



ZERO TO THREE[®]

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



Stories From the Field 2014

Child-Parent Psychotherapy
for Recovery From
Traumatic Loss

Standing Shoulder-to-
Shoulder With Parents in the
Criminal Justice System

Supporting Immigrant
Families With Infants and
Young Children

Also in This Issue:

A Literacy-Based Intervention to Talk With
Children About Difficult Topics

THIS ISSUE AND WHY IT MATTERS

Each summer *Zero to Three* focuses a Journal issue on the stories of how professionals are making a difference in the lives of children and families. In this issue, the articles address topics such as immigration and acculturation, recovering from traumatic loss, working with parents in the criminal justice system, group intervention to support parent-child relationships, and components of successful home visiting programs. Our readers tell us that these case studies are particularly useful for training and professional development experiences and that they are especially helpful in transdisciplinary settings. The *Zero to Three* Journal offers several professional development opportunities:

- You can download the free article “**Practical Tips and Tools: Using Stories From the Field for Professional Development**” at www.zerotothree.org/usingstories. The article provides general guidelines, plus strategies for using the case studies in team building, program development, teaching, and supervision, as well as building workforce capacity and advocacy for systems change.
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You may have noticed that the Facebook page for the *Zero to Three* Journal has recently merged with the larger organizational Facebook page at www.facebook.com/zerotothree. There you will find not only information about the Journal, but a wealth of information, practical tools, and resources for use by the adults who influence the lives of young children.

The *Zero to Three* Journal is also planning some changes in the Fall of 2014. Readers can look forward to a brand new updated design, including full color photos, and an appealing layout.

In other news from ZERO TO THREE, registration is now open for the 29th National Training Institute to be held at the Westin Diplomat in Fort Lauderdale, Florida, from December 10–12, 2014. Register online at www.zttntconference.org to take advantage of early registration rates.

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Where Do We Start?

Using Family Navigation to Help Underserved Families

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Marta looked down and, through the Spanish interpreter, asked, “Where do I start?” She had been concerned about her twin boys for some time. They had been born 6 weeks prematurely and had spent almost 2 weeks in the NICU growing big enough to come home. While their feeding and physical growth had been steady after leaving the hospital, Marta was worried that they seemed different from other children and weren’t doing what their cousins had done at the same age. At their 2-year checkup, she had told the pediatrician that one of the twins didn’t talk and the other used just some single words. He had reassured her that twins, especially boys, often talk later. Her family told her she spoiled them, doing so much for them that they didn’t have to ask for things. She wasn’t sure; she tried to be a good mother. Marta noticed that they were very independent and could play for long periods with their toy cars, rolling them back and forth and watching the wheels spin. Her sister reminded her that twins often entertain themselves. Now that the boys were almost 3 years old, after Marta brought up her concern again, the pediatrician had sent them to a developmental specialist, and she learned that both boys had autism spectrum disorder.

Family Navigation, an Adaptation of Patient Navigation

“**W**HERE DO I start?” is a pivotal question for all families of young children sitting in Marta’s position after a developmental or mental health concern is identified. This is also the moment when caregivers and clinicians faced with Marta’s question about where to start ask themselves, “How can I best help this family?” Determining the most appropriate answer to this shared question can be challenging and difficult. This is particularly true in the case of underserved families who may face a range of competing challenges such as not speaking English, recent immigration to the United States, or struggles with

poverty, which can seem overwhelming at times (Harstad, Huntington, Bacic, & Barbaresi, 2013; Lin, Yu, & Harwood, 2012). A novel approach called family navigation is one tool that can be used to help address the needs of underserved families in this circumstance. Our center has developed this program as part of a Health Resources and Services Administration-funded study to look at the efficacy of the approach in working with families and children facing a new developmental diagnosis. In doing so, we learned how we might need to think differently about intervention and how helping families truly means overcoming barriers one step at a time.

