manage since the death of his father. The pediatrician immediately asked the ITS to speak with the family, and together they learned that Benjamin's father had been killed 3 months previously in an episode of street violence. It was likely that both children observed the murder, as their father had just loaded them into their aunt's car and was walking down the sidewalk when he was shot and killed.*

At the conclusion of the well-child visit, the ITS continued to talk with Tamika who reported that neither she nor her children had been offered any counseling since the death of her husband. Although a full criminal investigation was under way, the mental health needs of this traumatized family had been neglected.

Their symptoms were severe. Benjamin cried out in his sleep for hours each night, constantly pleaded with his mother to see his father, and had become very aggressive toward others. Jasmine was unable to tolerate anyone crying or expressing feelings of sadness and refused to walk by the corner where her father was shot. Tamika admitted that she found it easiest to pretend the trauma hadn't occurred, and she wouldn't allow herself to think about her husband.

The ITS suggested therapeutic interventions for the family, to be delivered weekly either at home or in the pediatric clinic. Therapy focused on the trauma and bereavement experienced by the family, at appropriate developmental levels. Tamika also learned effective behavior management skills so she could,fill the discipline void left by her husband. Symptoms significantly abated in all three, and the pediatrician and ITS continue to monitor the family during routine medical appointments.

Preschools and Child Care Centers

Increasing numbers of infants, toddlers, and preschool age children spend a significant part of their day in some type of early childhood setting. Providers in early care and education programs report they are seeing growing numbers of children with severe behavioral problems connected to the complex array of difficulties faced by families, including parental stress and depression, substance abuse, and violence in homes and neighborhoods (Cohen & Kaufmann, 2000). The skills and resources of early care and education staff are frequently inadequate to meet these increased challenges. Preschool programs are expelling large numbers of children relative to higher grades (Gilliam, 2005), thereby contributing to disruptive transitions that interfere with children's need for stability. Early childhood providers have indicated that the most helpful type of assistance in caring for children with challenging behaviors is on-site consultation with a mental health expert (Brennan, Bradley, Allen & Perry, 2008).

ECC has responded to this need by placing an infant and early childhood mental health specialist within various child care and preschool programs in the Bronx. This clinician is a regular presence at the program and provides case consultation for children and families where there is a particular concern as well as program consultation to help staff develop policies, practices, and teacher behaviors that support children's sense of safety, self-regulation, and pro-social behaviors. The consultant provides teachers and administrators with support in developing more productive partnerships with families. To the extent possible, consultants provide the individual mental health and behavioral interventions for children on-site, and referrals are made for more intensive or specialized services when needed.

Jonathan was a 2½-year-old Spanish-speaking child who entered the child care program after moving into a new apartment with his grandparents and aunt. He adjusted well and was learning English rapidly, which facilitated play interactions with his peers. The custom in the child care center was to move the children up to a new age grouping when they reached each birthday to provide openings for incoming children. Therefore, without notice, Jonathan was moved to the 3-year-old room soon after his birthday. Almost immediately, Jonathan became highly disruptive in his classroom. His grandmother reported that at home he was having tantrums and was aggressive, noncompliant, and resistant when she was getting him ready in the morning. The teacher asked the consultant to help assess this sudden change in Jonathan's behavior and emotional state.

In a meeting with Jonathan's grandmother, the consultant and teacher learned that Jonathan's mother had been killed by his father when Jonathan was almost 2 years old, following several episodes of relationship violence. Not only did he lose his mother but, due to threats on the lives of his extended family, the entire family was relocated, leaving their apartment, belongings, and loved ones behind. The abrupt nature of his classroom change appeared to be a trauma trigger that revived the anxiety, sadness, and anger that Jonathan felt when his mother was killed. Once the child care staff understood his reaction, they planned a slower transition to his new room, supported by individual time with the mental health clinician. After several weeks, Jonathan adjusted to the new room and seemed to enjoy a sense of security with his new teacher and peers. Involvement of the infant mental health clinician enabled the child care staff to work in more comfortable collaboration with Jonathan's family, to understand his negative behaviors as symptoms of anxiety and distress, and to develop program-wide transition practices more appropriate for all young children and especially for those affected by trauma and loss.

Child Welfare

Young children known to the child welfare system are often considered the most vulnerable cohort of children. The circumstances that result in child welfare involvement typically include child neglect, abuse, or exposure to traumatic experiences such as adult substance abuse, family violence, police raids, arrests, and separation from parents, siblings, and other attachment figures. Despite the very high rate of trauma exposure in young children in foster care, there is little focus on this critical component of children's experiences in service planning for children and families or in the guidance provided to foster parents. And, although many of the traumatic events experienced by infants and toddlers placed in foster care are perpetrated by their parents or other close relatives, few interventions are put in place to help them heal from these interpersonal traumas (Osofsky et al., 2007).

Staff of the ECC have developed the following service models that bring trauma focused services and supports to foster agencies and the Family Court.

Therapeutic Visiting

Although family visits for children in foster care are a critical vehicle for achieving the goal of reunification, visits require children to be repeatedly reunited with, and separated from, the parent(s), and can also evoke memories of the traumatic event, causing child distress. Parents' anger at the system for removing their children, or frustration about the obstacles they face in getting their children back, often spills over in visits and frightens young children. Separation from foster parents for visits with biological parents with whom they have limited contact often creates anxiety for traumatized infants and toddlers, which further fuels their parents' anger. Consequently, visits are frequently followed by children's behavioral dysregulation, often prompting the recommendation that visits be discontinued (Haight et al., 2001).

In therapeutic visiting, an infant mental health clinician meets individually with the parents before and after the visit, and also participates in the visit. The clinician helps parents see the visit from the child's perspective and guides parental behaviors during the visit to provide the young child with a sense of security and the experience of positive engagement with the parents. This guidance frequently involves helping the parent to understand that the child has, in fact, been traumatized, something often initially denied or minimized by the parent to the detriment of the child's recovery.

Starr and Sam's three children were placed in foster care due to neglect resulting from parental substance abuse. While in their parents' care the children witnessed numerous frightening events, including violence and sexual activity on the part of strangers who were in and out of their home, adult alcohol and drug use, and police raids and arrests. After a year in foster care, and the parents' successful substance abuse treatment, two of the three children were reunited with their parents. The youngest child, 3-year-old April, , remained in care because of her high level of anxiety around reunification. Her anxiety was at its highest during visits with her parents at the foster agency and when any mention was made of returning back to her home. Her foster care caseworker did not understand April's resistance to visits and felt that April should be forced to visit in light of the mandatory time frame for reunification and the fact that her parents and siblings were doing well. The law guardian requested therapeutic visits to help April reconnect with her family with less anxiety as part of the reunification process.

The clinician, who had worked with the family in visits at the foster agency, agreed to accompany April for her first visit back to her home. Her parents had arranged a welcome home celebration complete with balloons, ice cream, and the presence of other family members, and were eager to show April how they had prepared the children's room for her return. In their enthusiasm, her parents did not notice April's signs of anxiety. April only agreed to look around if the visit coach was by her side and did not speak to anybody except her siblings. After the visit, the clinician was able to discuss with her parents the need to use a slower pace and more measured emotional tone with April. They were encouraged to focus on what their daughter needed from them, rather than what they wanted to do for her, which meant delaying their own need for immediate reunification. The visit coach worked with April and her parents over the course of several visits to help April develop trust and regulate her anxiety, while creating new experiences to replace the traumatic memories. Slowly, April became more responsive and interactive. At first, she was able to sit and eat meals with her family. Eventually, she was able to sing, dance, and laugh during visits. Reunification took place when it was clear to all, including the agency caseworker, that April had a sense of comfort with her family. The caseworker learned that April's reticence was a result of trauma and that this could be worked through with sensitive planning.

Family Court Consultation

Court personnel, including judges and children's attorneys, make daily decisions on critical issues for young children, including removals, family visits, service plans, reunifications, and terminations of parental rights. Often, these decisions are based primarily on the legal aspects of the case, without in-depth knowledge of attachment, the impact of chronic stress on infants, children's regulatory or developmental disorders, or the impact of parental mental health disorders on parenting. Although judges and attorneys appreciate the gravity of their actions, and thereby welcome collaboration with child development specialists, most do not have access to these practitioners and thus have limited opportunity to incorporate a focus on risk and protective factors in child development. In this context, ECC developed the Family Court Consultation Project.

In this project, an infant mental health clinician from the ECC visits the Bronx Family Court on a regular basis during the lunch hour to meet with judges or children's attorneys about their cases involving young children. In between consultation days in court, correspondence by telephone and email is readily available. Consultations often result in children's expedited referrals for developmental or infant mental health services. Consultations can be single events, or may develop into on-going clinician-court team relationships that span the full duration of the child's court involvement.

The attorney representing 3-year-old twin boys requested consultation. Her clients were 8 months old when their father repeatedly and fatally stabbed their mother at her workplace. The boys have been in the care of their maternal grandmother since that time. The


Photo: Marilyn Nolt

The circumstances that result in child welfare involvement typically include child neglect, abuse, or exposure to traumatic experiences.

grandmother, intent on protecting these children from emotional harm, never told them what happened to their mother. In the absence of information, the grandmother often heard the children wonder where their mother was, when she would return, or if visitors to their home were their mother, and worried both about telling them and about not telling them the truth. The grandmother turned to the children's lawyer for guidance, and the lawyer, in turn, asked for the consultant's input.

The clinician and lawyer met with the grandmother and spoke about the children's personalities, the details of the event, and how the boys could be told the truth in a way that would support, and not derail, their emotional development. The clinician provided the words the grandmother could use, and considered with her how she could also talk about their now incarcerated father. The clinician offered to do this together with the grandmother if she felt more comfortable, but the grandmother decided that, with the guidance she was given, she could speak to the boys by herself.

Learn More

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www.aap.org/mentalhealth

Healthy Steps for Young Children
www.healthysteps.org

Preschool Consultation
Center on the Social and Emotional Foundations for Early Learning (CSEFEL)
www.vanderbilt.edu/csefel

Child Welfare
Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents
www.nctsnet.org/nccts/nav.do?pid=ctr_rsch_prod_rpc_guide

Therapeutic Visiting
Visit Coaching: Building on Family Strengths to Meet Children's Needs
www.martybeyer.com/user_files/documents/visit_coaching_manual[1].pdf

Family Court
Healthy Beginnings, Healthy Futures: A Judge's Guide
www.abanet.org/child/healthy_beginnings.pdf

Follow-up with the grandmother revealed that she had, in fact, talked with the boys about what had happened to their mother. The boys asked appropriate questions about both of their parents. Although she is aware that the children will likely have many more questions, the grandmother is greatly relieved that there is no longer a secret in the family and that the children have the information they have been seeking. The law guardian reported she had never seen the grandmother, previously invested in her stoicism as a means of protecting the children, look as "freed" as she does now that this problem is behind her. The grandmother was assured that she would always have access to therapeutic supports for the boys if needed and was encouraged to address her own grief and bereavement as an additional support for her grandchildren. The grandmother was highly appreciative of the ready access to a child therapist to help her with this important, but painful, disclosure. The attorney was grateful to have had the opportunity to be part of this consultation as a means of helping subsequent families in similar circumstances.

Conclusion

Co-location of infant mental health clinicians in the child-serving systems discussed here provides a means for the identification and treatment of a larger number of infants exposed to trauma. These systems, accessed universally despite socioeconomic status or insurance coverage, serve as a safety net for the most vulnerable infants. By providing services in venues where parents and children access other services, children receive intervention despite barriers that may exist in accessing mental health services. By educating and collaborating with the extensive network of professionals beyond the discipline of mental health, we at ECC are able to ameliorate the severe developmental problems resulting from untreated affects of trauma in a greater number of children.

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Acknowledgments

The authors would like to acknowledge the New York City Council and the Far Fund for their support of this work.

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Families OverComing Under Stress (FOCUS) for Early Childhood

Building Resilience for Young Children in High Stress Families

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Abstract

Parental distress and trauma affects the entire family, including the youngest children. Families OverComing Under Stress (FOCUS) is a targeted prevention program for high-risk families that aims to enhance family cohesion; support the parent–child relationship; and build emotional regulation, communication, and problem-solving skills across the family. Developed at UCLA and Harvard, FOCUS is currently implemented with many populations, including U.S. military families. This article describes FOCUS for Early Childhood (FOCUS-EC), which addresses the developmental needs of families with very young children. A case example illustrates how FOCUS-EC helps parents to assist their children in navigating the developmental tasks of early childhood in the face of parental deployment during wartime.

A wealth of research has demonstrated that when parental functioning is compromised, the effects reverberate throughout the entire family, extending to even the youngest members. The impact of parental distress or trauma on children, including very young children, is well documented in many different populations, including families experiencing interparental conflict or violence, parental depression, medical illness, and combat-related posttraumatic stress disorder (Beardslee, 1984; Christ, Siegel, & Sperber, 1994; Lester, Stein, & Bursch, 2003; Mireault & Bond, 1992; Rutter, 1966; Rutter & Quinton, 1984). Such family environments may significantly alter the developmental trajectories of young children by jeopardizing the quality of early parent–child relationships, interfering with established roles and routines, and exposing children to the "spill-over" of distressing or frightening parental affect and behavior. These disruptions in family life can impede the child's ability to negotiate age-expected tasks and develop adaptive skills such as emotional and behavioral regulation.

Family-centered interventions that provide developmental guidance and increase adaptive skills (particularly parent–child communication, parent–child attachment relationships, and effective family management) can reduce problem behaviors and emotional distress in children and support development over time (for review see National Research Council & Institute of Medicine, 2009). However, although numerous studies have demonstrated the need for family-centered interventions, few interventions are specifically designed for families affected by psychological trauma

(Lester et al., 2003). Recent articles have highlighted the gap between theory and practice and have described innovative approaches geared toward treating child and family trauma that are emerging (Saltzman, Babayon, Lester, Beardslee, & Pynoos, 2008).

One such innovative approach is Families OverComing Under Stress (FOCUS), a family-level intervention that is based on more than 20 years of research demonstrating that targeted preventive interventions for families under stress can enhance the psychological health and developmental outcomes of both children and parents (Beardslee, Gladstone, Wright, & Cooper, 2003; Beardslee, Wright, Gladstone, & Forbes, 2008; Layne et al., 2008; Rotheram-Borus, Lee, Lin, & Lester, 2004). FOCUS has been used successfully with families facing several different types of stressors including parental medical and mental illness, pediatric cancer, community violence, natural disasters, and, most recently, with military families. In this article, we describe an adaptation of this program for families with very young children, FOCUS for Early Childhood (FOCUS-EC), and its implementation with military families who are facing parental deployments or psychological and physical injuries.

The Impact of Parental Deployment and Trauma

The ongoing wars in Iraq and Afghanistan continue to significantly impact families in the United States, undoubtedly contributing to higher distress levels for many parents and children. Almost half of all active duty service members have children, with the largest percentage of children being from birth to 5 years old (Office of the Deputy Under Secretary of Defense, 2008). Although previous studies suggest that many military children and families adapt quite well to routine deployments, the stress of multiple and prolonged wartime deployments may eventually strain some families (Lincoln, Swift, & Shorteno-Fraser, 2008; Palmer, 2008; Waldrep, Cozza, & Chun, 2004), with recent studies showing greater total months of deployment and poorer mental health among caregivers, contributing to increased stress among children (Lester et al., 2010) and adolescents (Chandra et al., 2009).

Much of the existing literature has focused on older children, but recent findings suggest that young children of deployed parents have higher rates of internalizing and externalizing behaviors than do similar-aged peers (Chartrand, Frank, White, & Shope, 2008). Young children's responses to separation from an important caregiving figure and to distress in the nondeployed parent may be expressed through their difficulties with routines and patterns (e.g., sleeping, eating), regression to previous behaviors, withdrawal, irritability, and behavioral difficulties (Carroll, 2009; Lester, 2009).

There are likely multiple avenues by which parental wartime deployment impacts military families and children. Such deployments likely affect the quality of parent–child, marital, and co-parenting relationships in these families. There is an increased risk for child neglect and maltreatment in families experiencing multiple and prolonged deployments, particularly those with younger parents with young children (Gibbs, Martin, Kupper, & Johnson, 2007; Rentz et al., 2007). In addition, deployments have been associated with increased marital conflict and domestic violence (McCarroll, Fan, Newby, & Ursano, 2008).

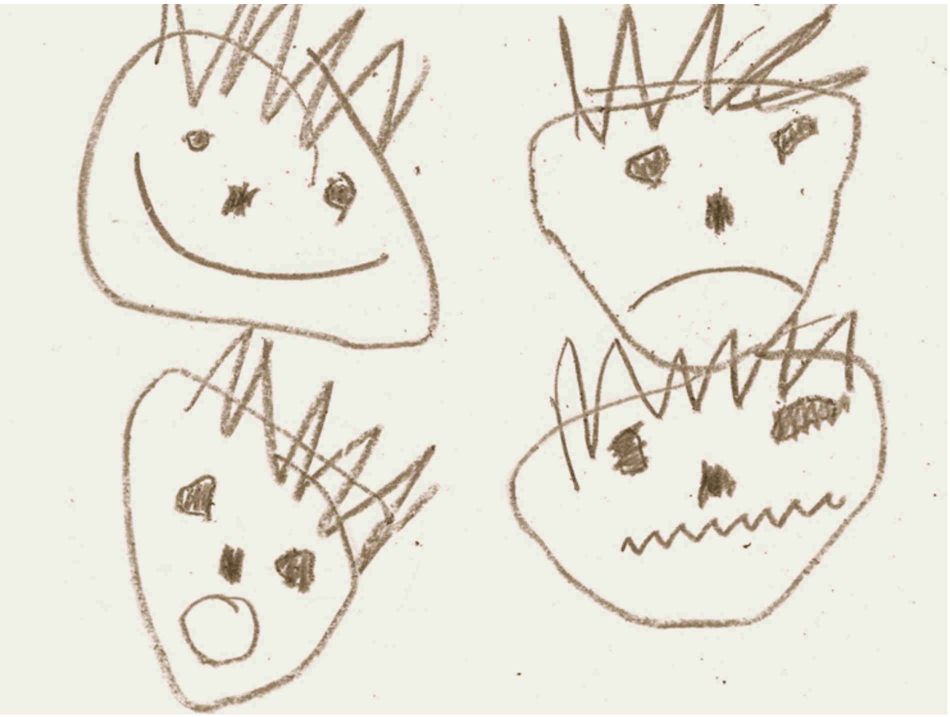
Such findings are not surprising given the significant demands that multiple deployments can place on these families. Military families must continually accommodate to the presence and absence of a deployed parent, reorganizing and readjusting to changing roles and routines. They often have fewer resources and decreased social connectedness because of the absence of a parent. Some families will be able to reorganize and adapt to these events relatively smoothly, whereas others may have more difficulty responding when the family's typical way of functioning is disrupted. For example, when a primary attachment figure leaves, some of a child's usual resources for dealing with stressful circumstances or emotionally distressing events are no longer available. Children may rely on the nondeployed parent for more comfort than normal during the deployed parent's absence. However, the nondeployed parent's own coping abilities may be taxed during deployment, as she assumes the responsibilities of both parents, while also dealing with her own concerns about the deployed parent.

Of particular concern when parents of very young children are deployed is the difficulty a parent may have in establishing a secure, trusting relationship with the child before deployment. In some cases, deployed fathers come home to a child who was born while they were away, and they must figure out how to establish such a relationship for the first time. Maintaining a positive co-parenting relationship may also be challenging when a nondeployed parent has become accustomed to performing all caregiving tasks on his own and then must relinquish some control when the other parent returns. Renegotiating the co-parenting relationships may create considerable marital conflict and strain, and children may be exposed to high levels of negative affect and behavior in the family. Young children may have few internal resources to deal with such exposure and parents may be inclined to underestimate the effects of interparental conflict on young children.

A child can give a high-five each day with an outline of an absent parent's hand as a way to keep the parent salient in the child's everyday life.