Patient navigation was first developed as an approach to improving care for the

underserved by Dr. Harold Freeman in the 1990s (Freeman, 2013). Initially developed to address disparities in cancer care among inner city adults in Harlem, patient navigation has become an integrated part of many cancer programs across the U.S. Although this approach emerged in the context of adult

Abstract

The period of time after a child is identified with a developmental or mental health condition can be highly challenging. This is particularly true for diverse, underserved families who may face competing concerns related to poverty, culture, language, immigration, and family issues. Likewise, clinicians working with underserved families may recognize that usual care is not as effective in this context and look for alternative approaches. The authors share the story of one such family and illustrate how family navigation, a novel approach that addresses individual-level barriers to care, can support families in accessing intervention during the critical period after diagnosis.

cancer care, it has potential applications in helping people dealing with many conditions and particularly those impacting children and families. Family navigation modifies patient navigation in several ways including (a) shifting the model from working only with the identified patient to working with the family and (b) from navigating only medical system barriers to also navigating a range of community, educational, and social barriers at an individual family level. Like patients newly diagnosed with complex medical conditions such as breast cancer, families of children diagnosed with special needs also have to access an often overwhelming range of systems and programs—medical, early education, mental health, social services, and government programs in a timely way. They are asked to do this at a time that often entails great family stress and upheaval. This need to effectively access intervention after diagnosis is particularly important with neurodevelopmental conditions such as autism, where it has been shown that early intense intervention can make a significant difference in outcome for young children. In recognition of the enormity of this task for families and the role for a targeted professional trained in both culturally competent family and infant mental health approaches and systems of care, family navigation is an innovative approach building on standard care.

Usual Care

IN USUAL CARE after an evaluation was complete, Marta would have a 40-minute office visit at the hospital with a medical clinician who would demystify the diagnosis and discuss further evaluation and treatment. A follow-up visit for 1 to 3 months later would be scheduled to address further questions the family might have. The visit would likely be conducted in English with a Spanish-speaking telephone interpreter. Marta would receive a short letter stating the diagnosis for her to share with either early intervention or the public school system, depending on the child's age. This letter would be followed by a full report mailed to her home and to the children's primary care physician several weeks later. Both documents would be in English. Marta would receive the telephone number of a clinic resource specialist to call if she had any questions in the meantime. The resource specialists do not speak Spanish; however, if she leaves a voice message they would call her back with the assistance of an interpreter.

In usual care, the diagnostic clinical encounter in many ways is the culmination of the family's journey. They receive a diagnosis and recommendations for intervention, and then they must act upon these to help their child. There may be available supports like medical follow up and possibly resource



Families of children diagnosed with special needs have to access an often overwhelming range of systems and programs.

specialists with whom the parent can initiate contact, but these may not necessarily be readily accessible to Marta who, as a monolingual Spanish-speaker and immigrant “without papers,” may not be able to read the report recommendations, get a telephone message to the resource specialist, or trust that by going to the public school system or state agencies her immigration status will not be questioned. These complicating factors often play out in significant stress for the family and in delayed or suboptimal treatment and intervention for the child.

The Navigation Approach

WHEN MARTA LEFT the clinic her mind was spinning with what the clinician had just told her, and she was somewhat panicked. She understood her children needed more help and that the specialists recommended they go to school to get the help they needed. She had both the letter the clinician had given her stating the diagnosis and recommendation for intensive intervention and an address where she needed to go to start her children in school. The following day, Marta told her family what had happened at the clinic. Her parents still weren't convinced that there was anything wrong with the twins. Her sister was supportive and asked more about what autism was. Marta explained what she remembered from the clinician's explanation. Later that week, Marta received her initial contact call from a family navigator.

The crux of family navigation is meeting families where they are and helping them overcome self-identified barriers to accessing intervention for their child. Family navigation differs from traditional care management in several ways. Navigators who work with the families address specific patient barriers as they arise during a defined critical episode of care, for example after a positive screening or immediately after a diagnosis, when the trajectory of a child can be significantly impacted. And most critical to this approach is that those barriers are addressed through to resolution. In assisting families to overcome self-identified barriers, navigators also are able to teach and model navigation skills, making the intervention particularly well-suited to traditionally underserved (e.g., low-income, immigrant, and limited-English) populations. The family's acquisition of new navigation skills allows for the impact of the intervention to extend beyond the 6-month period of direct interaction between the family and the navigator.

Who Are Navigators?

NAVIGATORS ARE MEMBERS of the community who have a range of backgrounds conducive to the tenets of the approach. In our program, individual navigators have backgrounds in human services, mental health, patient advocacy, law, and faith-based leadership. Prior to working with families, they complete a designated family navigation training curriculum. The

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curriculum includes didactics and experiential instruction on childhood developmental conditions such as autism spectrum disorder; communication and infant mental health approaches consistent with the Diversity-Informed Infant Mental Health Tenets (St. John, Thomas, & Noroña, 2013); the early intervention and special education programs; government agencies and social services; cultural competency; medical interpretation; and how to deal with common family issues such as parental depression, homelessness, child protection, immigration, and domestic violence. In Marta's case, the navigator was a native Spanish-speaker who had previously worked as a lawyer in Puerto Rico and had a background in community service. She had worked in the navigator role with our program for more than a year when she met Marta.

Establishing an Alliance

WHEN THE NAVIGATOR contacted Marta on her cell phone, Marta asked to meet the next day at the shelter apartment where she was living with the boys and their two older siblings. The family had moved there several months prior after an episode of domestic violence involving the twins' father. When the navigator arrived she was struck by the Marta's demeanor. She appeared calm but almost defeated. She nodded along as the navigator reviewed how they would work together over the coming 6 months. The mother was very soft-spoken, and later in the visit, when the navigator checked in with Marta, she realized that Marta didn't remember many of the things discussed. For her part, Marta was apologetic and blamed constant headaches and worries for her poor memory. The conversation, as almost all their interaction during the 6-month period, was continually interrupted by the boys' behaviors as their limited verbal abilities made it difficult for Marta to figure out what they wanted.

The first meeting is a pivotal time in the navigation intervention. It is a time to hear the family's story, establish trust, and empower the family to identify their true barriers to care. Often the first meeting involves a lot of listening and asking the same questions in different ways during the course of the visit. Although it is the navigator who contacts the family to set up the meeting, the context of the interaction is determined by the family and what works best for them. The navigator asks when and where they would like to have contact, what format they prefer (in-person, email, or telephone), and where the contact will take place (e.g., home, location in the community like a restaurant or library, an agency location). The goal of the first encounter is to determine a shared list of barriers to be addressed. These barriers

"Where do I start?" is a pivotal question for all families of young children after a developmental or mental health concern is identified.

are determined through discussion and subsequent review of a checklist of common tasks that families often hope to accomplish after a diagnosis. Typically, the family identifies 2–4 priority issues. Often, barriers are issues that might not be able to be effectively addressed as part of more traditional clinic-based care. After slowly going through their history and the boys' diagnosis and reviewing the checklist together, Marta and the navigator came up with a list of three concerns that Marta felt were important barriers to helping her boys—figuring out how to start intervention, addressing their basic needs with assistance from available social services, and working on her own feelings of isolation and depression.

Working Through the Barriers

OVER THE NEXT several months, the navigator and Marta met more than 12 times and had contact by text messages and phone as well. Much of the interaction was task-specific involving completing applications, writing letters, and going to the school system office and other agencies. In working through the tasks, the navigator acted as a hands-on coach accompanying Marta and modeling interactions, translating, and providing cultural interpretation as needed and encouraging her to take on an increasingly active role in advocating for her boys. During the course of their interaction, Marta's trust in the navigator grew, and she slowly shared that she still did not really understand autism and the treatment needed. Marta began to divulge some of the emotions related to her history of domestic violence and of being overwhelmed by her circumstances. She also eventually shared a sensitive, seemingly unrelated issue that was nonetheless keeping her mired in feeling deeply ineffective—her profound worry for the twins' older siblings who were good students but were finishing high school with limited opportunities because, unlike the twins, they had been born outside of the United States.

Obtaining Intervention Services

First on Marta's list was getting the boys intervention through the public

school system. Currently, recommended intervention for young children with autism spectrum disorder consists of at least 20–25 hours per week of services designed to address difficulties with communication, social interaction, daily skills, and behavior. Through the Individuals With Disabilities Education Act, children 3 years and older who have developmental challenges are entitled to a full evaluation and, if eligible, intervention services through the public school system where the family resides. Because the twins had not received early intervention before they were 3 years old, there was no one, aside from the navigator, to assist Marta with the complex process of obtaining this help. She did not know how to request the evaluation or where to go to make the request because the apartment shelter the family had moved to was located outside the community where they previously lived.

The navigator reviewed the medical clinician's letter with Marta and described in straightforward terms the recommended services, including a classroom program, speech and language therapy, occupational therapy, and behavioral therapy. She then pulled out a visual step-by-step diagram in Spanish outlining the process for Marta to request these services. Once Marta understood the steps, she and the navigator set a date to go together to the school district office so that Marta could sign the evaluation consent. Prior to their discussion, Marta had thought she just needed to bring the clinic diagnosis letter to the school system office and services would start. The navigator explained an actual consent form is generated by the school and that this form needed to be signed before the evaluation could begin. Marta also was worried that the family would soon be moved to different housing and questioned whether the children should start at one school only to have to change when the family moved from their shelter placement. Hearing this concern, the navigator was able to explain that because the family currently was homeless a federal law called the McKinney-Vento Act applied—if it was in the boys' best interest, they would be able to complete the current school year at the school where they were placed after evaluation, with transportation provided, even if the family moved to longer-term housing in another district.