Children in military families may also be impacted when a parent returns with significant levels of combat operational stress. Hoge and colleagues (2004) indicated the rate of combat related mental health problems at 18% among service members returning from Iraq. The secondary impact of posttraumatic stress disorder on veterans' families has been well documented and includes increased domestic violence, marital distress, and interference with parenting (Galovksi & Lyons, 2004). Among children of veterans, there is also the potential for intergenerational transmission of trauma (Dekel & Goldblatt, 2008; Pearrow & Cosgrove, 2009).

The symptoms of posttraumatic stress affect family relationships in a number of ways (Carroll, Rueger, Foy, & Donahoe, 1985; Westerink & Giarratano, 1999). Children may become confused or even frightened when they experience abrupt changes in a parent's mood or behavior that were related to a trauma reminder. Such changes may be particularly distressing to very young children who do not possess the cognitive abilities to understand their parent's behavior in the way an older child might. The tendency of returning service members to be highly reactive to threat may translate into difficulty tolerating normal family interactions, such as children arguing or engaging in physical play (Matsakis, 1988). These reactions can undermine parental involvement and may result in withdrawal from family interactions. Lower ratings of cohesion, support, and adaptability are often seen in families of service members with posttraumatic stress (Davidson & Mellor, 2001; Riggs, Byrne, Weathers, & Litz 1998; Westerink & Giarratano, 1999).



Identifying four basic feelings (happy, sad, mad, and scared) helps young children with appropriate expression of emotions.

FOCUS for Military Families

Such findings as those described in the previous section can leave little doubt that building and maintaining parental and child resilience among military families is critical. FOCUS training aims to enhance family cohesion and strengthen parent–child, marital, and co-parenting relationships by helping families develop a shared understanding of past experiences and by building emotional regulation, communication, problem-solving, and goal-setting skills across the family (Lester, 2009). Families are also taught how to support the service member in managing deployment and combat stress reminders. Parents learn about typical developmental reactions to deployment in order to promote age-appropriate expectations for children. Such skills and knowledge are intended to not only help families deal with the absence of a deployed parent, but also to assist with the reintegration process once the parent has returned and to better prepare for future deployments.

FOCUS for Early Childhood

Adapted from FOCUS for older children and their families (for description see Lester et al., in press; Saltzman et al., 2008), FOCUS-EC includes developmental modifications for families that include at least one child from 3 to 5 years old (Lester, 2010). Sessions are tailored to the developmental needs of the child and the specific goals of the parents. Goals often include communicating with children around risk and safety, supporting positive parent–child interactions, enhancing family closeness, improving behavioral difficulties, and planning for future challenges. In FOCUS-EC, trainers work with parents to develop strategies to assist the deployed parent in developing a nurturing, trusting relationship with his young child, particularly when he may have been absent for much of the child's life. For example, parents are taught how to develop a plan for the deployed parent to share in important early developmental milestones and remain involved in parental decision-making during his absence in order to strengthen the co-parenting relationship. Parents are taught skills to foster behavioral and emotional regulation in their child, a major developmental task of early childhood. Parents are also taught how to deal with some of the typical regressions that young children may experience when separated from a parent.

FOCUS-EC is delivered over the course of five to seven sessions. Generally, the trainer first meets with both parents (if both are available) for two sessions, followed by two sessions with the parents and child together, a parent "check-up" session, and finally one or two family sessions. Parent sessions last approximately 90 minutes, whereas parent–child and family sessions last 30–60 minutes, depending on the developmental level of the child. Ideally, both parents are present, but the intervention can be done even if only one parent is available. FOCUS-EC is manualized to ensure that each family is taught the same core skills but allows for flexible delivery to meet the needs of the family.

At the initial session, parents participate in an assessment to identify their family's strengths and challenges. This assessment provides feedback to the trainer, allowing her to work with the family to provide appropriate educational material, customize the intervention plan, and identify referrals when needed. The FOCUS assessment also guides parents in selecting clear, achievable, and appropriate family-level goals during the initial parent sessions. The parent sessions also focus on helping parents to create a narrative timeline which provides them with an opportunity to identify key family events, including important deployment-related experiences, and perceptions and feelings associated with those experiences. In jointly creating a narrative timeline, parents begin to develop a shared understanding of how historical and current challenges have affected their family. The timeline is organized around key events in the family's life: getting married, birth of children, moves, and parental absences. It promotes perspective taking and reflective parenting, highlights positive coping strategies, and underscores themes in the family's journey. The parents construct it together and are asked about the children's experience from their point of view. Education is integrated into the narrative timeline depending on the specific challenges of the family. For example, if key events are focused on a child's medical illness, the trainer would educate parents about the ways in which typical child development might be affected by major illness. If the key family events are related to a parent's deployment during wartime, the education would be focused on how families are affected when a parent is absent during important developmental milestones and how common combat-operational stress reactions can affect family functioning.

The child or parent–child sessions focus on enhancing emotional regulation skills among family members. By educating children and parents about four basic feelings (e.g., mad, happy, sad and scared) and the importance of using feeling words to express emotions, the trainer sets the frame for emotional regulation skills that are used in later sessions. Parents and children learn to identify triggers of emotional reactions and strategies that can help children calm down. The trainer may facilitate child-focused play between parents and children, modeling developmentally appropriate language that the parent may use with their very young child. During these activities, the trainer may highlight developmental tasks the child is attempting to navigate, provide commentary on the child's behavior and affect, or narrate the child's experience.

There is a parent check-in session at the midpoint of FOCUS-EC to help the parents review what they have learned and plan for the future. The trainer attempts to elicit parental observations and insights about the child's behavior and reactions during the previous sessions. The trainer also provides developmentally informed guidance to parents, enabling them to identify strategies to meet their goals and address challenges. For example, explaining that it is normal for a child to desire to sleep in the parents' bed after a traumatic or stressful event may help parents respond more effectively and supportively to the child. The trainer strives to educate parents while supporting their decision-making and leadership of the family.

Depending on progress toward the family goals, there may be one or two additional sessions that provide further opportunities to practice emotional regulation, communication, and relationship enhancement skills. During these sessions, the trainer may teach additional strategies, such as child-focused play (i.e., narrating play, following the child's lead, and increasing praise).

The Potter Family

The following example of how families with very young children can benefit from FOCUS-EC is drawn from the composite experiences of military families.

Jason (35 years old) and Jennifer (32 years old) Potter contacted FOCUS as Jason was preparing for his third deployment. Jennifer was feeling overwhelmed and anxious about how she would parent their two young children, Sara (4 years old) and Charlie (1 year old), during the deployment. Both parents were stressed by Sara's increasingly frequent tantrums. In addition, Sara had begun having accidents in preschool, despite having previous success at potty-training. Jason was concerned something might be wrong with his daughter. He was also concerned about Jennifer, and worried that she would "lose it" when he deployed the following month.

Jason described feeling irritable and reactive. He recalled an instance when Charlie was crying and he felt angry and annoyed that Jennifer could not calm Charlie down. He noted a similar reaction to Sara's tantrums, but felt he was able to manage her tantrums by giving her what she wanted. When asked to provide additional details, Jason acknowledged feeling guilty for not being available to Sara during his previous deployments; thus, he did not want his time with her between deployments to be spent setting limits and providing consequences. He discussed wanting every moment to be loving and fun. He became tearful as he described coming off the plane after his last deployment and Sara, then 15 months old, not knowing him.

Jennifer expressed mixed feelings about military life. She expressed concern that she would be unable to manage all of the household responsibilities on her own. She recognized the importance of having the children on a schedule, but was concerned she would not be able to maintain one in the face of becoming "a single mom" for several months. She expressed feeling frustrated at Jason for giving in to Sara's tantrums, and always making her "the bad guy." She also admitted to wondering how Jason's combat experiences had affected him. She feared that Sara and Charlie would sense her concern and that it would affect their relationship with Jason. She expressed guilt that she had not done a good enough job helping Sara to remember her father during the last deployment. Although Jennifer admitted that she and Jason talked about the upcoming deployment, she was angry that he was risking his life once again.

Jennifer and Jason's goals included increasing positive family interactions and having their family thrive in the face of a pending deployment. Emotional regulation skills were integrated throughout FOCUS sessions, as Jennifer had difficulty managing her own negative affect, which also interfered with her ability to respond to her children's emotional distress. Specifically, Jennifer learned to monitor her stress levels and identify key supports, such as a drop-in day care center on the installation and a supportive friend, both of which she could engage on high-stress days. Jennifer also identified exercise as a way to take care of herself and was able to attend two classes per week. Education about the impact of deployment on young children, normal child development, parenting, and the relationship between parental distress and children's behavioral difficulties helped both parents feel engaged by the strategies that were implemented.

In developing their shared narrative timeline, Jennifer and Jason were able to reflect on both their own and each other's experiences with previous deployments and to understand how differences in those experiences affected their family. Unhelpful thoughts were identified and changed into more realistic and helpful thoughts. For example, instead of viewing himself as a failure because Sara didn't recognize him at their last reunion, Jason was able to understand that Sara's reaction was normal and he praised himself for letting her get to know him again.

To deal with difficult questions about the risks of deployments, it can be helpful to allow children to try on and touch the equipment that keeps a service member safe.

Photo: Julie C. D'Amico

Jennifer and Jason discussed the ways in which the last month had been challenging, particularly their concerns about how this next deployment would affect their children. They wondered whether Sara's tantrums would increase, whether she would be able to attend preschool if she continued having accidents, how Charlie would be able to know his father, and what would happen if Jason did not return. They were able to link these fears and concerns to their previous experiences, challenge unhelpful thoughts, and identify a communication plan to talk about the deployment. They agreed to work on one challenge at a time and decided to review the communication plan in a few weeks, after spending time in sessions with Sara.

Jennifer and Jason participated in two sessions with Sara. The trainer introduced emotional awareness and affect regulation skills to help Sara increase her emotional vocabulary, understand how feelings affect her body, and identify what she could do to help her feel more calm, comfortable, and happy. Jennifer and Jason were also encouraged to practice and use these same skills with the children to support emotional expression across the entire family. The trainer reinforced moments when Jennifer and Jason supported each other in family interactions, explaining that when Sara and Charlie experience Jennifer and Jason co-parenting, they feel more secure in the guidance they receive from them. Co-parenting was also introduced as a way of maintaining connection over a distance and keeping Jason salient in his children's lives.

Sara was able to use feeling faces cutouts to express how she felt when her father was home and when he was gone. Jennifer and Jason learned skills to help Sara feel understood and supported. Specifically, they learned and practiced active listening and reflection skills. As Sara became more

Photo: Julie C. D'Amico

By helping parents to engage in and narrate a child's play, young children can sustain play for longer and express more enjoyment during the interaction.

comfortable expressing her feelings, she became more verbal and was able to share thoughts and feelings more openly. She asked her father if the bad guys would shoot him with their big guns. With support, Jennifer and Jason were able to validate Sara's feelings of concern about her father's safety and reassure her in concrete, developmentally appropriate ways. Jason showed Sara all the equipment that kept him safe. Sara was reassured by trying on her father's helmet to understand its sturdiness and wearing his shoes to see how thick they were. Jason also reminded Sara of the extensive training he received that taught him how to be safe, and also explained that he had many friends and coworkers who also helped keep him safe. In time, Sara came to feel less afraid of her father leaving.

Because the parents' goal was to increase positive family interactions, they agreed to learn strategies to enhance enjoyment during playtime. The trainer encouraged Jennifer and Jason to play with Sara. When Sara asked Jennifer to play with the dollhouse, Jennifer invited Jason to join in the play. Jennifer was enthusiastic and easily engaged in imaginary play, while Jason was quiet and only moved his play figure when Sara told him what to do. He admitted feeling silly, but added that he wanted to learn to play more so that he could join in Jennifer and Sara's playtime. Jason and Jennifer agreed to play together with Sara three times a week.

During a parent check-in session, Jennifer and Jason reported improvement in Sara's behavior at home. They also reported increased confidence in their parenting and in their ability to communicate with Sara and re-establish consistent routines. It was clear that they were working together as a team and felt mutually supported. They felt even more confident after learning that this kind of family leadership is exactly what Sara and Charlie would benefit from, even when Jason was deployed again. With these improvements, Jennifer and Jason began working on a deployment plan, which included identifying family rules that would be maintained and those which might be more flexible during the next deployment. They discussed a plan for communication during the deployment, including strategies for co-parenting at a distance, maintaining Jason's connection with Sara and Charlie, and sharing in important developmental milestones and key family events during his absence. Jennifer and Jason agreed on what kind of information they would discuss in emails and phone calls. Jennifer felt that Jason should not hear the details of life at home while he was deployed, explaining that she did not want to distract him from his mission. Jason expressed that, even though he appreciated her concern, withholding such information made him feel disconnected from his family. Upon learning this, Jennifer said that she would start sharing more information during phone calls. Jennifer and Jason discussed how to maintain stable routines at home, such as morning and bedtime routines.

To help maintain their connection at a distance, Jason had Sara help him trace an outline of his hand onto a piece of paper. Sara and Jason colored the drawing together and put it on the wall next to Sara's bed where, as part of the bedtime routine, Sara and Jennifer would each give Jason a high-five. They also agreed that when reminding the children of the family rules, Jennifer would say things that included Jason, such as, "Your daddy and I agree that you can watch 30 minutes of television after dinner and before bed." Finally, Jennifer would support phone calls from Jason to Sara, even if they were brief or made Sara sad. Jennifer planned to acknowledge to Sara that it is okay to feel sad when she missed her dad instead of rushing Sara off the phone.

In order to share important developmental milestones and family events with Jason, Jennifer agreed to provide a weekly email update and photos of Charlie and Sara engaged in any new activities. Jennifer also decided to keep a photo album throughout the deployment so that Jason could review all of the activities and events with the family when he returned.

Jason, Jennifer, and Sara returned for one final session. Jennifer and Jason wanted to focus on how to play with Sara to build her confidence and further decrease tantrums. Jennifer and Jason were amazed when they saw how long Sara could remain on one activity when they narrated her play. Both parents became very comfortable praising Sara's positive behavior, and providing her with frequent and concrete feedback (e.g., "I really like the house you built with those blocks"). They agreed to use these skills during a special playtime each evening, and discussed how they could also use these strategies with Charlie.

Learn More

FOCUS
www.focusproject.org

ZERO TO THREE Coming Together Around Military Families
www.zerotothree.org/about-us/funded-projects/military-families

National Military Family Association
www.militaryfamily.org

National Child Traumatic Stress Network: Information for Military Families
www.nctsn.org/nccts/nav.do?pid=ctr_top_military

Sesame Workshop Talk Listen Connect: Deployments, Homecomings, Changes
http://archive.sesameworkshop.org/tlc

Overall, the family was strengthened through their work with FOCUS-EC. They benefited from enhanced communication, identification and pursuit of achievable goals, more effective problem solving, and improved emotional regulation. Jennifer and Jason were able recognize how their own behaviors, thoughts, and feelings affected their children, such as how their own deployment reminders (e.g., Jason remembering how bad it felt when his daughter did not remember him) affected their parenting decisions (e.g., Jason giving into Sara's tantrums). When they were able to decrease feelings of guilt, they were able to focus on more positive interactions with their children. They were able to reflect on and understand their partner's perspective and express empathy toward one another. They were better able to reflect on their own internal reactions to the stress of deployment and work together as co-parents and leaders of their family to set the stage for improved family cohesion and support.

Conclusion

FOCUS-EC uses targeted prevention strategies that are strength-based and family-centered to mitigate the impact of parental stress or traumatic exposures and promote resilience in families with young children. It has been used effectively to enhance skills for families facing many different challenges, including parental medical illness, natural disasters, and military deployments, by providing parents with developmentally informed education; building emotional regulation, communication, problem solving, and goal-setting skills across the family; and providing strategies for managing deployment and traumatic stress reminders. FOCUS-EC is responsive to the developmental needs of younger children and uses strategies such as visual aids and play to engage and educate younger children who may not be able to communicate their feelings and thoughts verbally like older children. FOCUS-EC is a promising practice that warrants further research and exploration regarding application to other high-stress populations.

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Infant Mental Health and the Treatment of Early Trauma

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Editor's note: The following article is excerpted and reprinted by permission of the publisher, Wiley-Blackwell, from the book, Nurturing Children and Families: Building on the Legacy of T. Berry Brazelton, *edited by Barry M. Lester and Joshua D. Sparrow. Copyright © 2010 by Blackwell Publishing Ltd. In the first excerpt, Alicia F. Lieberman and William W. Harris explore the impact of violence and describe a treatment approach to the trauma of domestic abuse. In the second excerpt, Joy D. Osofsky and Howard J. Osofsky discuss traumatic exposure to natural disasters and share their work with young children and their families in New Orleans, Louisiana, following Hurricane Katrina. For permission to reproduce, please contact Blackwell Publishing.*

Conflict and Hope in Raising Babies

Alicia F. Lieberman and William W. Harris

Remarkably but also predictably, infants, toddlers, and preschoolers have been largely absent from epidemiological studies of children's exposure to domestic and community violence. The youngest children surveyed are usually of school age because preverbal children cannot articulate their experience, which is dismissed as unimportant by adults for whom language is the primary vehicle for communication. Yet Cicchetti, Osofsky, Zeanah, and others have demonstrated the destructive impact of violence in infancy and early childhood on social, emotional, and cognitive functioning (Cicchetti & Lynch, 1993; Osofsky, 1995; Zeanah & Scheeringa, 1997).

As understanding of how trauma affects babies and young children sharpened and expanded, the logical next question was: how does it affect their earliest interactions? How can a trauma lens elucidate component parts of the dyadic relationship and suggest opportunities for intervention? The search for answers led to the creation of the University of California, San Francisco Child Trauma Research Program, where Patricia Van Horn and I (AFL) introduced the assessment and treatment of traumatic stress in the parent–child dyad as the focus for child–parent psychotherapy with children aged birth to 5 (Lieberman & Van Horn, 2005, 2008). Present-day trauma became for us the next frontier in understanding and treating the etiology of disorders in the parent–child relationship. Building on Brazelton's and Fraiberg's work, child–parent psychotherapy incorporates sustained attention not only to the baby's individuality and the mother's enactment with the baby of internalized conflicts from her past, but also attention to the shattering impact that domestic and community violence and child maltreatment can have on the child's and parent's perceptions of each other.

We have come to believe that assessing for traumatic stressors in the parent–child relationship is a clinical duty because of their high prevalence, despite the widespread professional reluctance to openly inquire about them. Learning to probe for traumatic events is essential to helping parents and children overcome their shame and fear to disclose them. Without this information, it would be impossible to make a differential diagnosis, for example, between post-traumatic stress disorder (PTSD) and attention deficit/hyperactivity disorder and to provide appropriate treatment because symptoms such as inability to concentrate, hyperarousal, hypervigilance, constriction of affect, and excessive reactivity are key criteria for both conditions.

For each diagnosis, the child's relationship with the parents needs to be addressed differently. When there is family violence, our data show a significant relationship between the child's traumatic experiences and the mother's symptoms of PTSD. This finding complements the findings by Scheeringa and Zeanah (1995) that young children showed more symptoms of PTSD when they witnessed their mothers being abused than when the children were abuse victims. These two sets of findings suggest that mother and child are each deeply traumatized by the trauma of the other. This is the dark side of the exquisite mutuality between mother and child that Brazelton so masterfully describes.

Hope is intricately embedded even into this bleak picture. In our sample of preschoolers referred for witnessing domestic violence to their mothers, significant clinical improvement in the child and mother and in their relationship occurred when battered mothers and their children processed their traumatic experience together by using play with dolls and animals to enact the trauma and give it a safe ending, and talked with each other about it, dispelling the terrible taboo—associated with unspeakable events of family violence—against putting terror into words. On follow-up 6 months after child–parent treatment termination, mothers continued to improve in symptoms of global psychiatric distress when compared with the comparison group in which about 70% of mothers received individual psychotherapy (Lieberman, Ghosh Ippen, & Van Horn, 2006). Children's improvement at treatment's end serves as an ongoing source of well-being and increased self-esteem for mothers, an antidote to maternal depression, anxiety, and traumatic stress. An unpublished analysis of our outcome data shows that child–parent psychotherapy is particularly effective in repairing the parent–child relationship for children subjected to multiple traumas (e.g., physical abuse and witnessing domestic violence).

Addressing trauma directly is necessary, but focusing only on trauma can be traumatizing and derail the clinical process. This is where "angels in the nursery" become allies in our work. "Angels in the nursery" is a term coined by one of the authors (Harris) and represents the intersection of Fraiberg's focus on childhood experiences that haunt parents and Brazelton's positive focus. During the initial assessment we ask mothers about past and present trauma, but also about memories of times when they felt unconditionally loved and protected as they were growing up. Their early and current experiences are marked by poverty, violence, and cultural marginalization and dislocation, including ethnic discrimination and immigration from countries at war or civil strife. Sadly, 50% of the women cannot retrieve any memories of being unconditionally loved. For these women, our explicit message is that child–parent psychotherapy can offer an opportunity to create these loving memories for the first time in their relationship with their child. As the remaining 50% tell us about tender memories with their mother, father, a grandmother, or aunt, they often seem to rediscover an experience of themselves that had long been forgotten under the burden of present adversities. We then ask them how their loving memories might apply to what they want to create for their child. These memories become our guide, linking what is best in the mothers' past to what they hope for in their relationship with their children.

Energized by our successful outcomes, and the fact that 50% of mothers reported domestic violence starting during pregnancy, we expanded our protocol to include pregnant women battered by their partners, continuing treatment after delivery. The intervention model involves collaboration with our hospital's OB-GYN and Pediatrics departments to coordinate emotional and physical care of mother and baby. Our experience to date confirms Brazelton's wisdom in designating pregnancy as the first touchpoint of development.

The effects of domestic violence on pregnant women's health are equal to or greater than routinely monitored complications (e.g., gestational diabetes, preeclampsia), and include low weight gain, hemorrhage, infections, anemia, predelivery hospitalization, Cesarean sections, and complications from delayed medical care from fear of abuse disclosure (Gazmararian et al., 1996). Fetal exposure to domestic violence is linked to prematurity and low birth weight (Gazmararian et al., 1996) and behavioral outcomes like excessive crying and feeding and sleeping problems (Regalado & Halfon, 2002). Battered women have greater difficulty bonding with their infants and show higher rates of punitive childrearing practices and child abuse (Osofsky, 1995). Brazelton's emphasis on the affective loop between baby and mother appears to be at play.

When a traumatized mother's baby is not responsive to her care, blaming the baby for making her feel inadequate can lead to the predictable next link in a cycle of violence that is transmitted from battering father to battered mother to battered child. Our program's clinicians report that psychotherapy with battered pregnant women and their babies is the most emotionally demanding aspect of their work because of their acute sense of responsibility for the pregnant woman, her fetus, and later, the newborn. It is particularly rewarding that our intervention leads to dramatic improvements beyond treatment's end, when the baby is 6 months old. Comparisons of the spread of scores for maternal depression, PTSD, and parenting stress before and after treatment show no overlap at all between the pretreatment and the posttreatment scores—which we attribute to this relationship-focused intervention during pregnancy and babies' first months of life.

One of Brazelton's most persistent themes is the importance of involving fathers in every aspect of intervention on children's behalf and from the beginning, asking mothers to bring fathers for pediatric prenatal visits. We strive to meet Brazelton's stringent standards for paternal inclusion, but encounter formidable obstacles. One is the sobering instability of marriages and partnerships. In our sample of battered pregnant women, only 47% are still with the baby's father in the second or third trimester of their pregnancies, when they are referred for treatment. It is very difficult to engage fathers on behalf of their babies when parental relationships have ended—particularly when mothers want to maintain distance from them.

Another obstacle to paternal participation in this context is safety—for the mother, child, and therapist. There is a very high overlap between the incidence of domestic violence and of child abuse, ranging from 30–70% depending on the sample (Kitzmann, Gaylord, Holt, & Kenny, 2003). Many of the women we work with report harrowing histories of child-witnessed domestic violence. Stalking and threats of violence after separation are common. The father's denial of his aggression in spite of medical evidence and police reports jeopardizes the hope for his successful participation in our treatment, in which an explicit examination of traumatic events and their emotional impact is an integral component.

A third obstacle is the relative leniency of the courts in child custody disputes with allegations of domestic violence. Judges are often skeptical about maternal disclosures of domestic violence. They may order treatment as a condition for shared custody or visits with the child, but often fail to ask at the next hearing whether the father enrolled in or completed the program. Without court involvement to assure accountability, offending partners lack external incentives for treatment and therapists lack the institutional protection they need to provide treatment to these men.

Children are best served by meaningful relationships with loving and protective mothers and fathers. Mindful of the obstacles, we created a co-parenting model for child–parent psychotherapy with parents who committed acts of domestic violence. To nurture the violent parent's safe relationship with the child, safe cooperation between estranged parents with regard to their child is required. Prerequisites for treatment of court-referred parents locked in child custody disputes include continued court oversight of the violent parent's compliance with court decisions and specialized community programs or individual psychotherapy. The assessment with each parent addresses the violent partner's lethality, recognition of the aggression, remorse, and motivation to change, and requires the violent parent to make a commitment to refrain from aggressive behavior as a prerequisite to continue evaluation for treatment. Only when the clinician feels that he or she can work safely with both parents is treatment proposed. Both parents must sign information release consents for all institutions and service providers involved and agree to information sharing with the other parent.

Within this protective framework, the treatment format involves separate mother–child and father–child sessions with the same therapist. This single co-parenting therapist model enables the child to build a much-needed continuity of experience while going back and forth between the mother and the father. It also helps clinicians balance perspectives so that neither parent is demonized or idealized—a common pitfall when listening only to one parent's viewpoint. The child is our best information source. When the child engages with the parent without apprehension or fear, we feel more confident of the potential for treatment success. When the child remains guarded and hesitant after several sessions with one or both parents, this signals that the danger risk remains high. If joint sessions with each parent are not informative, individual sessions with the child are prescribed to offer a setting where frightening experiences can be safely disclosed.

We are cautiously extending this co-parenting model beyond parents engaged in child custody disputes to parents living together. The violent parent's commitment to refrain from aggression is again a prerequisite for treatment. We can't emphasize enough how shaky the ground feels in working with perpetrators of violence. The work calls for faith in the possibility of meaningful change combined with an unsentimental realism about the elements conspiring against change and a hard-headed determination to stop treatment if necessary and file reports that may lead to parental custody or rights termination. We cannot afford complacency when treating perpetrators of violence and their children. Not all clinicians are equipped for this work but, when they are and when parents cooperate, the results can be truly astounding as parents overcome lifelong patterns of interpersonal violence for their children's sake.

Trauma, Intervention, and Recovery: Children and Disasters

Joy D. Osofsky and Howard J. Osofsky

Unique opportunities have emerged in Louisiana in the past 3 years related to young children and trauma. In the aftermath of Hurricane Katrina, the authors and LSU Health Sciences Center Trauma Team have not only been able to respond to and help support communities following a major natural and man-made disaster, but also to take a leadership role in keeping a perspective on young children and families and their needs in a postdisaster and recovery environment. In the New Orleans Metropolitan Area, we are now 3½ years post Hurricane Katrina and yet mental health problems remain as the recovery continues. As one sensitive school administrator commented recently, it is as if some people are now "becoming unraveled." Once families are resettled in their homes and communities, they are coming to the realization that their life is not and will never be the same as it was before Hurricane Katrina. Their neighborhood and community is different, their extended family and close friends are no longer there, and their life is different. The LSU Health Sciences Center Departments of Psychiatry and Pediatrics in New Orleans are continuing to provide multidisciplinary training, research, consultations, evaluations, and clinical services, as well as play a key role in supporting the behavioral health recovery of young children and their families in Louisiana and throughout the Gulf Region.

Young children are particularly vulnerable during and after disasters because they are totally dependent on caregivers and others to take care of them—and they do not have a clear way to express their needs. Further, disasters also traumatize caregivers so that they are often less emotionally available and sensitive to the needs of young children. Many caregivers and responders do not recognize that developmentally specific responses to trauma and disasters vary for children of different ages. In fact, disaster response often does not take into account the needs of our youngest children for safety, consistency, nurturance, places to play, and ways to be children.

In considering the response of Louisiana to young children following Hurricane Katrina, it is important to note that Louisiana ranks 49th in the nation in a recent state-by-state study on the well-being of America's children (KIDS COUNT Data Book, 2008) and 50th in percentage of population lacking access to quality health and mental health care (Congressional Quarterly, March 2008, "Health Care State Rankings 2008"; Health Care Across America, The Advocate, March 27, 2008). The city of New Orleans has a tradition of being a community with much history and character but also a legacy of racism and continuing poverty. When Hurricane Katrina devastated New Orleans in August 2005, the reported poverty level was 23.2%, almost twice the national average of 12.7%. Thirty-eight percent of New Orleans children live in poverty (Fass & Cauthen, 2005), and two thirds of families living below the poverty level are headed by a single mother. Unfortunately, children who live in poor families often experience more trauma than children whose families are more advantaged, placing them at risk for mental health problems. Children who are exposed to multiple traumas are at greater risk of mental health problems, and also less likely to receive mental health services that can prevent more serious problems over time.

Separation from family members as a consequence of disaster is one of the most disturbing issues facing young children. Hurricane Katrina was particularly hard on children; within 1 week after the hurricane made landfall, the National Center for

Missing and Exploited Children received calls regarding 4,909 children who were missing or dislocated from their families (Broughton, Allen, Hanneman, & Petrikin, 2006). In addition to separation from family, young survivors of Hurricane Katrina lost their homes, their toys, stability from caregivers, relatives and surroundings, all of which are so important for children's healthy development.

TRAUMA SYMPTOMS IN YOUNG CHILDREN

The manifestation of trauma in young children is a function of age and developmental phase and is strongly influenced by the child's limited perceptual, cognitive, and linguistic abilities (Kronenberg et al., 2010; Lubit, Rovine, Defrancisci, & Eth, 2003; Osofsky, 2004). Posttraumatic stress disorder (PTSD), including re-experiencing, avoidance, and hyperarousal, has been shown to occur in young children in varying degrees and form with manifestations that are somewhat different from those of older children (Blank, 2007; De Bellis & Van Dillen, 2005; Lieberman & Knorr, 2007; Zero to Three, 2005). For example, young children re-experience the traumatic event, but are more likely to show their reactions through changes in play, new fears, regressive behaviors, and frightening nightmares. Young children are also more likely to engage in avoidant behaviors similar to older children. Young children can become withdrawn, emotionally restricted and numb, and lose interest in play. Regression may include the loss of previously acquired self-care, language, or motor skills; young children may demonstrate regression reverting to behaviors from an earlier developmental stage such as thumbsucking and clinging (Lieberman & Knorr, 2007). Symptoms of increased arousal may be manifested through exaggerated startle responses, irritability, hypervigilance, and physiologic deregulation (Blank, 2007). Following a trauma, preschoolers are more likely to engage in irritable, impulsive, and aggressive behaviors.

A limited number of studies have documented the chronicity of PTSD symptoms in young children. Lubit et al. (2003) found that while half of the traumatized children in their study were able to address and deal with their PTSD symptoms within 3 months, a substantial number continued to exhibit PTSD symptoms for a year or more. Based on maternal reports, Swenson et al. (1996) found that 33% of young children demonstrated emotional and behavioral problems 3 months after Hurricane Hugo, 16% showed them 6 months after the storm, and 9% still had problems 7 to 9 months after the storm. In our work (Kronenberg et al., in press, 2010; Osofsky, Osofsky, & Harris, 2007; Osofsky et al., 2009), in the most heavily devastated areas immediately following Hurricane Katrina to 4 years after the storm, we are finding that young children demonstrate increased dysregulation and aggressive or withdrawn behaviors. The most common symptoms for young children include clingy behavior and worries about separation, worries about what might happen, especially during hurricane season, a hard time concentrating and behavior problems. Their parents reported that 93% were displaced, 81% lost their homes and personal property, 75% were unemployed, 69% transferred to a new school, 31% were separated from pets, 17% were separated from caregivers, and 16% reported prior loss or trauma contributing to greater risk. Of this group of young children, 8% reported family or friends were killed. Perhaps, not unexpectedly, 34% of the parents requested counseling for their young children.

CONCLUSIONS AND LESSONS LEARNED

For prevention and early intervention, it is essential to raise awareness by providing immediate and ongoing education and training about trauma and the effects on infants and young children to service providers across systems that serve young children and their families. We have found these precepts to be crucial in a wide variety of settings, exemplified here both in work with young children in court settings who have been traumatized by abuse and neglect, and young children who have been traumatized by an overwhelming disaster impacting on them, their caregivers, and the community. The goal is to work toward the development of a coordinated system that focuses on social, emotional, and behavioral well-being for children under 6 years of age. From a preventive mental health perspective, child and family mental health needs are a crucial component of child-serving systems. At present, children under age 6 are seldom identified by primary care providers or childcare providers as needing mental health services, with a concomitant scarcity of referrals to mental health programs. The stigma associated with mental health problems and the fear of "labeling" children at such a young age are powerful reasons for this situation, as is limited knowledge about the developmentally grounded mental health needs of infants and young children. These obstacles can be addressed by providing more accessible consultation, assessment, prevention, and therapeutic services in ecologically acceptable settings, including homes, childcare centers, Head Start and Early Head Start Centers, schools, family resource centers, and community centers. By focusing on the needs of our most vulnerable citizens, our youngest children, we can prevent human tragedy and also save immeasurable human and financial costs for the repair and rehabilitation that may be needed later in their lives.

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for Traumatic Stress Studies; the Public Citizen of the Year Award by the Louisiana Chapter of the National Association of Social Workers; and the LSUHSC team from the Department of Psychiatry was awarded the Distinguished Partners in Education Award by the Board of Elementary and Secondary Education of the State Department of Education for their work in schools following Hurricane Katrina.

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Supporting Young Children in Combat-Injured Families

Call to Action

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The nation finds itself in the midst of the longest period of war since its inception, now well over 8 years, with ongoing conflicts in both Afghanistan and Iraq. To date, more than 36,000 service members have been wounded in action (Leland & Oboroceanu, 2010). Children less than 5 years old represent the largest group of children (41.5%) whose parents are in Active Duty and the second largest group of children (26.0%) whose parents are in the Reserves and National Guard. During 2008, there were close to 450,000 children from birth to 3 years old whose families were in Active Duty, the National Guard, and the Reserves (Department of the Under Secretary of Defense, Military Community and Family Policy, 2009). Cumulatively, more than 500,000 babies have been born into military families since the onset of conflict in 2001 (ZERO TO THREE, 2009).

The Davidson family, presented here, provides a framework for considering the impact of parental combat injury on families and young children at different developmental stages. The Davidson family represents a composite of clinical experiences with a variety of families; names and details have been changed to protect privacy.

The Wounds of War

Sergeant (SGT) Davidson, 26 years old, was injured in Iraq 7 months ago by an improvised explosive device during his third deployment, which resulted in burns on more than 50% of his body, with second-degree burns to his face, multiple fractures, and nerve damage to his left leg that will necessitate its amputation. He was initially not expected to survive his injuries. This amputation will be his 10th surgery since the injury, and he is expected to need an additional 10 to 15 surgeries before the completion of rehabilitation.

Because of advancements in protective equipment (body armor), medical care, and evacuation systems, an unprecedented number of service members are surviving catastrophic injuries sustained in Afghanistan and Iraq. In fact, only 8.8% of service members wounded in Iraq and Afghanistan die from their injuries, compared with 22.8% in World War II (Eastridge, Jenkins, Flaherty, Schiller, & Holcomb, 2006). Injuries seen at military hospitals in the current conflicts include burns, amputations, traumatic brain injuries (TBIs), and soft tissue injuries such as gunshot wounds and orthopedic injuries, to name a few. Severely injured service members often sustain multiple types of injuries with lasting changes to their functioning as illustrated by SGT Davidson in the case study. Blast injuries from weapons such as improvised explosive devices and rocket-propelled grenades are new to the current conflicts and can result in physical, cognitive, and psychological injuries.

Psychological injuries, such as post-traumatic stress disorder (PTSD) and depression, may accompany physical injuries (Grieger et al., 2006). PTSD has been termed a signature wound of the wars in Iraq and Afghanistan, (Altmire, as cited in Tanielian & Jaycox, 2008) because of its high rates in returning service members, both injured and uninjured. Mental health conditions in general have also been called "the invisible wounds of war" (Tanielian & Jaycox, 2008), because they can occur without significant visible changes to the physical exterior of the service member and may therefore remain unrecognized, unacknowledged, and untreated. Cognitive

Abstract

Military families are currently facing the longest period of combat in the history of the nation, along with the attendant challenges of prolonged or repeated deployment. With the return of 36,000-plus service members wounded in action, including nearly 11,000 requiring medical evacuation and those with additional "invisible injuries," there are pressing needs for ongoing community support. This article considers the experiences and needs of the youngest children in combat-injured families. The authors provide an overview of how combat injuries and their recovery and rehabilitation have an impact on family life and on young children and provide strategies for support and intervention.

impairments from TBI have also been described as both a signature wound and an invisible wound of war in the current conflicts.

Service members who return home with complex trauma injuries require protracted medical care and rehabilitation that affect families over time, not just immediately after the initial injury. In fact, in combat-injured families, preschoolers and school-aged children referred for services at Brooke Army Medical Center (BAMC) exhibited a series of adjustment disorders in which they sought treatment multiple times in response to different and changing stressors during parental treatment and rehabilitation: adjustment to stressors such as parental injury, family disruptions, parental reintegration and role realignment, caregiving roles, marital conflict, and developmental and educational transitions (Jackson, Barber, & Arata-Maiers, 2010).

Family Disruption After Injury

SGT Davidson has been married for 6 years to Diane, and they have a 3-year-old son, Julian, a 2-year-old daughter, Cindy, and an 8-month-old son, Stephen. Mrs. Davidson and baby Stephen came to BAMC within a day after notification of SGT Davidson's injury while the older children lived with family relatives for several months and then moved to Fort Sam Houston during a break in the preschool year.

In studies completed at BAMC and at Walter Reed Army Medical Center (WRAMC), most combat-injured families were young families that included young children. In the only published study of combat-injured families based on a clinical record review of interviews with the spouses of injured service members at BAMC and WRAMC (Cozza et al., 2010), 66% of the injured service members and their spouses were less than 30 years old and 63% had been married for 5 years or less. Although the average age of the children was 5.3 years old, 75% of the families had children less than 3 years old. A BAMC study of children of the combat injured (Jackson et al., 2010) also indicated that children as young as 1 year old were referred for behavioral health services.

The immediate focus of the family on notification of the injury is on the service member, with the noninjured parent typically traveling to wherever the service member is hospitalized. Decisions must be made about whether to take the children, how to care for children who do not accompany the spouse and for those who relocate with the spouse, and how to maintain remote household responsibilities such as house maintenance, pet care, and finances while the spouse is absent. Families often depend on an extended network of relatives and friends to provide care and support at this time.

Postinjury, families consequently experience multiple disruptions to their lives: changes in living circumstances, social networks, geography, and caregivers. Families identified as most at risk for problems during deployment—those with other family stressors such as pregnancy, financial problems, family members with medical or mental health needs, and foreign-born spouses (Weinstock, n.d.)—are likely to be similarly at risk postcombat injury. National Guard and Reserve family members face the unique challenge of becoming "suddenly military" (National Military Family Association [NMFA], 2005) during the service member's first deployment, with its sudden integration of the entire family into the military culture, structures, benefits, and procedures. After combat injury, Reserve and National Guard families may be much less familiar with the military support services and may experience routine military family stressors, such as relocation, for the first time.

The Impact on Children

Baby Stephen's sleep and eating habits actually improved when his father returned from deployment because of his combat injury. Mrs. Davidson reported that he was initially fussy at the hospital and in their new lodging with all the new people and environments but that he had subsequently made friends with the hospital staff and other combat-injured soldiers.