Over the next several weeks, the school completed the eligibility evaluation with the boys and held a special education team meeting to discuss the intervention the boys would receive. This experience, in particular, highlighted how far Marta had come in the weeks since her boys' diagnosis. The navigator attended the meeting with her at her request. Together they reviewed

the children's Individualized Education Programs and identified that occupational and behavioral therapy evaluations had not been done. The navigator helped Marta draft a letter requesting that these evaluations be completed and the therapies added to their program. Marta then was able to deliver the letter to the school office on her own. She signed additional consent forms for these evaluations, and they were eventually completed.

Midway through her work with the navigator, the twins began their special education preschool. Although the first several days were difficult for them because of the change in setting, they adjusted quickly and soon began showing progress with increased engagement. Those initial days were also challenging for Marta, who had never been separated from her boys and worried that only she could understand them. However, with support from the navigator, Marta was able to visit their classroom and see that they loved going to school. Marta and her boys were no longer isolated in their apartment but now had a small team of teachers and therapists in their corner.

Accessing Social Service and Financial Supports

At the same time, they were working on getting school set up for the boys. Marta and the navigator also began to tackle the next issue on her list, accessing available social services. Almost all of Marta's time was spent caring for the twins who, because of safety concerns and their severe communication difficulties, needed constant, high-level supervision. Although Marta would occasionally help a friend with cleaning jobs, she had been otherwise unable to work since the twins' birth. There are several programs that are available to help families with children who have significant developmental disabilities, including the state Department of Developmental Services and the Supplemental Security Income program. Unfortunately, like many programs, the applications are detailed and it can be difficult for families to understand the application process and gather the necessary paperwork. In the case of immigrant families like Marta's, there also can be significant confusion about and fear of entities related to the government. The navigator helped Marta complete the applications, and the family ultimately was assigned a case manager and received nominal but much-needed financial support. Unfortunately, as can happen, there was a misunderstanding between agencies and Marta's Supplemental Nutrition Assistance Program benefits were markedly decreased after the twins qualified for Supplemental Security Income. Given



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The crux of family navigation is meeting families where they are and helping them overcome self-identified barriers to accessing intervention for their child.

that the nutrition plan benefits were used to help provide food for the family, this was a big blow. The only way to rectify the situation was to go to the agency office and meet with a representative. The navigator was able to accompany Marta, providing much-needed emotional support. Prior to the visit, they talked through Marta's feelings of unworthiness and fear in asking for help which related to her current circumstances, immigration status, and history of domestic violence. At that visit, they were able to work out the misunderstanding, thereby restoring the family's benefits.

Isolation and Depression

Over the course of their relationship, Marta and the navigator often would touch on Marta's feelings of sadness and somatic symptoms. In the initial weeks after her sons' diagnosis, simply meeting and checking in regularly with the navigator provided much-needed adult contact for Marta, who had been very isolated by the boys' behavioral challenges, her previous abusive relationship, and subsequent placement in a shelter outside her home neighborhood. Some of Marta's symptoms began to improve as she became less isolated and she and the boys developed supports in the community. Within the safety of their trusting relationship, the navigator also began to reframe Marta's somatic symptoms such as headaches and fatigue as possibly reflecting feelings of stress and depression. With the navigator's encouragement, Marta eventually made an appointment with her adult primary care clinician and addressed her depression through her own medical treatment.


Defined Endpoint

AN INTEGRAL ASPECT of family navigation is that the intervention takes place during a critical point in a family trajectory and that there is a defined endpoint. Ideally, the navigation intervention ends when the family has successfully overcome barriers to transition from point A to point B. In the case of our study, this was from point of diagnosis to receipt of intervention. On the basis of chart review of our clinical population, we established the 6 months after diagnosis as the critical timeframe during which most families will initially process a child's diagnosis, access intervention, and begin to establish an ongoing support system. At the final visit with the navigator, the family is provided a diagrammatic chart of what they have accomplished tackling each of their identified individual-level barriers. The chart has one final column that lists "next steps" with respect to each barrier. When Marta and her navigator sat down to review the chart, as with many families, this was the most difficult column to discuss. While looking back at all a family has accomplished during their time with the navigator is reinforcing and empowering, the "next steps" column is a concrete reminder that the journey the family has embarked upon with respect to their child's disability is one that will be ongoing, and in the case of conditions like autism, life-long. The column lists the names and contact information of the designated people from each system (in Marta's case the school system, social services agencies, and mental health clinician) who the family will be able to work with going forward. Although the navigator is not listed in the final column, a

primary aim of navigation is for the family to on some level internalize the lessons learned in working with the navigator. When that happens, in a sense, the navigator continues with them on their journey.

Making A Difference

FAMILY NAVIGATION IS a novel approach to improving care for underserved families. The critical foundation of the approach is empowering families to overcome self-identified barriers through to resolution during a discrete, critical period. Additional important components include that it is diversity-informed, offers flexibility in delivery format, and is highly supportive but ultimately parent-directed. On an individual level, for many families we have worked with, as for Marta, family navigation has been a tremendous help during one of the most difficult times in their lives; the effects of which we hope will extend well beyond the direct intervention. In Marta's case, her boys continue to make progress and she has blossomed into an active member of the hospital Parent Leadership Committee, working to help other families of children with special needs. On a systems level, future studies using patient-centered and clinical outcomes (Karst & Van Hecke, 2012) will help

further develop this and other innovations in addressing the unique needs of underserved families and children. 

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Benefits of Child–Parent Psychotherapy for Recovery From Traumatic Loss

An Example of One Family’s Strengths

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The Louisiana State University Health Sciences Center, Harris Center for Infant Mental Health, funded by the Irving Harris Foundation and known as the Harris Program, provides mental health services to infants and toddlers from birth to 5 years old. The Harris Program aims to raise awareness of mental health problems that can affect young children and their families as well as to provide prevention, intervention, and treatment services at an early age in order to have a positive impact on development. The program provides training, education, and supervision to predoctoral and postdoctoral psychologists, child psychiatry fellows, and social workers in order to increase knowledge among clinicians about ways to treat mental health problems that may arise in young children. The primary treatment modality used in the training program is Child–Parent Psychotherapy (CPP; Lieberman & Van Horn, 2005, 2008).

CPP was the primary intervention used in the treatment described in this article. CPP is an evidence-based treatment for children from birth to 6 years old who have been exposed to interpersonal violence and multiple traumatic events. Treatment focuses on improving the relationship between a parent or caregiver and young child. The goals of treatment are to strengthen the attachment between the parent (or caregiver) and child, help them regain a sense of safety, and help

the child resume a normal developmental trajectory. The family learns more about how the child may respond to a traumatic event, including potential changes in behavior, delays in reaching developmental milestones, and inability to regulate emotions. The child together with the parent is given the opportunity to retell their story of the trauma that was experienced through words or in play, using a trauma narrative. Through this therapeutic process, an opportunity is provided

Abstract

Child–parent psychotherapy (CPP) can strengthen the relationship and attachment between caregivers and children. Young children who have experienced multiple traumas, such as the destruction caused by a natural disaster and the sudden, traumatic loss of parents, depend on support of other caregivers for recovery and resilience. The case presentation describes the course of CPP for a young child and his maternal aunt who was also impacted by the loss of her sister and brother-in-law. The relationship-based treatment helped the child develop a secure, nurturing relationship with his aunt that gave them both the strength to keep moving forward following their losses. This case illustrates not only ways that young children can recover from trauma, but also the impact that the trauma can have on a family and steps that are needed to support resilience.

PHOTO: ©ISTOCKPHOTO.COM/PATTIES



When Hurricane Katrina hit the Gulf Coast in August 2005, the entire community where Sam's family was living flooded.

for them to strengthen their relationship with one another (Lieberman & Van Horn, 2005, 2008).

Presenting Problem

SAM¹, A VIETNAMESE and Asian-American boy, was 32 months old (2 years and 8 months) when he was referred to the Harris Program for evaluation and psychological treatment. The referral came from the young child's day care center and his maternal aunt after Sam witnessed his parents being murdered. Following the loss of his parents, his aunt reported that he had been having difficulty sleeping at night, had a poor appetite, became withdrawn at day care, and stopped speaking even though he had already developed language skills. His aunt spoke Vietnamese and some English. In initiating the treatment, it was important to be sensitive to issues related to the reluctance of many Asian-Americans to use mental health services because of cultural issues, language barriers, and lack of awareness of resources. Many individuals from Vietnamese communities are reluctant to talk about their personal issues with others outside of their families, preferring to manage mental health concerns inside their own community.