Infants are generally unaware of illness or injury, but they are aware of changes in their environments, especially those that affect the fulfillment of their needs. Infants are highly dependent on their parents to meet their physical and emotional needs. The limited physical and emotional availability of parents in a combat-injured family may result in inconsistency or even neglect in meeting these needs. When mothers are emotionally nonresponsive, infants will seek emotional contact with them through smiling, eye contact, stretching out their arms, and friendly verbalizations. They will subsequently exhibit protesting, crying behaviors, and finally resigned, depressed behaviors (Spitz, as cited in Diareme et al., 2007). Even a temporary loss of the primary caregiver may result in infant distress anytime during infancy. A developmentally normal separation anxiety, generally manifested during the second half of the first year, could be intensified by the physical or emotional nonavailability of parents. Just how parental combat injury affects the developmental trajectory of an infant across the lifespan is unclear.

Babies may exhibit a host of signs and symptoms potentially indicative of distress. Sleep and feeding problems may arise. Difficulties with separations from caregivers or with self-comforting and ineffective comforting by caregivers in the baby's life may manifest as increased irritability, fussiness, and crying. In alignment with developmental expectations for infant distress responses, spouses of combat-injured service members at BAMC and WRAMC reported that their infants' sleep, eating, and separation behaviors were affected (Cozza et al., 2010) after the combat injury.

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Because of her father's facial injuries, 2-year-old Cindy did not initially recognize her father until he tickled her tummy, a favorite game of theirs. She is having behavioral problems at home and preschool, with her parents questioning whether Cindy is demonstrating normal behaviors for a 2-year-old or is having a difficult adjustment to her father's injuries and subsequent life changes. Her parents have not told her caregivers that her father is a wounded warrior.

Toddlers may have little understanding or even awareness of the parent's illness but may react to the inconsistency of the parent in limit-setting, attention, or availability. Separation from their parents may be experienced as abandonment or punishment (Diareme et al., 2007). Two-year-olds have not developed the linguistic skills to articulate their feelings when they are frustrated

Photo: Marilyn Nolt

Two-year-olds have not developed the linguistic skills to articulate their feelings when they are frustrated and so are prone to temper tantrums.

and so are prone to temper tantrums. Regressive behaviors, including a return to thumb sucking and baby talk, may be seen. Extended separations or distress of the parents may be a source of frustration and severe tantrums (Diareme et al., 2007).

Children of all ages benefit from preparation for hospital visits, which typically involves telling children what changes to expect in their parent's appearance along with a developmentally appropriate explanation of the parent's injuries. Use of dolls or drawings to indicate the location and appearance of injuries before hospital visits can prepare children for their initial meeting with the injured parent. Anecdotal reports indicate that young children sometimes do not recognize the injured parent, perhaps as a result of limited memory of the parent because of parental absence or as result of the changed physical appearance of the injured parent.

Given that behavioral disruption is developmentally expected in 2-year-olds, Cindy's parents are correct in questioning whether her behavior is developmentally appropriate or injury-related. Consultation with child care providers to determine whether her behavior is atypical of her peers may be useful, as well as observing the frequency, intensity, and duration of the problematic behaviors relative to her same-age peers. Also of importance is communication about parental combat injury with child care providers and school personnel. In the face of intense focus on the injured service's medical and emotional needs and multiple family disruptions, communication with child care providers or schools about the injury may be overlooked. Child care providers and school personnel can use such information to contextualize the child's behavior, report concerning behaviors to parents, and provide support within the child care setting.

Injury Communication

For several weeks after the injury, 3-year-old Julian refused to take baths, stating that he was afraid of alligators in the bath water. Caregivers at his preschool report that Julian engages in frequent repetitive play with toy alligators. Family members had not known how to explain his father's injuries to him, and Julian had overheard a description of his father's leg injuries looking "like an alligator bit him."

Preschoolers may have an elementary understanding of illness and injury and the resulting changes in their parents. Their egocentric and magical thinking, however, may lead to primitive guilt feelings for causing parental injuries through their misbehavior, anger, or negative thoughts about their parents. They may think they can make the parent well through good behavior and respond with anger and despair when the parent does not fully recover. They typically cannot sustain negative emotion states for as long as adults can, so they will be playful in the midst of adults' negative emotion states unless they sense that their play and fun is perceived as inappropriate by the adults (Diareme et al., 2007). In addition to regressive behaviors, reenactment of distressing events or themes can be observed in the play of young children in their attempts to master their fears and confusion, as is seen in Julian. Young children from combat-injured families experiencing separation stress may exhibit aggressive behaviors and attachment difficulties similar to those in young children experiencing parental deployment separation (Barker & Berry, 2009; Chartrand, Frank, White, & Shope, 2008).

Injury communication, a term coined by Cozza and Guimond (in press) to describe communications about the injury within the family and with providers, is an important factor in the family's adjustment. Julian's reactions illustrate the importance of injury communication, which allows parents to address children's fears with realistic information and to allay guilt feelings. Without parental guidance about parental changes from injury or illness, children will construct their own understanding of the situation, which can provoke significant fear responses. Cozza and Lieberman (2007) also warned that providing too much information, such as forcing children to view the wounds, can have as negative an effect as providing too little information. Children may also respond to the injuries of other patients with additional questions or distress, a common theme being fear of "catching" the injury themselves. Children may become particularly concerned that injury will affect their parent's ability to play (Rauch & Muriel, 2006).

Toxic Stress

Almost 90% of brain size is complete by the third year of life (ZERO TO THREE, 2008). This critical period of rapid, complex brain growth and development presents a window of particular vulnerability to the effects of toxic stress. Toxic stress has been defined as "intense adverse experiences that may be sustained over a long period of time—weeks, months, or even years" (Middlebrooks & Audage, 2008, p. 4.) as may be seen in combat-injured families. Adults in the lives of babies and toddlers can buffer toxic stress exposures through consistent, engaged nurturing, stimulation, and responsiveness, which are absolute requirements for optimal brain growth and development in the early years of life (National Research Council & Institute of Medicine, 2000).

The family is currently experiencing increased sibling, parent–child, and spousal conflicts. After SGT Davidson's initial discharge from the hospital, Mrs. Davidson spent 5 to 7 hours per day in wound care for several weeks. SGT Davidson was upset that her caregiver role was overshadowing her spousal role and "wanted his wife back." Parents and children report that SGT Davidson has been more easily angered, more forgetful, and more hesitant to interact with the children because he is not currently able to be the physically active parent he had been in the past. They also report that SGT Davidson's rehab period is the longest uninterrupted period of time the children have spent with their father in their lives, given his previous deployments, work-related travel, training, and job demands.

Studies on American families with parents injured in Afghanistan or Iraq are just emerging. Consequently, most of the literature used in working with combat-injured families draws from the literature on deployment, serious or chronic parental illness (e.g., diabetes or cancer), injury or disability, parental mental illness, families in natural disasters, and literature from other countries engaged in ongoing conflicts (e.g., Israel).

Combat injuries represent a sudden, feared ending to a combat deployment. Postdeployment surveys (U.S. Army Community and Family Support Center, 2005) of noninjured families indicated that parents report adjustment difficulties with changes in the service member, handling children, reestablishing roles, communication, household routines, family decisions, children's expectations, and marital intimacy, difficulties made more complicated in combat-injured families.

Although current literature on the mental health of the spouses of the combat-injured does not exist, military wives whose husbands are deployed experience more mental health diagnoses, including depressive disorders, sleep disorders, acute stress reactions, and adjustment disorders, than the wives of the nondeployed, according to a recent study (Mansfield et al., 2010). Nondeployed spouses endorsed personal depressive symptoms in Chartrand et al.'s (2008) study of preschoolers, and school-age children with deployed parents reported that the nondeployed parent's behavior and mental health are affected by the challenges of deployment (Chandra et al., 2010). The parental deployment and civilian caregiver literature suggest that the noninjured parent's support needs should be a focus of intervention.

Increased demands on military spouses of combat-injured service members and long-term, possibly permanent, changes in the injured spouse can be expected to affect the marital relationship. In civilian families in which a parent experiences a TBI, the long-term changes in the injured spouse can place the spouse in caregiving or parental roles and alter or end spousal intimacy. In fact, 30–50% of civilian marriages end in divorce within 8 to 10 years after the TBI (Verhaeghe, Defloor, & Grypdonck, 2005). Respite and in-home nursing care can be invaluable to these families.

Parental symptoms related to the injury or illness affect children: fatigue, pain, concentration or memory loss, difficulty speaking, changes in appearance, and anger, according to the parental illness literature (Rauch & Muriel, 2006). Children may interpret parental forgetfulness or fatigue as a loss of parental interest and may personalize parental irritability. Increased parental depression, parental conflict, parental divorce, and disrupted parenting have been associated with civilian families with parental illness. In disrupted parenting, parental support of the child and discipline decreases while changes in family routines, unintended neglect, and parental absence and unavailability of the parents increase related to a reorganization of the family around the medical needs of the ill parent (Armistead, Klein, & Forehand, 1995).

Combat-injured soldiers are also likely to experience psychological symptoms such as PTSD postinjury (Grieger et al., 2006), which may affect the parent–child relationship. The PTSD symptom of emotional numbing has been related to the parent's perception of the quality of the relationship with children (Ruscio, Weathers, King, & King, 2002). Increased health risk behaviors, such as increases in smoking, alcohol consumption, fast driving, and irritability, seen postdeployment may place children of deployed and combat-injured families at risk for injury or maltreatment.


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Studies on American families with parents injured in Afghanistan or Iraq are just emerging.

Emotional or behavioral symptoms were endorsed in 49% of the children of the combat-injured families in the Cozza et al. (2010) study, with 93% of those children displaying internalizing behaviors. Some school-age and adolescent children also displayed adaptive and prosocial behaviors, such as assisting with chores or siblings (Chun et al., 2009). It is surprising that the spouses' perception of injury severity was not predictive of child distress, whereas the level of predeployment stress and postdeployment disruptions was.

Strategies for Support and Intervention

Behavioral health providers, medical providers, child care staff, preschool teachers and staff, extended family, friends, neighbors, and community members will all have opportunities to provide support to the child and family over time. First, neither pathology nor resiliency on the part of the family can be assumed. Community care providers working with these combat-injured families can facilitate sensitive engagement by incorporating the *Principles of Caring for Combat Injured Families and Their Children*, developed by the Workgroup on Intervention With Combat Injured Families (2007; see box Principles of Caring for Families Affected by War Injuries). In addition, the simple identification of "military connections" in families allows professionals to assist with the military family life challenges these families are facing. The American Academy of Pediatrics already has such a national campaign for civilian pediatricians in place.

Behavioral Health Professionals

Community behavioral health professionals can assist parents in identifying developmentally normal and abnormal behaviors and assist with adjustment problems and behavioral disturbances in

PRINCIPLES OF CARING FOR FAMILIES AFFECTED BY WAR INJURIES

- Family focused and helpful with injury communication
- Supportive of the family's strengths and resilience
- Informed about the military culture and the effects of war injury on the family
- Developmentally and gender sensitive
- Responsive to the family's changing needs over a course of treatment and rehabilitation
- Encouraging of partnerships between military and civilian professionals
- Engaged in providing safety, comfort, practical assistance, and connections to support resources within health care and community

Note. Adapted from *Principles of Caring for Combat Injured Families and Their Children*, by the Workgroup on Interventions with Combat Injured Families, 2007, Bethesda, MD: Center for the Study of Traumatic Stress.

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Routine health care visits afford opportunities for ongoing assessment of family support needs and serve as a safety net to identify escalating stressors.

Learn More

Resources for Providers and Families

Courage to Care, Courage to Talk…After War Injury
www.centerforthestudyoftraumaticstress.org
Resources from the Center for the Study of Traumatic Stress at the Uniformed Services University public awareness campaign for supporting young military children during wartime

Military Child Education Coalition
www.militarychild.org
Information on the Living in the New Normal program, with resources to foster military child and family resiliency

Military OneSource
www.militaryonesource.com
1-800-324-9647
An information and referral service for military families, including family assistance counseling, providing nonmedical counseling for military families dealing with stressors related to deployment

National Child Traumatic Stress Network
www.nctsnet.org
Addresses services for traumatized children, families and communities; see Military Children and Families

National Military Family Association
www.militaryfamily.org/
A grassroots advocacy organization to improve the quality of life for military families; sponsors Operation Purple Camps for children impacted by deployment, including those with injured parents.

Talk, Listen, Connect: Deployments, Homecomings, and Changes
www.sesameworkshop.org/initiatives/emotion/tlc
Bilingual toolkit designed to help young military children cope with feelings, challenges, and concerns experienced during various phases of deployment and parental changes with injury

ZERO TO THREE
www.zerotothree.org/about-us/funded-projects/military-families/
Coming Together Around Military Families increases awareness to more effectively care for very young children and their families facing deployment-related trauma, grief, and loss (including the Duty to Care training series)

Severely Wounded Warrior Programs

Air Force Wounded Warrior Program (AFW2)
www.woundedwarrior.af.mil
1-800-581-9437

Navy Safe Harbor-Severely Injured Support
www.npc.navy.mil
1-877-746-8563

U.S. Army Wounded Warrior Program (AW2)
www.aw2.army.mil
1-800-237-1336

U.S. Marine Corps Wounded Warrior Regiment (WWR)
www.woundedwarriorregiment.org
1-877-487-6299

Wounded Warrior Resource Center (WWRC)
www.woundedwarriorresourcecenter.com
1-800-342-9647
Department of Defense supplementary support program

children and parents through individual, family, and marital therapy. For example, a tool developed by Cozza, Chun, and Miller (in press), the Parent Guidance Assessment–Combat Injury (PGA-CI), provides a preventative intervention focusing on family members' developmental needs, adjustment to combat injury, and resultant changes in the families' lives. The PGA-CI is a semistructured interview that addresses the impact of combat injury on the spouse and children, behavioral changes in the child, the effects of hospital experiences, and injury communication. The PGA-CI is currently used at several military hospitals including BAMC and WRAMC.

The Center for the Study of Traumatic Stress has developed an educational campaign, titled "Courage to Care, Courage to Talk," to facilitate communication around war injuries between families and health care providers and within the family itself, especially in talking to children. This educational campaign is currently being implemented at military and Veterans Affairs hospitals.

Pediatric Primary Care

Pediatric primary care providers can offer anticipatory guidance to include: recognizing stress reactions in young children, behavior assessment, paying attention to safety, keeping routines, and following up with scheduled well-child care. A number of excellent parent education materials and programs on combat injury and the needs of children have been developed. For example, the Bright Futures Developmental Tools for Families and Providers serve as a guide for when to seek help for parental or family stress and behavioral concerns. This resource can be accessed at www.brightfutures.org/tools (Mayer, Anastasi, & Clark, 2006a, 2006b).

Routine health care visits afford opportunities for ongoing assessment of family support needs and serve as a safety net to identify escalating stressors. Recent studies describe risks for child maltreatment with parental deployment stress (Gibbs, Martin, Kupper, & Johnson, 2007; McCarroll, Fan, Newby, & Ursano, 2008; Rentz et al., 2007). Providers should address parental mental health issues as concerns arise. Brief, validated mental health screens can be used, with referrals made as needed. In a recently published study (Eide, Gorman, & Hisle-Gorman, 2010), infants and toddlers of single military parents were seen less frequently for well-baby and outpatient visits during deployment whereas the children of married military parents were seen more frequently during deployment. Because both underutilization and overutilization of child health care resources may occur, attention to outreach and reminder strategies as well as the determination of the need for additional support services are important.

Child Care and Preschool

Free or reduced-fee respite services, a critical need for the combat-injured family, can be offered within civilian communities by certified, accredited child care programs. ZERO TO THREE has also developed curriculum and training resources for staff working with military families at a number of military locations around the country through its Coming Together Around Military Families initiative (See Learn More box).

Individuals and Communities

Family, friends, and neighbors can offer practical supports by reaching out to families, offering assistance with transportation, babysitting, running errands, providing meals, and offering emotional support with phone calls or visits. Faith-based organizations can offer child care or "mother's day out" programs, outreach visitation to families with gift baskets or meals, and prayers for healing. Businesses and organizations within the community at large have assisted with home remodeling and vehicle adaptations to accommodate the needs of recovering service members, military appreciation days at sports and recreational venues, and other creative responses showing gratitude and the collective community's desire to assist families facing the challenges before them.

Conclusion

The local community has gathered for the annual Fort Sam Houston Combat Medic Run. SGT Davidson joins in with his family. He wears a soft floppy hat to cover his healing burns and walks with a prosthetic device on his lower leg. He and Mrs. Davidson together push a double baby stroller with baby Stephen and Cindy inside, and with energetic Julian beside him proudly carrying his cane. The community runs and walks together beside the Davidson family in solidarity.

As current conflicts continue, the ongoing need for support for military families and children now and into the foreseeable future cannot be overstated. Given the nature of the catastrophic injuries that service members are experiencing in today's military conflicts, they and their families have an ongoing, arduous rehabilitation process ahead of them. At a summit hosted by the National Military Family Association in May 2010, First Lady Michelle Obama challenged every sector of American society to mobilize and take action to engage and support military families today and for decades to come (Obama, 2010). For no group is this call to action more urgent than for the children and families of our wounded warriors.

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Grief and Coping in Early Childhood

The Role of Communication in the Mourning Process

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Losing a parent in childhood is a profoundly painful experience and one that has major repercussions for almost all aspects of a child's life (Bowlby, 1960, 1961). The person who delighted in the child, who held and watched the child, and who protected the child and made things right is gone. With the death of a parent, children lose their basic sense of security and continuity. Daily rhythms and familiar, shared ways of relating are changed forever (Lieberman, Compton, Van Horn, & Ghosh Ippen, 2003). Younger children are particularly vulnerable to the vicissitudes of loss due to their almost complete dependence on a parent for survival (Bowlby, 1960, 1961). Children who lose a parent by death are more prone than children who have not lost a parent by death to suffer from chronic anxiety (Elizur & Kaufman, 1983) and to develop later episodes of depression, especially if the loss occurs before age 5 (Brown & Harris, 1978).

Processes of mourning help bring closure to loss (Parkes, 1972), but for many children, especially those who lose a mother early on, mourning remains incomplete. To resolve mourning, children need to openly express their grief at the loss. They must also tolerate intense feelings of despair, disbelief, sadness, yearning, and anger. A critical part of mourning involves coming to terms with the reality of death and understanding that the parent will not return. Bowlby (1960, 1961) underscores this notion, noting that for very young children mourning almost always takes an unfortunate course. Children with unresolved mourning may fantasize that the parent is alive even after much time has passed. Long after the death, children may continue to believe that they did something wrong and deserved to be left, or they may strongly deny the deep extent to which they were frightened and hurt by the loss (Lieberman et al., 2003).

What factors contribute to the course that mourning takes in children? Children's age and developmental level at the time of the death are important (Bowlby, 1980; Elizur & Kaufman, 1983; Raphael, 1983). Children even as young as 2 years old can resolve mourning if they are helped to do so (Lieberman et al., 2003). For very young children, grasping the finality of loss is likely to be difficult due to their cognitive immaturity (Furman, 1974). Preschool-aged children, for instance, may see death as something reversible, a belief that can be reinforced by cartoon characters who die and come to life again (American Academy of Child and Adolescent Psychiatry, 2008). See Conditions Responsible for Mourning Outcomes for factors that influence how children grieve.

Abstract
This article draws on interviews with women who experienced the death of their mothers during early childhood to explore the grieving process of a child for a lost parent. The author describes the women's recollections of how the loss was talked about, or not, in their families and how this impacted the women's mourning and coping. Most women who lost their mothers in early childhood had not resolved their grief. Women whose mourning was unresolved had experienced "walls of silence" (Bowlby, 1990) around the death and had felt pressure to care and comfort others who grieved, and they often idealized their mothers. In contrast, women whose mourning was resolved had experienced more open, supportive communication at the time of the death, which permitted asking questions, sharing information, and ultimately coming to terms with the loss.

Children with unresolved mourning may fantasize that the parent is alive even after much time has passed.

Photo: Marilyn Nolt

Children younger than 2 years clearly experience grief and pain at separation and loss (Lieberman et al., 2003). Although a continuum of responses exists, the responses of infants differ in important ways from the responses of children 2 years and older (Bowlby, 1980). For a young infant without language, object constancy and permanency have not yet been achieved. This makes it difficult for an infant to spontaneously recall an absent person and to understand the irreversibility of loss, both of which are important aspects of the mourning process.

Conditions Responsible for Mourning Outcomes

Factors that influence the course of mourning in children include the following:

- The quality of the child's relationships with both parents before the loss and the quality of the marital relationship
- How the parent died; whether the death was sudden or violent or associated with stigma
- Whether the child received prompt and accurate information about the death and whether there were opportunities to talk about the loss in the aftermath
- Family relationships after the loss; whether there was a comforting presence of a surviving parent or a trusting substitute following the death

Source: Bowlby (1980. pp. 311, 381)

Very young children are highly dependent on information from others (Bowlby, 1980), and it is important that children 2 years and older learn about the death from the surviving parent or caregiver (Bowlby, 1980; Becker & Margolin, 1967). According to Bowlby (1980, p. 271), "the two crucial items of information which sooner or later a child needs to know are first that the dead parent will never return and secondly that his body is buried in the ground or burned to ashes."

Children need information and emotional support to cope with the death. The surviving parent is typically the person who can best help the child come to terms with parental death, but this person is also grieving for a lost spouse (Lieberman et al., 2003). As a result, this parent may be so immersed in his own grief that it becomes hard to help the child. Surviving parents who withdraw in their own pain may not give a child the information they need to understand the death. Other surviving parents may give young children abbreviated or altered versions of how a parent died or they evade talking about the loss (Becker & Margolin, 1967), for example saying at the time of the loss that the parent is "sleeping" or has gone to a "garden." The child may interpret these statements literally and become confused about the permanency of death or cling to a belief that the parent may still return. A young child shielded from critical information or told with much delay will find it harder to fully believe that a parent has died.

The ways that families support a child in talking about the loss in subsequent years likely play a major role in how children mourn (Bowlby, 1980; Lieberman et al., 2003; McClowry, Davies, May, Kulenkamp, & Martinson, 1987), but there is little systematic work on such communications or on their links to different forms of mourning. Support and communication are always important, but they are especially critical for young children who have not yet internalized the ability to regulate intense feeling states (Lieberman et al., 2003) and who are not old enough to have stable and persisting memories Remembering the lost parent can be difficult for young children unless their memories are shared and talked about with an adult who knew the parent. If grief cannot be tolerated or talked about in the years that ensue, children will likely respond by suppressing their own grief and questions and hiding their feelings (Bowlby, 1980; Miller, 1997). Unresolved grief can contribute to longer term defensive processes that interfere with healthy mourning (Lieberman et al., 2003).

In the following section, I draw on retrospective interviews to examine how women mourn and coped after the death of their mothers in childhood, in relation to the ways the women's families talked about the loss in subsequent years and the emotional support the women received. I give particular emphasis to early loss, that is, to the mourning processes and memories of women were between 2 and 5 years old when their mothers died.

Looking Back at Early Loss

I interviewed 22 women who lost their mothers in childhood, specifically seeking out women who had memories of their mothers and of their responses to the loss. I visited the women in their homes and asked them what they remembered of their mothers in the years before the death, what the circumstances were surrounding the death, how they felt and responded to the loss over time, and how they mourned. I also asked the women how they were supported and how their fathers, relatives, caregivers, and siblings talked about the loss in the years that followed. I also queried them as to why they thought their fathers and families communicated as they did. I was particularly interested in finding out whether women who lost their mothers between ages 2 and 5 years were prone to show unresolved mourning and why.

The Losses

The women in the study were between 2 and 13 years old when their mothers died. All of the women lived in London, England, and had participated in an earlier study on the association between childhood bereavement and later vulnerability to depression (Bifulco, Brown, & Harris, 1987; Brown & Harris, 1978). As my aim was to better understand early grieving in relation to family communication patterns about death, I contacted women who had participated in the childhood bereavement study. Those who showed an interest in my study were further interviewed about the losses and about family communication patterns. At the time of the interviews the women ranged in age from 36 to 70 years old. Seven of the women lost their mothers in early childhood, between 2 and 5 years old; the remaining women were between 6 and 13 when the loss occurred. Ten of the women's mothers died suddenly, as the result of an accident, due to complications during childbirth, or after a short illness. One woman's mother committed suicide. For the other women, the loss occurred after a prolonged illness, often cancer or tuberculosis, which required long or repeated stays in a hospital or sanitorium. For women who were 5 years old or younger when their mothers died, most were shielded from their mother's sick bed in the preceding months and saw her only rarely before she died.

Assessing Women's Responses to Loss

I used Bowlby's seminal work on loss to determine whether the women had resolved their mourning or not. According to Bowlby (1980), in *resolved mourning* the individual is able to express and tolerate the intense feeling states which often accompany loss. The individual also comes to a cognitive understanding that the loss is final and reorganizes his or her feelings on this basis. *Unresolved mourning*, by contrast, results from defensive processes that permanently shield the individual from thinking about the loss (Bowlby, 1960, 1980). Consciously or unconsciously, an individual with unresolved loss still believes that the loss is reversible.

Unresolved mourning manifests itself in different ways, such as in the prolonged absence of conscious grieving. Chronic mourning, another form of unresolved mourning, involves an unusually intense and prolonged response to loss, often coupled with self-reproach or anger and a continued sense of connection with the lost person (Bowlby, 1980). Combinations of the two main types can also occur, with the individual showing no conscious grieving for some time and then later being overwhelmed by intense anger and longing. Unresolved mourning can also occur in different degrees of severity, with various discernible subtypes.

I was fortunate to have John Bowlby as a supervisor at the time I conducted my study, and I discussed with him the womens' responses to their early losses. We categorized the women's mourning into three types—resolved, unresolved-absent, unresolved-chronic—and identified different subtypes of unresolved mourning. In the next section I discuss the various types and subtypes, grouping together greater and lesser degrees of unresolved mourning.

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The younger the woman was at the time of the loss, the more likely her mourning was to have taken an unfavorable course.

Resolved and Unresolved Mourning

Six of the 22 women had resolved mourning. For the remaining 16 women, there was evidence that the mourning process remained incomplete. Nine women showed an almost complete absence of mourning. Seven showed a chronic form of mourning. The younger the woman was at the time of the loss, the more likely her mourning was to have taken an unfavorable course. Of the seven women who were 5 years old or younger when their mother died, only one had resolved the loss. Six of the 15 women who were 6 to 13 when their mother died showed resolved mourning.

Resolved Mourning

Women who had completed the process of mourning were between 2 and 11 years old when their mothers died. For these women, mourning appeared to have taken a largely healthy course. The women recalled openly expressing some grief at the loss during their childhoods. They indicated, for instance, that they felt sadness, anger, or both after the deaths, as well as a yearning for their mothers.

These women gave convincing evidence that their feelings regarding the loss had changed over time. They had reorganized their behavior and thoughts on the basis of the lost person's permanent absence, a process that often took years. This reorganization was often evidenced in language: These women consistently spoke in the past tense while talking about their mothers. For one woman who lost her mother when she was 4 years old, an important step in the process of mourning occurred only after she had an intense dream years later, in which the woman's mother came to her and told her that it was now time to let go.

Women who had resolved the loss but were very young when their mothers died found it difficult to remember their mothers' face in later years. One woman who lost her mother at age 2 noted, "I had a dickens of a time in ever bringing Mum's face to mind." Most of what this woman remembered came from what others told her; it took "years and years of talking" about her mother to make her real. She observed that only over time was she able to "make her own idea of a mother and what she must have been like."

Absence of Mourning

Women who had not mourned openly claimed not to have ever grieved much over their mothers' loss. Sorrow and anger were noticeably absent from their memories. These women also gave the clear impression that the loss did not disrupt their lives. Absence of mourning was closely linked to the women's age at the time of loss. Five of

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Remembering the lost parent can be difficult for young children unless their memories are shared and talked about with an adult who knew the parent.

the nine women in this group were 5 years old or younger when their mother died (range = 2 to 13 years).

Some women showed compulsive caregiving for others, a subtype of unresolved mourning (Bowlby, 1980). In compulsive caregiving, the individual attributes needs and feelings that they cannot recognize in themselves to another person (Bowlby, 1980). Women with compulsive caregiving did not express grief at their mothers' deaths; instead, they showed deep and excessive concern about the welfare of others. The caring was almost obsessive and did not always appear to be welcomed by the cared-for person. One woman (whose loss occurred when she was age 4 years old) became a nurse and nursed not only people in the hospital, but also people in the neighborhood. She became easily upset if her neighbors refused her help.

All of the women who had not mourned their mother's death noted that they missed having "a" mother. However, this longing seemed muted and the women made it clear that it was not "their" mother who they yearned for. Two women nonetheless attended séances to establish contact with "some" person in their past. Another saw a small bluish face "probably from my childhood" peering through her window. These behaviors suggest that although the women outwardly denied their feelings about the loss, their thoughts and feelings remained oriented around their lost mothers.

The women who were 4 years old or younger when their mothers died had a particularly difficult time remembering what their mother looked like. One woman could only remember her mother as a "shadowy figure." Another said her mother's face was "very vague," "just a face with glasses, which seems to fade." Another, who was 3 ½ years old when her mother died, could remember the colors and shapes of the embroidered flowers on her mother's pillow but not her mother's face, suggesting that she had put the most painful memory out of mind.

Chronic Mourning

Women who experienced chronic mourning were between 5 and 13 years old when their mothers died. These women showed often intense and prolonged responses to loss. One woman, 5 at the time of her mother's death, recalled tying herself to her mother's grave so as to feel close to her mother. Strong anger and self-reproach were present to varying degrees in these women, and they maintained a belief that the loss was not permanent, expressed often in an ongoing connection with the dead person or in the belief that they could find their mothers in another person.

Evidence of the difficulties the women in this group had in putting the loss in the past came in slips of the tongue. Several women with chronic mourning slipped into the present tense when talking about their mothers, or they suggested in odd statements that they expected her to return. Some of the women in this group maintained contact with their mothers by having long talks and conversations long after their mothers had passed away. For one woman, the contact came through a photograph. This woman, who was 9 years old when her mother died, regularly brought "Mother" down in the form of a photograph to participate in family festivities. Another woman noted that she had recently stopped conversations with her mother, not because she was convinced her mother was dead, but because after all of the years, she didn't quite know what to say to anymore. In both cases, the women still seemed to cling to a belief that their mother was still present.

I could readily identify subtypes of chronic mourning. The subtypes all involved a mislocation of the lost person. A few women mislocated their lost mothers in another person. For example, one woman who lost her mother when she was 5 years old frequently gave a teacher at school gifts whenever she could; when she gave the gifts, she saw not her teacher's face before her, but her mother's face. Two women mislocated their mothers within an animal or an object, another subtype of chronic mourning (Bowlby, 1980). One of these women (6 years old when her mother died) believed that her mother had returned in the form of a cat. Another mislocated her mother in old furniture—this woman spent hours removing varnish to let the wood "breathe" and to bring it "back to life," a wish she likely harbored for her mother.

Another woman (5 years old when her mother died) developed "identificatory" symptoms after her mother's death—another subtype of mislocation (Parkes, 1972). Individuals who develop identificatory symptoms mislocate the lost person within the self (Bowlby, 1980). This woman's mother was 8 months pregnant at the time of her death, and the woman herself developed all the symptoms of pregnancy when she turned 29, but eight months into the pregnancy, it became clear that it was a false pregnancy.

All of the women with chronic mourning could bring at least one vivid and absolute image of their mothers to mind. Half of these women could only recall their mother's face just before she died. One recalled seeing lumps on her mother's head (from cancer) and two could remember only how she looked on her deathbed. These memories underscored the traumatic nature of the deaths for these women.

How Loss Was Talked About

Women gave different descriptions of how their families talked about their mothers in the aftermath of the deaths. These ranged from more open, supportive patterns of communication to "walls of silence" or pressures to feel in certain ways.

Open and Shared Communication

Women who had resolved their loss were most likely to have had supportive families who communicated with each other, talking about the loss over the years. Talk about the loss was not always frequent, but it was present at least to some degree. Communication was often initiated by the women who asked their father, a grandmother, or an aunt to tell them about the loss and about what they remembered about their mothers. Some women remembered communication with siblings who shared their memories. Family talk about the loss was valued by all of the women, but those who were very young when their mothers died said that the conversations were "all they had" to hold on to.

Walls of Silence

For women with unresolved mourning, the patterns of communication were different. Several women who did not mourn reported experiencing "walls of silence." Their families didn't talk about the loss, or the women felt they were not permitted to talk or feel. "It was a type of family where everything was kept out of the way," noted one woman who lost her mother when she was 4 years old. "You wasn't [sic] allowed to ask or anything like that." Often the walls of silence started early. One woman, also 4 when her mother died, was only told 6 months later that her mother had died. In some families, the walls of silence were extreme and all talk about the loss was strictly forbidden. Pictures and personal belongings of the lost person were discarded or hidden away.

In other families, the silence was only partial. The loss may have been talked about, but children were not supported nor included in family grieving. One woman, 2 ½ years old when her mother died, stayed home during the funeral. All she remembered of the loss was watching "what probably was Mum's funeral going by" from the front window. Another woman, 3 years old when her mother died, recalled that her father never talked about the loss with her, but called out to his wife in his sleep.

Pressured Communications

Other women who did not resolve mourning recalled that their lost mothers were continuously talked about in the years following the death, but the communications were one-sided. Women felt they had to listen to others grieve or to care for others. One woman noted "my grandmother never stopped talking about my mother ever. She was always saying 'do you know what today is?" on the anniversary of the mother's birth or death. The woman herself was expected to listen and felt she could not ask questions or share her grief. Other mothers in this group were expected to become a caregiver for younger children or for their grieving father. As one woman noted, "Dad went down the pan and was unable to cope with the death." All of the women in this group noted that relatives were greatly upset by the loss. The women themselves, however, kept their feelings and thoughts to themselves. As one woman noted, "It's not you who gets over it, it's them."

Some women with chronic mourning felt that relatives could see their dead mothers only in a highly idealized manner. One woman (5 years old when her mother died) related that her mother "didn't seem like a normal person. I felt as if she was a saintly person. They never said that she would do anything like normal mums would do—like moan at you or nag at you." Other women felt guilty that they had not grieved in the way that relatives thought they should. One woman (4 years old at the time of her mother's death) recalled her grandmother's reproaches not crying in the way her grandmother thought she should.

What Contributed to the Silence or Pressure?

Some women noted that their fathers remarried soon after their mothers died. For these women, the new marriage and the presence of a stepmother became a barrier to open communication and sharing about the past. In other cases, fathers' own grief appeared to make it hard for them to help children come to terms with the death. Other women thought their fathers tried to shield them from pain, thinking they were too young to understand what happened. In a few cases, the lack of talking seemed to continue earlier family patterns of not talking or sharing. In two families with extreme walls of silence or pressure, however, the deaths involved considerable stigma. In one family, the woman's mother committed suicide after she heard that her husband was having an affair. In the other family, the woman's mother died after giving birth to a baby from a man who was not her husband. In both cases, shame, guilt, and moral judgment likely contributed to the strong silence and pressure that ensued (Lieberman et al., 2003).

Conclusions

Women's patterns of mourning were closely influenced by their ages at the time of their mothers' deaths. Of the women who were very young when their mothers died only one had resolved her mourning. These women who did not resolve their mourning did not remember any grief at the loss, and they could hardly remember their mothers.

Whether mourning had been resolved was closely linked to the support the women received as children and to the ways families talked about the deaths in the aftermath. Those who had resolved mourning experienced more open and supportive communication patterns in their families. Although talk was not always frequent, it was nevertheless present and women felt they could share their feelings and ask questions. This type of communication helped the women to successfully mourn and to construct some memory of what their mother was like.

Women who had not completed their mourning were not supported or included in family grieving. Those who experienced walls of silence in the years after the loss coped by closing down their feelings or by displacing them elsewhere. Women in this group who were very young when their mothers died struggled to remember any feelings about the loss. Most had almost no memories of their mothers.

Other women with unresolved mourning were expected to listen to others mourn or to care for them, or they were pressured to think of their mothers in an idealized manner. Women who experienced these pressures coped by maintaining an ongoing relationship with their dead mothers. Because the women had little outlet to express their own feelings, they did not resolve their mourning. These women usually retained some memory, often a traumatic one, of their mother's image.

What factors contributed to the pressured communications or silences that characterized some families after the deaths? In some cases, a father's new marriage contributed to the silence or pressure that women reported experiencing. In other cases, a father appeared to be so absorbed in his own grief that he failed to support his child's mourning. In a few cases, the silence and pressure were linked to social stigma. In other cases, however, the pressure or silence was a continuation of earlier ways of communicating.

Learn More

Publications

Attachment and Loss: Vol. 3. Sadness and Depression
J. Bowlby (1980)
New York: Basic Books

Motherless Daughters: The Legacy of Loss
H. Edelman (1994)
New York: Dell Publishing

A Secure Base: Clinical Applications of Attachment Theory
J. Bowlby (1988)
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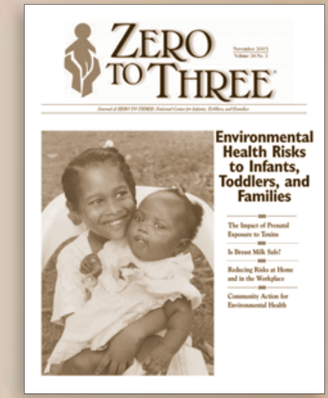

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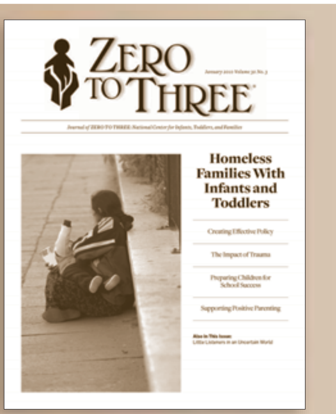

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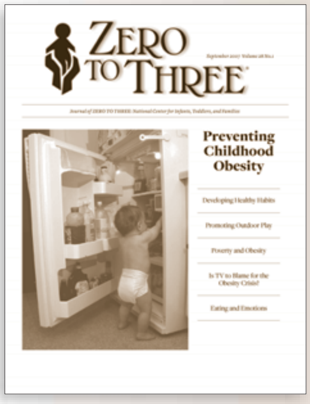

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Other factors clearly played a role in women's responses: how their mothers died, what their relationship was like with her before the death, and what type of relationship they had with their fathers or caregivers afterwards (Bowlby, 1980). Still, the women's ages at the time of the deaths and the way the loss was talked about appeared to exert unique effects.

What can be learned from the interviews? Many women said that they would have liked someone to explain to them what happened. They had wanted information; they had wanted the truth. All of the women were interested to know that young children experience longing and pain at loss. They underscored that they wished they had been part of family grieving. They said they would have liked to share and ask questions. Some women stressed that they had wanted to know that their fathers were "okay"; they had worried he and others would not survive the loss. It is important to note that many women wanted to know what their mothers were like, what they looked like, and whether their mothers loved them. They had also wanted someone to be there for them after the loss, and they wanted to move on.

Surviving parents and other caregivers have a painful and arduous task ahead. They must grieve themselves while helping their children to come to terms with parental death. The more father and other caregivers can be supported and the more they can hold their children's needs in mind, helping their children to share feelings, ask questions, and talk openly, the more children will be able to face the truth about their past and to embrace the present (Bion, 1962).