Sam had lived with his biological parents and younger sister for the first 2½ years of his life. Sam's grandparents and his aunt and uncle lived in their own homes on the same street. The family was very close and enjoyed having dinner together every weekend. The small neighborhood where the family lived was a predominately Catholic Vietnamese

American community in the eastern part of New Orleans (Leong, Airriess, Li, Chia-Chen Chen, & Keith, 2007). When Hurricane Katrina hit the Gulf Coast in August 2005, the entire community where Sam's family was living flooded. Before the hurricane made landfall and the family's house flooded, they evacuated to northern Louisiana. The entire family lost their homes and belongings in the destruction caused by Hurricane Katrina and the breaching of the levees. Vietnamese families were among the first to return to New Orleans and start rebuilding their community. This close-knit community was described as being self-sufficient and having hard workers especially in a time of chaos when there were few resources available (Hill, 2006). Sam's family returned to New Orleans approximately 1 year later and rebuilt their homes in the same neighborhood. They re-established their family business and began to move forward with their lives. After the family returned to New Orleans, Sam began attending a bilingual (Vietnamese and English) Catholic day care center near his neighborhood.

About 1 year later, Sam's mother went out to the grocery store one evening, and Sam stayed at home with his father and baby sister, who was 3 months old. When his mother returned home, she was approached by two men and held at gunpoint while entering her home. The men followed her in the house and shot both of Sam's parents, but did not harm either child. About 1 hour later, Sam's grandfather walked down to their home because they had not answered their phone. When he entered the house, Sam was sitting in between his two parents who were lying dead

on the floor. He was holding their hands, sitting silently with tears running down his face and covered in blood. His baby sister was crying, still lying on the bed in the bedroom where she had been having her diaper changed. These murders occurred in conjunction with a series of robberies and homicides that took place over a 2-week period targeting this particular neighborhood. Community leaders and local police responded to this violence with an increase in police response time and protection for residents (McCarthy, 2007).

After his parents' death, Sam's maternal aunt and uncle were given custody of both children. Sam also spent a lot of time with his maternal grandparents, who lived across the street, and usually slept over at their house. The family still owned the home where Sam's parents were murdered but they had not returned inside the home since the incident. When Sam asked where his mom and dad were, his aunt would tell him that they were in heaven because that was what they believed based on their culture and religion.

Sam's daily routine remained the same. He continued to attend day care every day for 5 hours. In the classroom, his teachers reported that he had difficulty sitting still and paying attention. When he was redirected, he was able to focus on what the teacher was saying. He often clung to the teacher during the school day. He had difficulty communicating with his peers, but did have one close friend at school with whom he played regularly. He also appeared to get along well with the other students in the classroom. His teachers reported that he rarely ate his lunch or snack at school. He started receiving speech-language therapy at school when he was 3 years old and was given an individualized education plan because of the sudden onset of delays in his development. He met with a speech therapist once a week and a special educator went to school for 4 hours to provide specialized instruction.

In order to learn more about Sam's life and development prior to the death of his parents, background information was gathered from Sam's aunt. She reported that she did not have many details about Sam's birth history. She knew that his mother received prenatal care during her pregnancy and was looking forward to having a baby. Sam was born full-term and weighed 7lbs, 20zs. The aunt was not aware of any complications during delivery or in the first few weeks of life. Sam was reported to have a sweet and easy-going temperament as a baby. She reported that his developmental milestones were delayed, including walking alone, speaking in single words or phrases, and being toilet trained. However, she was not able to identify specific months when these events took place. Sam's

¹ Name has been changed to protect the anonymity of the patient and his family.

grandparents spoke primarily Vietnamese; however, his aunt, uncle, and cousins spoke some English at home. Sam did not have any significant medical history and was taking medication for allergies. She reported that he had six to eight ear infections before he was 24 months old, but passed all hearing tests. There were no significant psychiatric problems reported in the family history.