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Connecting Science, Policy, and Practice

ZERO TO THREE's 25th National Training Institute

December 9–11, 2010 ◆ Phoenix, Arizona
Pre-Institute December 8

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An Open Statement to Members of the ZERO TO THREE Community

Regarding the Arizona Immigration Law and Our National Training Institute in Phoenix

ZERO TO THREE is deeply concerned about the adverse impact the law recently enacted in Arizona will have on infants, toddlers, and their families if implemented. The law orders immigrants to carry their alien registration documents at all times and gives the police broad power to question and detain people if there is reason to suspect they are in the United States illegally. Some legal experts interpret the law as sanctioning racial profiling and it could be implemented in such a fashion. Opponents have called it an open invitation for harassment and discrimination against Hispanics regardless of their citizenship status, and the law has escalated political tensions across the country related to race, border security, and immigration. **We believe the law promotes discriminatory actions that create intimidation and fear in minority families and communities and are damaging to the emotional health and overall well-being of young children.** We urge the law be repealed or overturned and are heartened by the recent action of U.S. District Judge Susan Bolton, at the request of the U.S. Department of Justice, to enjoin Arizona from implementing the law before it became effective. Judge Bolton's decision opens the way for a lengthy legal review of the constitutionality of the law by the federal courts.

As many are aware, our 25th National Training Institute (NTI) is scheduled to be held in Phoenix on December 8-11, 2010. This location has raised significant questions for us because we are highly sensitive to the concerns raised by those urging a general boycott of conferences in Arizona as a form of protest of the recent legislative action. We are also faced with the reality that site selections and legal contracts for conferences of this size and scope are made several years in advance. Had the law been passed when we were making the site selection we would not have chosen Phoenix. We will communicate with the appropriate authorities in Arizona that we will not schedule future conferences in the state until the law is repealed or overturned.

ZERO TO THREE has seriously analyzed our ability to cancel or move the NTI in order to protest the law. We have decided to continue to hold the NTI in Phoenix primarily because our colleagues in Arizona, many of whom serve on our Host Committee, have made an impassioned plea for the NTI to proceed in Phoenix. The families they serve are the direct victims of the climate of serious fear and distrust resulting from racial discrimination and often live in the communities plagued by the epidemic of cross-border violence fueled by drug cartels. Our colleagues' work with these families creates high levels of stress, and we want to offer them the help and support a conference like the NTI would provide.

To meet their needs, and those of all interested attendees, the NTI will showcase programming designed to improve services and policies for very young children in immigrant families. For example, the opening keynote will be given by an internationally known researcher who will discuss early childhood development among the children of undocumented residents. In addition we will hold a number of informational sessions, distribute special resources to learn more about immigration issues for babies and toddlers, and create opportunities for attendees interested in learning and discussing the impact of the Arizona law, and those like it, on infants, toddlers, and their families.

We hope you will join us in Phoenix as we continue our tradition of providing cutting-edge training on a wide range of topics concerning infants, toddlers, and their families while also supporting the needs, courage and dignity of professionals who work with immigrant families in Arizona and throughout the nation.

Traumatic Experience in Infancy

How Responses to Stress Affect Development

MOLLY ROMER WITTEN
Parent Child Workshops, Chicago

In the first 3 years of life, as at no other time, a child's development influences the expression of traumatic stress. For example, developmentally imposed motor limitations, such as lack of capacity to independently move away from the source of traumatic stress, influence the baby's response to trauma. If the baby cannot avoid the perceived source of traumatic stress by physically escaping, she may develop physiological strategies to limit overwhelming feelings of pain, terror, or rage. To further complicate the situation, when traumatic stress occurs without the benefit of a sensitive primary caregiver who can offer appropriate and contingent responses, the infant may withdraw and experience disruptions in her ability to form healthy relationships and feel safe with others. Thus, traumatic experience in infancy can derail part or all of the baby's developmental processes, such as the capacity for regulating emotions, sensory motor integration, cognitive development, and social interaction, in ways that may not become apparent until the child is older.

When overwhelming trauma-related physiological stress imperils day-to-day functioning of a baby, his body will adapt to reduce the experience of the physiological fight-or-flight response to stress. The adaptations cause internal physiological changes, termed *developmental transformations*, which occur in response to stress and can have an ongoing effect on the infant's developmental capacities and limit his future cognitive, social, and emotional growth. Developmental transformations occur when specific motor behaviors, relational synchronies between the baby and caregivers, and internal representations take on new or altered meanings, as an infant attempts to cope with traumatic stimulation. For example, a baby's waking at 2-hour intervals falls within the expectable range of behavior for a 2–3-month-old infant. However, if a 24-month-old child who is experiencing traumatic stress as a result of family violence begins waking at 2-hour intervals, after sleeping through the night for many months, the behavior has a very different meaning. The night waking constitutes a potential indicator of a developmental transformation secondary to the yelling and fighting in the home.

If the child lacks a supportive relationship with an adult caregiver who can facilitate the child's regulatory capacities, the developmental transformation can cause, for example, distorted motor patterns that support continued functioning while limiting the trauma-induced stress. Babies tend to express feelings through motor actions, facial expression, and vocalizations rather than verbalizations. Therefore, it is important to be alert to transformation of affect—such as, when a child laughs during a painful exchange—or reversal of affect—such as

Abstract

Responses to traumatic stress during the earliest years of life can change quickly and can be difficult to identify because of both the young child's rapid rate of development and the child's developmental level. The symptoms of traumatic stress will depend on the child's developmental level and individual coping styles, as well as the quality and nature of the child's most important relationships. Through three case examples, the author describes how children's responses to traumatic stress can influence developmental functioning and can be successfully resolved with the support of sensitive and caring adults who recognize and support the child's expression of trauma-induced stress.

when a baby's crying stops and instead inhibits the motor behaviors associated with protest—as well as freezing or quieting as possible expressions of an infant's struggle to cope. These developmentally distorted motor patterns will provoke changes in the integration of sensory, perceptual, and motor functioning that will influence the quality and effectiveness of motor functioning, and the relational responsiveness between infant and caregiver.

The physiological effects of traumatic stress change, and often limit, a child's future developmental capacity. The effect of the traumatic experience is to constrict, restrict, inhibit, or stop the baby's capacity for optimal growth, and sometimes can prevent any growth at all. However, when the traumatic stress is addressed within a caring relationship, and when the relationship receives the support it needs to acknowledge the baby's silent but destructive suffering from the physiology of traumatically induced fight-or-flight panic, the opportunity for optimal development is restored.

Photo: ©iStockphoto.com/Martin Valigursky

Traumatic experience in infancy can derail part or all of the baby's developmental processes.

Developmental Transformations of Traumatic Stress

Developmental transformations can be hard to identify because a baby's capacities change so fast—month-to-month, day-to-day, and sometimes even hour-to-hour—and it can be difficult to ascribe causality to a new variation in behavior. Typical developmental adaptations and shifts can obscure how the infant protects herself during traumatically stressful moments. The way that traumatic stress is expressed will vary over time. For example, if a 5-month-old experiences a traumatic event, the expression of traumatic stress will differ 3 hours after the trauma, 8 months after the trauma, and at any other point in the future. This variation will be a function of how much relationship-related soothing and support are made available to the baby (Kaplow et al., 2006).

The following anecdotes reflecting infant responses to traumatic events illustrate the developmental transformations that embody the baby's coping capacities.

Tay

Tay was 23 months old when he was brought to the hospital. He had been found curled up under the crib of his baby brother who—along with his mother—had been shot at close range within the previous 24 hours. When Tay was found, he kept repeating the gesture for shooting a gun with his hand and saying, "daddidoot." The police reported this as random babbling. There was a hypothesis that Tay may have been trying to tell the police that found him that his father had shot his mother and brother, but there was no behavioral evidence that Tay had experienced such a traumatic event. He seemed quiet but alert and interactive when the police found him. In the hospital, his grandmother, whom he knew well, came to see him as often as possible and spent long periods caring for him and playing with him. He showed no behaviors suggestive of traumatic stress, fear, or other indicators of what he must have experienced. A psychologist, who had been asked by law enforcement to assess Tay's functioning, observed him with his grandmother and also engaged in play with him in the grandmother's presence. In interactions with both his grandmother and the psychologist, Tay's developmental level of communication included two-word phrases and noun labeling. The grandmother did not know whether his functioning level was different prior to the traumatic experience.

As the psychologist and Tay began to play, the psychologist made a ball out of Play-Doh and asked Tay what it was. He answered, "ball," readily enough and then eagerly requested, "tiger, tiger." Together the psychologist and Tay made a rough approximation of a tiger, which Tay responded to by roaring delightedly and saying, "See tiger, a tiger." Then the psychologist made a likeness of a gun and began gesturing at the tiger with the gun. Tay's demeanor changed from animation to stilling behavior. When asked what the object was he replied, "mess" and "Play–Doh." Rather than naming the object, Tay used a developmentally less sophisticated but symbolic label: "mess." He stopped playing and began fretting, and moved nearer to his grandmother. He took out the large Lego blocks in the playroom and signaled that he wanted the psychologist to construct a "car" for him. Enthusiastically, Tay took the Lego vehicle and called it a "tuck" (truck). Together, he and the psychologist constructed a small building that he labeled a "house" to put the truck in. When a simple version of a gun was made with the Lego blocks, Tay again seemed to function at a developmentally younger communicative capacity and called it "blocks, blocks." He did not indicate representational comprehension of the object, which looked like a gun. And, notably, he began fretting. He responded to his grandmother's soothing and reestablished his capacity to play imaginatively, while she and the psychologist talked briefly.

Were Tay's fretting behaviors and quieting an embodiment of his traumatic stress? It seemed so, but the observations did not provide definitive data because the psychologist did not have any developmental baseline for Tay to compare the behavior against.

Two days later, an occurrence at the hospital confirmed that Tay did experience a traumatic stress reaction. In the hospital, he was in a room with a boy, approximately 5 years old, who had just been diagnosed with diabetes. On this Sunday, Tay's grandmother was not present, so he was without his usual secure relationship. About 2:00 in the afternoon, the head nurse called the psychologist, asking what to do about Tay's behavior. He had been crying in an inconsolable manner for 45 minutes. Not only could no one soothe him, no one understood what had triggered his crying. They took the extreme measure of requesting that the psychologist either help the nursing staff stabilize his behavior or recommend that he be medicated. The psychologist found Tay just as described, crying inconsolably, rocking, and refusing anyone's attempts to soothe him. Eventually, after much explanation from the psychologist about wanting to help, and acknowledging his suffering, Tay allowed her to put him on her lap. She rocked him for about 15 minutes, after which he began to calm down. But he would not get off her lap, nor would he allow the nurses to approach him without beginning to cry again.

The head nurse informed the psychologist that Tay and his roommate were playing in their room when a nurse came in and told his roommate, "It's time for your insulin shot." At that point, Tay became tearful. When the nurse administered the injection and his roommate began whimpering, Tay began crying in a frantic manner. Sitting with Tay, the psychologist spoke of the difference between an injection that was called a shot and a gun that made a shot.

Tay seemed to understand the word *shot* in the context of his recent experience and responded instantly with terror. He had begun to perceive nurses as potentially dangerous. As the psychologist discussed Tay's experience with him, she also provided an empty, safe syringe for him to play with. He "shot" objects, such as his bed and his stuffed monkey, as well as people, such as his grandmother and the nurses, throughout the afternoon, making the sound of a gun discharging but without any verbal comment. The next day, when the psychologist played with him, Tay spoke of "daddidoot" while making a gesture with his syringe. He did not say the words "shoot" or "shot" at any time.

Initially Tay's behavior did little to suggest that he had been affected by the overwhelming violence he had been subjected to. However, the safety of the sensitive and caring relationship with the psychologist allowed Tay the opportunity to communicate a wide range of emotional and motor expressions and revealed the depth of his suffering.

Julie

Julie, 10 months old, was hospitalized with a blood-borne infection that settled in her left femur. Her mother was with her from the very start, never leaving her side even when the doctors performed painful "cut–down" procedures to insert an IV line in her tiny arteries. Several times during the infant's 6- week hospitalization, the doctors had to perform emergency cut downs to maintain the level of antibiotic she received. Because Julie was so small, they simply strapped her into a papoose board and proceeded quickly, without anesthetic, to complete the procedure, believing that a baby of that age would have no memory experience. Further, as a result of the need for an IV line, one of Julie's legs or arms was "boarded" (i.e., bandaged to a hard splint in order to hold the site immobilized) to hold the heparin lock (the entrance site of the IV), which meant that she lost use of that appendage until the heparin lock site changed. The effect was to prevent her from crawling, walking, or using two hands in a coordinated way.

Photo: Stephen Bobb

Young children tend to express feelings through motor actions, facial expression, and vocalizations rather then verbalizations.

About 4 weeks into her hospitalization, Julie's pediatrician told the consulting psychologist that Julie's parents reported that she had become very quiet, had stopped playing, and seemed increasingly clingy. The parents said that Julie had begun spontaneously and precociously to use two- and three-word phrases. She was observed to say, "No! Top it!" (Stop it) repeatedly, as soon as a person in a white coat entered her room. She also began calling, "Mommy, Mommy, I good" any time her mother left her sight.

In addition, when in the presence of medical personnel, Julie seemed to give up cuing for discomfort almost as soon as she experienced the need for comforting. The parents reported that whenever anybody else was in the room with Julie, she got an "empty smile" on her face and seemed "precious" and "adorable" to the medical staff, but without emotion to the parents. Her parents reported feeling uncomfortable with Julie's coping strategies of empty smiles and sudden onset of verbal language. The medical staff found the baby to be a "good," compliant patient, who immediately quieted when they approached her. They complimented the parents on Julie's suddenly developed verbal language skills and her precocious development that was "ahead of schedule." The consulting psychologist diagnosed traumatic stress response and recommended infant–parent psychotherapy. The focus of the treatment was to help the mother and father learn about Julie's transformed cues when she needed soothing. Rather than reach out for comforting, she stopped expressing any affect and motorically quieted. She also began using verbal language in a manner that seemed disconnected from her feelings. When Julie was given a doll with Band-Aids, she put them on the same leg or arm as the location of her own heparin lock, but did not offer any verbal comment on the implied fantasy. After about a year of weekly family play intervention, the parents felt as though their daughter was back to normal, and psychotherapy stopped. There was no more contact with Julie, who seemed to have become an engaging interactive, happy 2–year-old.

The psychologist had the opportunity to talk with Julie 5 years later when she came to the hospital for a routine visit. Julie anxiously asked, "I don't have to stay here, do I? You know hospitals are not nice places to sleep. They are noisy." Also, when noticing a papoose board hanging on the wall, Julie commented, "That looks like a terrible thing to do to a baby," even though the board was extraneous to her current medical visit. When the psychologist asked about what Julie knew of her earlier hospitalization, the mother reported that no one had knowingly discussed the early hospitalization with her. In fact, family members were happy to forget it, and the early hospitalization never came up between Julie and her parents yet Julie's comments suggest that she had some emotionally colored memories of her experience.

Tory

Tory was 2 years old when her father committed suicide. Her mother went into complicated mourning, although she continued to be the primary caregiver for Tory and her older sister. The mother sought consultation with a child psychologist 4 months after the father's death because Tory had become extremely oppositional and willful. Because the mother came from a family that believed that childish opposition could be eliminated with increased structure and punishments, her own mother (Tory's maternal grandmother) supported firm disciplinary responses to such behavior. However, Tory's temper tantrums and stubbornness did not seem to subside with the expectation of structure and discipline; her angry outbursts became amplified, creating chaos within her family and threatening her mother's capacity to feel affection for her.

Upon beginning a course of infant–parent psychotherapy, Tory began to express her experience of herself as a "monster." She took all of the therapist's baby dolls and threw them in the wastebasket. She forbade anyone from taking the dolls out, and she called the baby dolls "T. rex monsters." If the dolls were on the shelves when Tory entered the room for a session she threw them into the wastebasket before anything else occurred. After a few weeks of throwing out the baby dolls, she began to play with a toy airplane in the therapist's room. She began to describe her dream of flying up into the clouds and visiting her father. Her mother reported that Tory was jumping off everything in a dangerous and risky way, and saying that she was learning to fly so that she could go visit her father up in heaven, in the sky.

At 36 months old, Tory was too young to comprehend the concept of loss resulting from death. However, her lack of cognitive understanding did not prevent her from the overwhelming feelings about the loss of her father and the emotional unavailability of her mother. Her mother was often not aware of her daughter's pain because of her own mourning process. However, Tory was too young to regulate her outrage and sadness without her mother's help. She had no psychological structure for regulating autonomic nervous system responses or managing the psychological pain of separation and loss or her mother's denial of her feelings. Tory transformed these affects into temper tantrums or entered into her fantasy of flying up to her father. Over time and through a number of sessions, the therapist interpreted Tory's fear that she had somehow caused her father's abandonment by her own uncontrollable feelings of anger. She also counseled the mother to quietly stay with Tory when her daughter engaged in tantrums rather than attempting to send her to her room. The mother reported that it took all of her energy to sit quietly and tell Tory that she would not leave her and that she wasn't going to let her hurt herself or anyone else with her anger, but she did it.

With regard to Tory's fantasy of flying up to her father, the therapist used very concrete statements to help Tory understand that she could no longer find her father. The therapist explained that her father could no longer play, could no longer push her on swings, did not eat, did not sleep, did not walk, and did not do all those actions that Tory associated with her satisfying relationship with him. As the therapist played and talked with Tory about these concrete expressions of her loss, her mother sat tearfully listening on the couch, watching. Often when her mother cried, Tory would go to her, and they would hug tightly. Sometimes Tory also cried, and when she did, her mother took great care to comfort her and acknowledge both of their sadness. Over quite a number of months, Tory began to adapt her fantasy to the new knowledge and cognitive structure she was developing about the meaning of her father's absence; she knew there was no way to reestablish a relationship with him, and all she could do was try to remember him and be with her mother when she was sad. With her mother's considerable capacity for comforting her, Tory worked through her sadness and anger. Tory and her mother stayed in psychotherapy for 2years, with the last year consisting of monthly consultations between the mother and the therapist.


Photo: Stephen Bobb

The caregiver's behavior can deeply influence the child's capacity to cope with traumatic stress.

Learn More

Mourning in Children: A Theoretical Synthesis and Clinical Application.
B. Garber. (2008) The Annual of Psychoanalysis, 36, 174–188.

What Babies Say Before They Can Talk: The Nine Signals Infants Use to Express Their Feelings.
P. C. Holinger & K. Doner. (2003)
New York: Fireside

Sensory Integration and Self-Regulation in Infants and Toddlers: Helping Very Young Children Interact With Their Environment
G. G. Williamson & M. E. Anzalone. (2001).
Washington, DC: ZERO TO THREE.

Helping Children Cope With Trauma

To help children successfully resolve their responses to traumatic experiences, caregivers must understand the internal or the developmental "context" of the child's behavior. It may be difficult for parents and professionals to acknowledge when children are struggling or suffering. Without careful observation and professional support when necessary, caregivers may make an erroneous assumption that the child's reaction is a personality characteristic or developmental stage rather than a developmentally appropriate form of communication regarding traumatic stress. For example, a hypervigilant child who "freezes" under stress may be interpreted as shy, without thought for how this shyness began or why it began when it did.

In the anecdotes above, neither Tay's grandmother nor his medical caregivers seemed to understand what he was attempting to communicate motorically and affectively. Julie's parents did notice that something had changed in their baby's expression of emotion and the quality of her relatedness, but they were unsure what, if anything, needed to be done about those changes. Because it is so difficult for adults to acknowledge the pain that infants experience, attributing infants' struggles to "development" becomes a way to lessen the pain. Tory's mother was preoccupied with her own painful mourning and did not look for the meanings beneath her daughter's tantrums. Tory's mother did not experience her tantrums as a developmental expression of mourning but rather as developmentally normal (albeit inappropriate and unpleasant) behavior. When Tory's mother reengaged with Tory through the process of therapy, she realized that Tory was trying to mourn but was too young to engage with or manage her feelings of loss without her mother's soothing presence. The mother reported that it also helped her own mourning process to know that she could comfort her daughter better than anyone else.

The aspects of a caring relationship that help an infant reestablish homeostasis after traumatic stress are (a) consistently acknowledging the child's feelings, (b) closely following the baby's motor cues to determine what he needs in terms of environmental buffering, and (c) empathically soothing or comforting the baby to support the reestablishment of satisfying interactions. Although the parent's behavior can deeply influence the baby's capacity to cope with traumatic stress, it is also true that the baby's behavior can influence the parent's motivation to soothe and to care for the child. That is, not only does the quality of the caregiver's behavior affect the baby's capacity, but also the quality of the baby's behavior affects the caregiver's attempts to ably provide sensitive, contingent soothing. Fajardo (1998) indicated that "infants with certain patterns of state organization promote better caretaking responsiveness in their mothers" (p. 203). If the baby's relatively smooth functioning is disrupted by traumatic stress, it will affect the parent's capacity to be sensitive and responsive in return. It is important for professionals to create an environment for parents that is safe but also promotes curiosity, to prime the parents' intention to learn about their baby's emotional and motor cues that have been brought on by traumatic stress (Oppenheim & Koren-Kari, 2002)

In the anecdotes above, the caring relationships that the children's primary caregivers provided facilitated the infants' recovery from their traumatic experiences without long-term disruption to their developmental rates or capacities. In these relationships, the children found meaningful connection with accepting, empathic adults who could tolerate the possibility of the child's suffering and provide appropriate support.

Molly Romer Witten, *PhD, works as a clinical psychologist in Chicago. She is the director of the Parent Child Workshops, a space for groups of parents and their young children to engage in therapeutic play together. She has published in the areas of child maltreatment, evaluation of attachment disorders in children within the welfare system, depression in infancy, and diagnosis of pervasive developmental disorders during infancy and early childhood. She teaches in the Infant Mental Health Program at The Erikson Institute in Chicago.*

Acknowledgment

I would like to thank Dr. Henry Seidenberg for many fruitful discussions leading to the concept of developmental transformation *presented in this article.*

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Oppenheim, D., & Koren-Kari, N. (2002). Mothers' insightfulness regarding their children's internal worlds: the capacity underlying secure child–mother relationships. *Infant Mental Health Journal, 23*, 593–605

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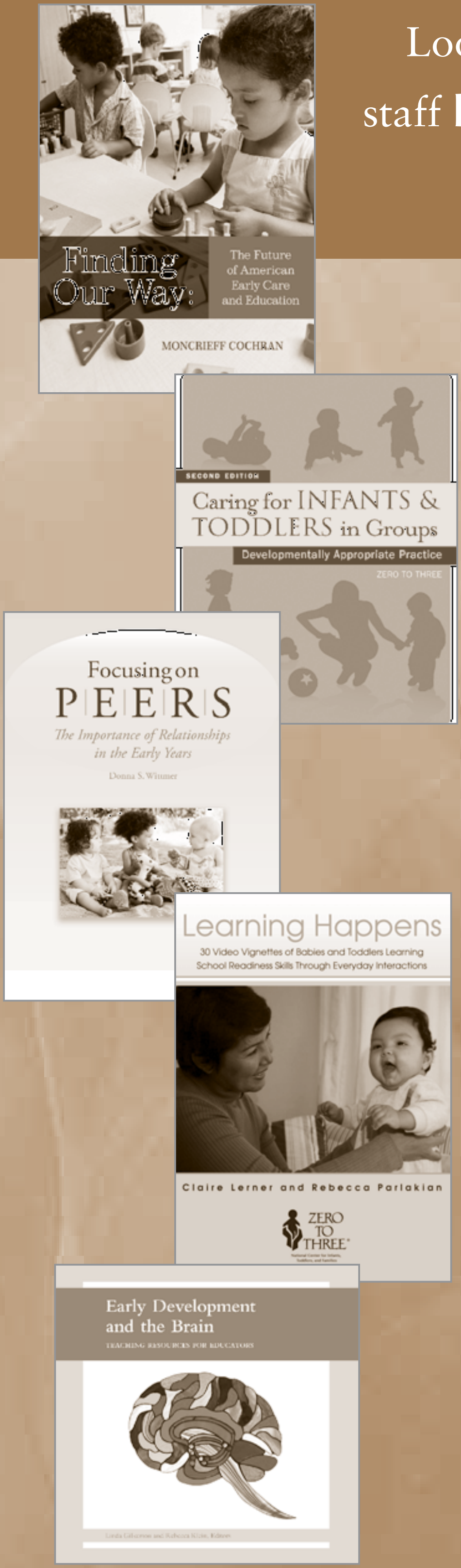

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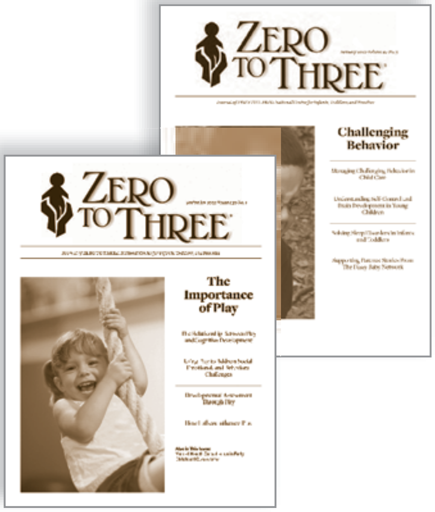

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Teaching to Transform

Infusing Cultural and Linguistic Diversity

SYLVIA Y. SÁNCHEZ
EVA K. THORP

Editor's Note: This article is excerpted from *Practical Approaches to Early Childhood Professional Development: Evidence, Strategies, and Resources*, edited by Pamela J. Winton, Jeanette A. McCollum, and Camille Catlett (2008, ZERO TO THREE). Available at www.zerotothree.org.

Dealing with diversity is one of the central challenges of 21st century education. It is impossible to prepare tomorrow's teachers to succeed with all of the students they will meet without exploring how students' learning experiences are influenced by their home languages, cultures, and contexts; the realities of race and class privilege in the United States; the ongoing manifestations of institutional racism within the educational system; and the many factors that shape students' opportunities to learn within individual classrooms. To teach effectively, teachers need to understand how learning depends on their ability to draw connections to what learners already know, to support students' motivation and willingness to risk trying and to engender a climate of trust between and among adults and students (Darling-Hammond & Garcia-Lopez, 2002, p. 9)

American schools are educating approximately 11 million children of immigrants, more than ever before. About 5.5 million students, 10% of public school enrollment, speak little to no English. Children of color are the majority of students enrolled in all of the largest five school districts. African American children make up approximately one third of all children enrolled in public schools (National Center for Education Statistics, 2000). This increase in the diversity of the children can be juxtaposed with the decreasing diversity found in the teaching pool, including the ethnic and racial imbalance between identified students in special education and the professional special education personnel and leadership that currently exists (Becket, 1998; Henke, Choy, Gies, & Broughman, 1996). The low enrollment of individuals from diverse racial and ethnic backgrounds in colleges of education (Campbell-Whatley, 2003; Sleeter, 2001), the dearth of faculty members from underrepresented populations in institutions of higher education (American Council on Education and the Education Commission of the States, 1988), and the low numbers in the field of special education further alert us to the lack of preparedness for teaching diverse learners that may result from the mismatch between individual practitioners, the higher education faculty pool, and the children and families they serve.

Those involved in pre-service and in-service professional development will play a significant role in responding to the central challenges of 21st-century education (Isenberg, 2000). They must ensure that professional development programs are designed in ways to support the development of knowledge, skills, and dispositions needed to work competently, comfortably, and confidently with culturally and linguistically diverse young children and their families. The primary premise of this article is that meeting the challenge for early care and education in the 21st century requires a commitment on the part of faculty and other individuals supporting professional development to examine early care and education for diverse learners with a transformed, sharper, and more critical lens.

The Meaning of Culture and Dimensions of Cultural Diversity

"*Wow, I* NEVER *knew that I had culture. I always thought I was just a regular American. I assumed that culture was something exotic, something other people have.*" This statement frequently is heard during pre-service and in-service interactions and is at the heart of the personnel preparation challenge for scaffolding personnel to better understand cultural and linguistic diversity. Successful professional development requires that we tackle head-on the assumption that culture is something exotic to fully explore the meaning of culture and the meaning ascribed to the term cultural diversity. For example, the term *cultural diversity* may be understood as a socially constructed code for "new immigrants," for those who are different from oneself, or for persons of color. By untangling meanings, practitioners are able to come to the understanding that we all have culture and that culture plays a central role in our beliefs, biases, assumptions, and in the decisions we make when teaching children and working with their families. Without this understanding, well-meaning practitioners will continue to see children and families from cultures other than their own as "other" and "different," ultimately occupying positions across an invisible divide. Several key understandings can assist practitioners in acquiring this new lens.

Understanding the Tangible and Intangible Role of Culture

Culture has dimensions that are both tangible and intangible. The tangible elements are what have become most closely identified with common definitions of culture. These often form the basis for culture fairs and cultural exchanges that are the limited ways in which schools and programs take on a multicultural agenda. Tangible representations of culture include dress, typical foods, holidays, and artifacts. Because these tangible representations of culture are those most easily addressed in venues such as family dinners or culture weeks, they can lend themselves to supporting cultural stereotypes rather than deep understanding of others.

However, it is likely that the intangible elements of culture have the more powerful effect on our daily lives and perhaps have the greater influence on the interactions between professionals, children, and their families. The intangible elements of culture are the beliefs, values, and practices that have shaped us and that we take for granted as just being the way things are and should be. Because it is the medium that surrounds us, it has been suggested that these intangible elements of culture can be as difficult for us to recognize as water is for the proverbial fish. Thus, it is in the intangibles that cultural clashes potentially can occur. Examples of intangible elements of culture that can challenge practitioners in the context of early care and education are their deeply held beliefs about childrearing, such as when, what, and how to feed children; when and how to toilet train children; when and how to discipline and under what circumstances; and when and how children's independence should be encouraged. In each of these beliefs lies the potential for serious power struggles with families or the potential for powerful learning dialogues with families.

Understanding the Role of Culture in the Lives of Children and Families

Culture plays a central role in each of our lives. It is what shapes who we are and how we view the world. It is not something someone else has; rather, it is something we all have. It is essential that practitioners recognize the ways in which culture plays a role in the lives of the children and families with whom they work. In so doing, they are more able to create learning opportunities that reflect the beliefs and values of families and that reflect children's cultural communities (Moll, 1990). These culturally responsive environments ensure continuity for young children as they enter early care and education (Sánchez & Thorp, 1998).


Photo: Marilyn Nolt

Children of color are the majority of students enrolled in all of the largest five school districts.

Understanding the Role of Culture in the Lives of Professionals and in Their Practices

As has been stated earlier, culture is something we all carry, invisible and powerful. Consequently, it is impossible to believe that early care and education providers are culture-free in their provision of services. Culture plays a central role in the design and implementation of early childhood services. For example, there has been much study of the Reggio Emilia approach to work with young children in Italy, and several preschools in the United States are attempting to replicate the approach here. However, Lally (2001) suggested that the model is derived from a culturally shared view of children and families and of the responsibility of the community for supporting families and children. As a result, he has suggested that it would not be possible to fully replicate the model in the dominant cultural climate in the United States. Decisions about the form and function of early care and education, as well as about the roles of professionals and families in early care and education, and ultimately, decisions about the nature of learning and what is to be learned, are all culturally linked (Kincheloe & Steinberg, 1998).

Furthermore, attitudes about disabilities, about the role of individuals with disabilities, about expectations for them, and about the nature of appropriate curriculum are also bound by cultural beliefs (Skrtic, 1995), as are attitudes about the families of children with disabilities (Harry, Kalyanpur, & Day, 1999; Kalyanpur & Harry, 1999). Consider, for example, the following situations:

- A teacher does not understand why family members are always late for their appointments and then still want to talk with the teacher;
- A family, embedded in a large extended family network, does not understand the rule that only one family member can go on a field trip, so they keep their child home;
- A family seems to refuse to collaborate with the child care center on their goal for a toddler to feed himself using utensils;
- A mother appears to lack any structure or routine and instead follows her young preschooler around offering her food whenever she seems to be hungry.

In each of these instances, there is a frustrated caregiver and perhaps a frustrated or misunderstood family because two cultural views are clashing, and that fact goes unacknowledged. When practitioners bring cultural understanding to these dilemmas, they are able to engage in discussions with family members until there is a shared understanding of events, even if there is no agreement.

As powerful as these examples are, there are even more serious examples of ways in which caregiver lenses or cultural beliefs can affect the provision of services, and that is when deeply held biases affect expectations for children. For example, a teacher of migrant children was heard to say, "No wonder these children can't speak English, their parents don't keep them in one place long enough to give them that opportunity." Not only does this statement demonstrate a lack of knowledge about the realities faced by migrant families, but there are also implicit biases about the value of home language, about the value of family, and about the role that migrant workers play in the economic life of the community (Plous, 2003).

There is now a fairly substantial literature on the ways in which practitioner bias appears to directly affect the performance of children of color. These biases come from deeply held sociocultural beliefs, and they perpetuate a system of inequality and seem to result in significant underachievement (Loury, 2002).

Understanding Culture Through Understanding Individuals

It is important to remember that there is a great deal of variation within any cultural community, and no descriptions can adequately describe the variations of that culture. Although it is important to be familiar with the literature on different cultural communities, it is more important to keep in mind that we need to learn from families as individuals. If we do not, we may overrely on stereotypes derived from textbooks or from prior interactions from persons of the same culture. Ultimately, hearing individual stories is what provides the best information about how to provide culturally responsive care and, through creating connections and challenging assumptions, ultimately is what changes hearts (Sánchez, 1999; Thorp, 1997).

Understanding the Continued Role of Segregation in Sustaining Cultural Stereotypes and Reducing Opportunities for Natural Interactions

Despite the more than 50 years that have elapsed since the landmark Supreme Court decision on *Brown v. Board of Education of Topeka*, the United States continues to be segregated, in residential communities and in schools, along racial lines and along economic lines. Furthermore, even when settings are nominally integrated, unwritten practices sustain an atmosphere of segregation (Tatum, 2000). As a result, few practitioners have had experiences with individuals from cultures other than their own. Because as a society we continue to be so segregated, an experiential component is essential in professional development to move practitioners out of their familiar cultural contexts and safe comfort zones and to increase their awareness of the stereotypes they may knowingly or unknowingly hold about individuals from cultural groups other than their own.

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Tangible representations of culture include dress, typical foods, holidays, and artifacts.

The Role of Critical Reflection in Exploring Issues of Culture and Language

Given the hidden but powerful role of culture in caregivers' interactions with children and families, it is important to prepare personnel who are able to examine their practices critically through a cultural lens (Delpit, 1995; Derman-Sparks & Brunson Phillips, 1997). Thus, it is our position that underlying all of the pre-service and professional development recommended practices is a core practice, that of critical reflection (Miller et al., 2003).

Professional organizations, including the Division for Early Childhood of the Council for Exceptional Children, have recommended that practitioners be aware of the sociocultural context of education—in particular, the role of education in a democratic society—and implications for ensuring equity and access for diverse young learners (Stayton, Miller, & Dinnebeil, 2003). Pre-service programs must also prepare students to consider the sociohistorical influences on how disability is defined and how services for young children with disabilities are designed (Skrtic, 1995). These issues are equally important for in-service professional development. For practitioners to be able to consider these issues, professional development programs need to create contexts that enable them to embrace critical reflection so that they become better able to explore the cultural lens through which they view the world and to see how their cultural assumptions and experiences influence their interactions with children and families.

Brookfield (1987) suggested that two activities are central to critical thinking: (a) identifying and challenging assumptions and (b) exploring and imagining alternatives. He suggested, however, that embracing critical reflection can be an "almost Herculean act of will…" because, "[i]f we are comfortable with our existence…we are imprisoned in our own histories and constrained by the inevitably narrow paradigms of thought and action we inhabit" (p. 91). Consider then that the majority of practitioners are Caucasian Euro-Americans (Hamayan, 1990; Sleeter, 2001; Tyler, Yzquierdo, Lopez-Reyna, & Flippin, 2004; Wald, 1996). Although perhaps through no active choice of their own, they have benefited from the cultural messages of the dominant culture and the implicit associated privileges (McIntosh, 1989).

Essential Components of Critical Reflection

Several elements are central to providing support for practitioners in order for them to take on the task of critical reflection. These elements—acknowledging and embracing difficult issues, analyzing dilemmas for assumptions, considering the sociocultural context of dilemmas, and exploring and imagining alternatives—are the components that make reflection "critical." Often, students and training participants, and perhaps faculty and trainers alike, experience discomfort at the term *critical*, mistaking it for negative criticism. For example, one group of students with whom we worked, when asked to use critical reflection to consider meanings conveyed as a hidden curriculum within a preschool project proposed by their classmates, registered a great deal of resistance and discomfort, indicating that they did not want to "criticize" their peers. It is essential that faculty, trainers, and participants engage in dialogue that clearly differentiates criticism from critical reflection. In fact, it is our view that the absence of critical reflection results in more criticism, because practitioners are more likely to fall back on blaming in the absence of a formal strategy for interpreting the personal meanings they associate with dilemmas.

Acknowledge and Embrace Difficult Issues

To commit authentically to infusing issues of culture and language into personnel preparation and professional development requires embracing the fact that this will require orchestrating difficult discussions. Typically, the most difficult discussions will involve what many view to be taboo topics. Florio-Ruane (2001) has suggested that "a major problem in teaching and teacher education is the difficulty educators have coming to terms with their own biases and perspectives" (p. 152) and that the taboo around discussing issues of race contributes to this. In many schools and programs, a key element of professional identity is the notion of "color-blindness," linked to the notion of equal treatment for all children. Although perhaps well intentioned, this notion of color-blindness has led to silence about issues of race, thus perpetuating bias (Paley, 1979). Florio-Ruane challenged faculty to change the conversation that is occurring in pre-service education from a posture of studying about culture to one of learning with others, thus transforming one's view through dialogue. She said "the knowledge teachers 'need'—in this case about culture or power or inequality—is 'out there' for the taking" (p. 155). It merely requires "joyful" participation in difficult conversations. One of the most fertile fields for these difficult conversations arises out of the experience of dilemmas or cultural discontinuities (Sánchez & Thorp, 1998). This view acknowledges that when early care providers interact across cultures, there are bound to be cultural conflicts and dilemmas. To engage in critical reflection, providers need to address these dilemmas consciously and embrace them as having the power to lead to learning and change. Too often, without a framework for critical reflection, pre-service faculty and students, as well as practicing professionals, allow dilemmas to support existing stereotypes and, if anything, fix a negative view in consciousness. John Dewey, as early as 1933 (Dewey, 1933, as cited in Brookfield, 1987) saw perplexity and doubt, coupled with critical reflection, as the way in which individuals could make meaning and reach resolution. Incorporating the use of dilemmas as a tool for critical reflection requires that programs create a structure and process in which practitioners (a) open their eyes to acknowledge dilemmas and stay in that state of discontinuity rather than jump to solutions, (b) describe dilemmas in ways that ensure that they see themselves at the center of the dilemma, (c) interpret personal and professional meanings of the dilemma through interpersonal dialogue and systematic problem solving (Brookfield, 1987; Sánchez & Thorp, 1998), and (d) practice applying new understandings.

Photo: ©iStockphoto.com/Jo Unruh

Few practitioners have had experiences with individuals from cultures other than their own.

Analyze Dilemmas for Underlying Assumptions

It is not unusual that individuals think that their dilemmas are obvious dilemmas that would be shared by anyone who heard the facts of the dilemma. They do not immediately realize that dilemmas stem from interactions that challenge deeply held beliefs and values that are personal as well as culturally and contextually constructed (Brookfield, 1987). Analyzing dilemmas for underlying assumptions asks the learner to reflect on the following questions: (a) What meaning did this dilemma have for me? (b) Why was it a dilemma? (c) In what way did it challenge my deeply held values and assumptions? (d) What memories and early experiences did it trigger?, and (e) How might these help me understand the source of my assumptions? Applying these questions encourages professionals to analyze experiences they identify as problems or dilemmas from the perspective of their cultural lens (Sánchez & Thorp, 1998).