Intervention

SAM WAS REFERRED to the me while I² was doing my psychology internship. He was 3 years 7 months old when referred following a year of treatment with another psychology intern who was finishing her training. CPP was used in order to help Sam and his aunt be able to work together on gaining an understanding and integrating the traumatic events that led up to the referral, and to strengthen the attachment relationship between Sam and his new caregiver. It was agreed at the onset of treatment that sessions would take place at Sam's day care center where the center director spoke Vietnamese and English and was able to translate for Sam's aunt. With the aunt's consent, I shared with the director the purpose of treatment and potential benefits of therapy in an initial meeting with Sam's aunt. An important aspect of treatment to consider is being sensitive to a family's culture and using support and resources that are familiar to them. In engaging with a family, it is often helpful and leads to greater success for the clinician to consider the current problem in the context of their cultural background and needs of the family (Ippen & Lewis, 2011).

When Sam first met me, he was slow to warm up and engage with me. His aunt appeared to be at ease with me, but communication was often difficult because of language barriers. Sam and his aunt were very quiet during the first few sessions with Sam saying only short phrases or single words when he wanted to communicate. He often pointed to toys that he wanted instead of using words.

At the beginning of each session, Sam would greet me when I arrived at his classroom in the day care center. He walked right up to me when he saw me enter and held my hand as we walked together to the library at school where we met his aunt and set up the toys to play. Once Sam became more comfortable in the room with me and his aunt present, he began to explore the toys. He gravitated toward the dollhouse, dolls, and animal figures. He generally appeared content while playing with the dolls and dollhouse and was drawn to these toys each week. His aunt sat quietly next him and seemed unsure of how to engage in his



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In engaging with a family, it is often helpful and leads to greater success for the clinician to consider the current problem in the context of their cultural background and needs of the family.

play. Several themes emerged in his play. He would set up the furniture and dolls inside the dollhouse and then move on to another toy. The dolls would stay inside the house and very rarely leave the house. One day after all of the dolls and furniture were placed in the house, he had another doll come to the front door of the house. Sam stopped playing suddenly, cleaned up the toys, walked toward the door, and said "go." His aunt walked over to him, gave him a hug, and asked if he wanted to continue playing. Sam continued to stand silently by the door staring outside and did not return to the toys or look back at the dollhouse.

Following this session, I provided parental guidance to the aunt, without Sam present, including information about how a child typically reacts to witnessing a traumatic event and also talked to her about her experiences following her sister's and brother-in-law's death. His aunt became very emotional when retelling the story of the trauma and expressed the great sadness her entire family felt following their loss. She shared that the family often felt frightened in their neighborhood and generally stayed inside their homes. They were unable to move out of the neighborhood for lack of financial resources. His aunt expressed a desire to leave the area and the difficulty of living down the street from the scene of the crime. His aunt reported that Sam asked if he could go inside his house. She was worried that he did not understand that his parents were no longer there. I helped the aunt learn about how young children

understand death and how similar questions may emerge as he grows older.

About 6 months into treatment, Sam was preparing to celebrate his 4th birthday. He appeared to be very excited about it and told me that he was going to a family-style restaurant with games and entertainment to celebrate his birthday. At a session after that party, his aunt smiled as she talked about the day they had together and the enjoyment they shared on the outing. His relationship with his aunt was strengthening, and he appeared to be feeling more secure with her. Around this point in treatment, Sam began to smile more and make increased eye contact. His language improved with his vocabulary including words like *surprise*, *Happy Birthday*, and *pirates*. He enjoyed saying "Happy Birthday" and would have dolls and animal figures celebrate birthdays during his play. His aunt seemed more relaxed and was able to enjoy playing with him. Sam wanted to be near his aunt during sessions and would bring books to her for them to read together. They sat together flipping through the pages of the book, while they talked about the pictures.

For the final 3 months of treatment, sessions with Sam and his aunt took place at their home because the day care center was closing for summer break. At this time, the family felt more comfortable with me coming to the home. Sam became more active and started to enjoy building with blocks. He would build towers, knock them down on the floor, and laugh. He repeated this activity over and over, and his aunt laughed along with him

² Throughout this article, "I" refers to Michelle B. Moore.

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The goals of treatment are to strengthen the attachment between the parent and child, help them regain a sense of safety, and help the child resume a normal developmental trajectory

and provided positive responses as he played. He appeared to enjoy this interaction and the time they spent together. One day when I arrived at the home for the session, Sam took my hand and led me to his bedroom. He was eager to show me his toys at home and brought his stuffed animals out for the session. He gave the animals hugs and passed them to his aunt. When she gave the animals a hug, a huge smile emerged across his face.