Consider the Sociocultural Context of the Actors in Dilemmas

This element of critical reflection, which requires perspective taking and structural analysis, asks the learner to leap across the cultural divide and consider how the dilemma was experienced from the point of view of one or more other participants who may bring a different cultural lens. For example, a participant in an in-service training describes the frustration she feels with a mother who always picks up her baby at the slightest whimper. The professional wonders how this mother can be so overprotective and how the baby will ever learn to calm himself, to self-regulate. This participant must be supported to begin to wonder what beliefs and values may undergird the mother's behavior and how these behaviors have served the mother in her cultural context. Dialogue can begin when the in-service participant is able to recognize that there may be another culturally constructed vantage point different from her own (Darling-Hammond, 2002).

This process is challenging, requiring the practitioner to at least entertain the notion that there may be another way to engage in any number of child-rearing routines or to interpret any number of events that occur in a child's day. It requires continued careful orchestration to avoid truncating the process, leaving the practitioner with an acknowledgment that there indeed may be other perspectives but that "my way is still the right way." However, as challenging as this process of supporting personal perspective-taking is, even more challenging is encouraging practitioners to engage in sociocultural analysis of dilemmas—in wondering about social justice elements that may be embedded in the dilemma; about elements of institutional bias, of race, social class, power, and privilege; and about how these are reflected in early care and education practices (Brookfield, 1987; Darling-Hammond, 2002; Kidd, Sánchez, & Thorp, 2004).

In the context of early childhood, these larger issues of social justice may lie in unpacking dilemmas around why particular families fail to participate (Thorp, 1997) or in how particular early childhood professionals behave with children and families (Ballenger, 1999) or—as suggested by the title of Tatum's book (2003)—"why all the Black kids sit together in the cafeteria." The process is challenging for faculty and trainers who provide professional development because, as Darling-Hammond (2002) noted, they must be prepared to support conversation in which

> *some students would bear the brunt of explaining how injustices work from their own life experiences, and that others would struggle to find a way to become agents of social justice when they found that they had been beneficiaries in their lives of the system which produces so much educational injustice* (p. 3).

Explore and Imagine Alternatives

This element of critical reflection extends logically from perspective taking. The practitioner begins to recognize that there are other ways of behaving and that, from the perspective of others living in a different sociocultural milieu, these other ways are completely logical and explicable. As Brookfield (1987) noted, the learner comes to realize that

> *every belief we hold, every behavior we cherish as normal, every social or economic arrangement we perceive as fixed and unalterable can be and is regarded by other people (in our own culture as well as in other cultures) as bizarre, inexplicable, and wholly irrational* (p. 18).

At this point, the practitioner is able to identify alternative ways to address the dilemma, at the very least engaging in deeper dialogue with the actors in the dilemma whose behavior seemed inexplicable, perplexing, and frustrating. At best, the practitioner is able to identify new ways of behaving in the dilemma.

Finally, to create safe environments for practitioners to engage in successful reflection, university faculty and professional development trainers may themselves need to go through their own cultural process and model critical reflection for participants.

Furthermore, they will need to model a habit of wondering, asking "Where are the migrant families? Whose voices are heard in this community? Why are some people invisible? Whose contributions are valued?" Their authenticity and their ability to embrace perplexity create a safe place for reflection and dialogue (Brookfield, 1987; Florio-Ruane, 2001).

Talking about the need to address diversity as the educational challenge of the 21st century is easy, but to effect changes in programs and practices at multiple levels, faculty, trainers, and learners will need to commit to a deeper, longer term, and more painful process of critical reflection and continuous dialogic interaction with diverse cultural communities. The work cannot simply involve creating new courses or providing in-service training on "cultural competence"; rather, it must begin with self-reflection. Furthermore, there is new content to be learned by instructors as well as by learners. The issues of culture and language are complex and are related to all of us, not just to new immigrants or those who speak languages other than English. Thus, partnerships with diverse communities, families, and professionals are essential. As instructors of the practitioners of the 21st century, we have the potential to develop the knowledge, skills, and dispositions that help create more culturally and linguistically responsive programs that welcome and nurture all children.

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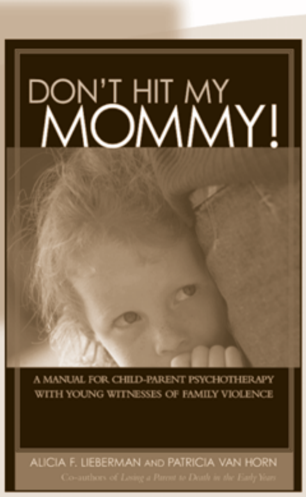

Building Resilience

The Power to Cope With Adversity

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Many families face stressful situations, including parental depression or related mental illesses, serious medical illness, community violence, and poverty. Adversities like these can be painful for the children in these families. But the hopeful news is that research on children facing such problems has shown that many children show resilience and do surprisingly well. Resilience is the ability to cope with the stress caused by such challenging situations. Dr. Ann Masten, one of the leading researchers on resilience, described it as "ordinary magic" (Masten, 2001) a quality that shows itself in children's curiosity, in their ability to relate to others, and, above all, in their ability to survive and be successful even though their lives include many challenges. Two important ways that early childhood professionals can help parents and young children foster resilience include identifying strengths and building on resources.

Understanding Resilience

RESILIENCE CAN BE understood at four levels: the individual, the family, the school and caregiving system, and the larger community. Important qualities of resilience were identified in studies of older children who grew up with the stressor of a depressed parent and yet managed to do well.

At the individual level, these children were able to:

- **Engage in age-appropriate activities**, such as going to school or participating in community or religious activities.
- **Relate to others**, including parents, siblings, other family members, peers, and other community members.
- **Understand their family life**, in particular, the fact that their parents were depressed and that they were not to blame. Repeatedly, these young people said that understanding that their parents had an illness, that it had a name, and that they were free to go on with their lives, helped them a great deal.

At the parenting level, despite the challenges they may be facing, many parents remain deeply committed to parenting, commonly saying things such as, "I will do what I need to do to take care of my child, even if I cannot do anything else."

At the caregiving level, schools and health centers were vital in building strengths by providing care for those suffering from adversity.

At the larger community level, risk factors like community violence, unemployment, or lack of access to resources can make depression more likely. On the other hand, safe neighborhoods, strong social ties, and shared purpose can build resilience. In this sense, a strong and well-functioning early care and education program such as Early Head Start can be an important community resource against adversity and is in a key position to strengthen families.

What Promotes Resilience?

IT IS IMPORTANT to recognize resilience in children, in parents, and in oneself as a professional and to understand which systems in the community promote resilience. Resilience can be recognized and fostered at these four levels.

For the individual child:

- Supporting a child's capacity to learn, to relate to others, to use imagination, and to see himself as part of a community.
- Developing a child's awareness and regulation of his own feelings, as well as skills and strategies for letting other's know how he feels.
- Encouraging children's relationships with their peers, their caregivers, and their parents.

For families:

- Understanding the many cultural variations and different ways families can show strength and resilience is one of the great challenges and one of the great opportunities.
- Encouraging parents in their efforts to be more effective by having regular routines for their children to follow, maintaining appropriate limits, and engaging in positive parent–child interactions, such as reading together or talking about what happened during the day at school.

At the caregiving level:

- Encouraging consistent positive

attachments with children and making parents feel welcomed and comfortable.
- Understanding adversity and resilience in the families they work with can help teachers be a resource to families and more effective in their work.

At the community level:
- Understanding what exists and what is missing in community resources is an essential step to better parent outreach.
- Sharing knowledge and experience with families to find the right service or information from a variety of settings, including health clinics, schools, places of worship, and community centers.

The study of strengths and resilience in children has shown the importance of positive caregiving relationships and the capacity children have to change and adapt in the face of adversity. There is no one set result for children, even in the most difficult life situations. This knowledge provides hope for parents, but it is important to emphasize that schools, health clinics, and community centers can provide help and support.

Helping Parents Build Resilience

It is possible to build family coping skills even while living under stressful conditions or during difficult times. Three key messages for parents are:
- "You and your child have strengths." Parents welcome information about resilience. At the same time, many have trouble at first in accepting the notion of strengths. Asking parents what they like best about their child or what makes them happiest about their child is a good starting point.
- "Reflect on what you need." Asking a parent "What do you need?" may seem simple, but many parents require support in understanding their needs before they can ask for resources. Encourage parents to think about how their current experience compares to how they would like things to be before asking them what resources they need. This means reflecting on "the now" and imagining "the future"—something that families facing adversity may find difficult to do. Depressed parents may need extra support when trying to imagine their options because depression can make it challenging for a person to think beyond their day-to-day coping. Building trust in their relationships with families is an important strategy for professionals to encourage reflection. Another important activity is, over time, helping families to remember the strategies that work for them and use them.
- "Take care of yourself." Many times, parents will move toward changing their lives in the name of being a better parent. Let parents know that energy invested in self-care can have positive results for their children as well. Encourage parents to consider how they are taking care of themselves. Offer examples of "first steps" for better self-care. For instance, a goal to change one's diet can be started by eating more fresh vegetables or cutting back on candy. A goal to exercise more can start with taking the stairs rather than the elevator.

On a daily basis, parents can build their child's resilience by:

Teaching self-care: Making time for healthy eating, exercise, and rest supports parents' efforts to feel strong and teaches a child good habits to last throughout his lifetime.

Emphasizing the positive: Helping parents remember and celebrate important events either within the family or in the larger culture is another important way to build resilience. Singing songs with children, drawing pictures with them, looking at photographs together, acknowledging important holidays such as Martin Luther King's birthday or Thanksgiving can help.

Building a strong parent–child bond: Developing a consistent, loving bond by showing affection and responding to a child's needs can help her feel secure and support the parents' effectiveness.

Reading together: Sharing books and stories has numerous benefits for children and parents, including language and literacy learning, creating routines, and fostering a love of learning and discovery through books. Books are also great tools that can open and support conversations about positive feelings and difficult events experienced by either the child or the family.

Encouraging social skills: Teaching children how to make friends and reaching out to your own friends can help your child see what it means to be friendly and learn to get along with others. Make time for and encourage children to play with peers and participate in positive group activities such as sports or clubs.

Maintaining a daily routine: Knowing what to expect can be comforting to children and adults. Keeping a routine and following simple daily rituals such as reading a story each night together before bedtime can also be reassuring.

Nurturing positive self-esteem: It is important to build upon strengths. Parents can help their child to trust himself and to try new activities by complimenting his successes and helping him to learn from his hardships.

Practicing self-reflection: Taking time to reflect on life is one of the most important things parents can do to gain perspective and problem-solve. Some ways to cultivate productive self-reflection include keeping a journal or talking with others about positive events or getting through difficult times. Creative projects such as taking photos, creating artwork, or making music and sharing those art forms with children provide meaningful opportunities for reflection and communication across the family.

Acknowledgment

The material presented in this handout is adapted with permission from the Family Connections Project *at Children's Hospital Boston, developed under the Innovation and Improvement Project grant from the Office of Head Start, Administration for Children and Families, U. S. Department of Health and Human Services. For more information about Family Connections, visit www.childrenshospital.org or www.ECLKC.ohs.acf.hhs.gov*

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Learn More

Family Connections: Helping Early Head Start/Head Start Staff and Parents Address Mental Health Challenges.
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Field Notes

ZERO TO THREE Fellows share news and information about research, policy, and practice innovations in their work with infants, toddlers, and families.

Maternal Post-Traumatic Stress and Response to Toddler Distress

Daniel S. Schechter, University of Geneva Hospital

THREE DIFFERENT PROGRAMS of research launched by myself and colleagues over the past decade (Schechter et al., 2006; Schechter et al., 2007; Schechter et al., 2008; Schechter & Willheim, 2009; and Schechter et al., in press) support the overarching hypothesis that mothers who have experienced interpersonal violence and who suffer from related post traumatic stress disorder (PTSD) tend to have particular difficulties in the regulation of their own emotion and arousal, especially when faced with helpless states of mind in their young children or themselves. These difficulties, which can be viewed at the level of maternal mental representations and self-reported stress, behavior, physiology, and neural activity, are associated with impairment in their parental function of assisting their young children with regulation of their emotion, arousal, and aggression. As a result, some children showed dysregulated aggression, increased anxiety, avoidance and withdrawal as well as less coherence concomitant with severity of maternal PTSD symptoms. Similarly, there was a robust link between maternal PTSD diagnosis and disturbances of attachment as observed by clinicians. Therefore, young children can represent a threat to mothers with PTSD and a mother's fear-response can present problems for her child's social–emotional development.

A current study underway in Geneva, with support from the Swiss National Science Foundation, is seeking to understand what contributes to individual differences in behavioral expression in the mother, child, and the mother-child relationship, especially for the child over time. It is important to note that an experimental intervention, the Clinician Assisted Videofeedback Exposure Session(s) (CAVES), contributed to a significant change in the way mothers have viewed their children (i.e., less negatively) in both studies. But it remains to be understood if these changes are sustainable—given varying "doses" of this intervention, and if so, for whom. Researchers, including myself, Sandra Rusconi-Serpa, Francois Ansermet, and others on the University of Geneva Hospitals Department of Child and Adolescent Psychiatry Research Team, are working on this and other questions such as whether any such changes translate into caregiving behavior and its neurobiological correlates, and whether these changes carry over effects to the child.

Schechter, D. S., Coates, S. W., Kaminer, T., Coots, T., Zeanah, C. H., Davies, M., et al. (2008). Distorted maternal mental representations and atypical behavior in a clinical sample of violence-exposed mothers and their toddlers. *Journal of Trauma and Dissociation, 9*(2), 123–149.

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Schechter, D. S., Willheim, E., Hinojosa, C., Scholfield-Kleinman, K., Turner, J. B., McCaw, J., et al. (in press). Subjective and objective measures of parent-child relationship dysfunction, child separation distress, and joint attention. *Psychiatry: Interpersonal and Biological Processes.*

Schechter, D. S., Zygmunt, A., Coates, S. W., Davies, M., Trabka, K. A., McCaw, J. E., et al. (2007). Caregiver traumatization adversely impacts young children's mental representations on the MacArthur Story Stem Battery. *Attachment and Human Development, 9*(3), 187–205.

Trauma and Loss in Adolescent Pregnancy

Bethany Ashby, Aurora Mental Health Center and **Ayelet Talmi,** University of Colorado

ADOLESCENT PREGNANCY OFTEN involves experiences of trauma and loss and requires specialized services and supports for this vulnerable population. The Colorado Adolescent Maternity Program/Young Mothers' Clinic (CAMP/YMC) at the University of Colorado and The Children's Hospital is a program for pregnant and parenting adolescent girls less than 21 years old. Pregnant teens receive their obstetrical care in the clinic and, once they deliver, both they and their babies continue to receive primary care services from the same team of medical providers. In addition, clinic patients have access to mental health providers including social workers, psychologists, and psychiatry coverage.

The teens in CAMP/YMC are predominately low income (85% enrolled in Medicaid) and slightly more than half live with one biological parent. About one third of the adolescents are African American, 44% are Latina, and 16% are Caucasian. Nearly one third have dropped out or are failing school. Between 30%-40% of patients have some mental health concern and, during pregnancy, rates of depression are approximately 20% (Sheeder, Kabir, & Stafford, 2009).

The CAMP/YMC program recognizes that teens are at higher risk of pregnancy complications and has designed services to meet these needs. For example, teenagers are more likely to deliver prematurely, to have low birth weight babies, to develop high blood pressure during pregnancy, and to become anemic, among other medical complications (de Vienne, Creveuil, & Dreyfus, 2009). Many of these complications arise from lack of regular prenatal care or lack of commitment to stopping activities, such as substance abuse and smoking, which are harmful to the baby. Adolescents are also typically unprepared to cope with and face difficult issues when they arise due to their own developmental level. In addition, although teens are not allowed to make medical decisions regarding their own care, they are the only ones who can consent to their babies' medical treatment. Adolescents who have not finished high school and are forced to make complex medical decisions without really comprehending the risks to their babies—frequently without support from a medical team who understands their unique issues—can be traumatized by these experiences. The final outcomes, even when they are considered positive outcomes, are ones that these mothers are not prepared for—such as babies who require oxygen at home or who need tube feedings. For example, an 8-month-old Caucasian infant is followed both by CAMP/YMC and Pulmonary Medicine due to chronic lung disease. By the time she was 6 months old, the baby had been hospitalized 6 times and ultimately was determined to need oxygen at home. Her mother, a 17-year-old, has had difficulty recognizing the signs that the baby is struggling with breathing or understanding the critical necessity of oxygen, and often removes the nasal canula because she thinks the baby doesn't like it.

The vast majority of pregnancies in CAMP/YMC are unplanned and unwanted. The patients who choose to continue their pregnancies must deal with altered relationships with partners and family members, particularly when their parents were unaware they were sexually active or their partners want them to terminate their pregnancies. Many of the activities they participate in—parties, drinking, drug use—must change as a result of the pregnancy, which ultimately may mean changes in social interactions and peer groups. In short, the pregnancy itself causes huge losses in multiple areas. In addition, the pregnancy may also bring up issues around previous sexual traumas, and retraumatize the patient as she is once again faced with an experience of her body that she cannot control. In response to these challenges, CAMP/YMC provides integrated mental health services with obstetric, specialty, and pediatric primary care services, leading to better outcomes for adolescent parents and their babies.

de Vienne, C. M., Creveuil, C., & Dreyfus, M. (2009). Does young maternal age increase the risk of adverse obstetric, fetal and neonatal outcomes: A cohort study. *European Journal of Obstetrics, Gynecology, and Reproductive Biology, 147*, 151–156.

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To sign up, go to **www.zerotothree.org/child-development/from-baby-to-big-kid/**

The Baby Monitor

The Baby Monitor is the ZERO TO THREE Policy Network's bi-weekly e-newsletter, focused on policy and advocacy news about infant–toddler issues. Stay updated on key federal and state policy issues and learn how you can get involved. ***The Baby Monitor*** also features publications, online resources, and advocacy tools that can help you be a big voice for little kids.

To sign up, join the Policy Network at **www.zerotothree.org/babymonitor**

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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
FOCUS for Early Childhood (FOCUS-EC)	FOCUS is a family-level intervention, based on more than 20 years of research, demonstrating that targeted preventive interventions for families under stress can enhance the psychological health and developmental outcomes of both children and parents. FOCUS-EC has been used successfully with families facing several different types of stressors including parental medical and mental illness, pediatric cancer, community violence, natural disasters, and, most recently, with military families. (Find it in Mogil et al., page 10)
Injury Communication	The term *injury communication* (Cozza and Guimond, in press) describes communications about combat injury within the family and with providers and is an important factor in the family's adjustment. Effective communication allows parents to address children's fears with realistic information. Without parental guidance about changes from injury or illness, children will construct their own understanding of the situation, which can provoke significant misunderstanding and fear. (Find it in Arata-Maiers & Stafford, page 22)
Signature Wounds of War	Psychological injuries, such as posttraumatic stress disorder (PTSD), have been termed a *signature wound* of the wars in Iraq and Afghanistan because of its high rates in returning service members, both injured and uninjured. (Find it in Arata-Maiers & Stafford, page 22)
Therapeutic Visiting	Therapeutic visiting in the child welfare system is a process whereby an infant mental health clinician meets individually with the biological parent(s) before and after the family visit, and also participates in the visit. The clinician helps parents see the visit from the child's perspective and, during the visit, guides parental behaviors that provide the young child with a sense of security and the experience of positive engagement with the parent. (Find it in Chinitz et al., page 4)
Unresolved Mourning	Unresolved mourning results from defensive processes which permanently shield a person from processing the loss of a loved one in a psychologically healthy manner (Bowlby, 1960). Either consciously or unconsciously, a person with unresolved loss still believes that the loss is reversible. (Find it in Ostler, page 29)

Bowlby, J. (1960). Grief and mourning in infancy and early childhood. *Psychoanalytic Study of the Child, 15*, 9–52.

Cozza, S. J., & Guimond, J. M. (in press). Working with combat-injured families through the recovery trajectory. In S. M. Wadsworth & D. Riggs (Eds.), *Military families under stress.* New York: Springer.

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