In the last six to eight sessions, I began to discuss termination of treatment with the family, and his aunt agreed that they were ready for treatment to end. Sam was starting kindergarten the next month, and his aunt felt confident in her ability to understand his needs and manage his emotions as well as her own feelings following the loss of his parents. During the last few weeks of treatment, Sam, his aunt, and I drew a map of the places we had been in treatment together, where Sam would be going to school in the fall, and where I worked. The different places on the map were reviewed each week. Sam

learned that even though we would not meet for therapy any longer, we still shared special places together and would always remember each other in the same way that he would always remember his parents. The decision was made to videotape the second-to-last session. Sam was given a copy of the tape, so that he could remember the special playtime that was shared.

Outcome

SAM AND HIS aunt were referred for psychological evaluation and treatment following the traumatic death of his parents. After Sam witnessed the shooting death of his parents, his aunt, who became his guardian, was concerned about changes in his behaviors and emotions. Sam had difficulty sleeping at night, had a decreased appetite, appeared to be withdrawn, and was not talking as much as he once was. Sam and his aunt began to engage in CPP to help them overcome the loss in their family and to re-establish a sense of safety and nurturance.

At the culmination of treatment, Sam's development and relationships had greatly improved. He was learning new words and using words and sentences to let his family know what he needed and wanted. He engaged more readily with family members and classmates, and he was able to sleep through the night in bed by himself. He also shared his feelings openly without being overcome by negative emotions. He pointed to the pictures of his parents on the wall at his aunt and uncle's home, said "in heaven," and smiled. After about 1½ years of living with his aunt and uncle, Sam started to call his

aunt and uncle "Mom" and "Dad." His aunt allowed him to use whatever name felt comfortable to him and responded when he called her mom. Sam's aunt expressed her gratitude to me, and to the Harris Program that allowed her to receive treatment with her nephew in a familiar, comfortable environment for her family.

Lessons Learned

THE FAMILY HAD never sought out mental health treatment before and had previously handled any problems that had arisen within their own family system. This reaction is common in the Asian-American culture where seeking out mental health treatment is atypical for a family (Meyers, 2006). The maternal aunt, who became the guardian for both of the children, benefited greatly from having an opportunity to share her reactions to the traumatic event in a safe and supportive environment. She cried as she told her experience of the event, and she reported that her family very rarely talked about what happened. She shared a sense of relief and appreciation at the end of treatment in being more prepared and capable to raise her nephew and niece. She felt confident that they were all going to be okay and be able to move forward in their lives following the losses they had experienced.

As a professional, I learned a great deal from this family. I was introduced to the Vietnamese culture in a new way through this therapeutic work and felt accepted coming from a different culture. I also learned firsthand what vicarious trauma feels like and appreciated the support of my supervisor and team during this experience. Vicarious trauma can be experienced by mental health professionals when working with victims of trauma where they begin to experience intense emotions, flashbacks, feelings of panic, and other symptoms that are similar to what the victim of trauma may have experienced (Osofsky, 2011; Pearlman & Saakvitne, 1995). At the end of treatment when sessions took place at Sam's aunt's home, I woke up one night with a nightmare. I found myself crouched on the side of my bed in a panic. I had been experiencing a nightmare that someone was in my house, had shot my husband in the living room, and was coming down my hallway with a gun. My breath was shallow, my heart was racing, and I felt panic racing through my body. It took a few minutes to calm myself down and to realize that it was just a dream. Later that day, I understood that I was reliving this family's trauma and had not been able to acknowledge how intense the treatment with this family had been for me as a psychology intern, especially when sessions were taking place on the same street where

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the murders happened. I shared the experience with my supervisor, who helped me to further process this trauma and the subsequent emotions I was experiencing. This experience reminded me of the importance of self-care, supervision, and consultation with colleagues when working with trauma survivors. From this case I learned the importance of acknowledging when treatment can become overwhelming and when, as a therapist, I need support to be a better therapist for my patients. ♣

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Standing Shoulder to Shoulder With Parents in the Criminal Justice System

Advocacy as a Bridge to Understanding and Engagement

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I¹ first met Sean's mom, Nicole, in a small classroom at Santa Rita County Jail in Dublin, California, where she had been incarcerated for 4 months. After hearing about Families in Recovery program (FIRST) within the Early Intervention Services Department at UCSF Benioff Children's Hospital Oakland, in her parenting class, she reached out for help for her 5-year-old son. Because the FIRST program has an ongoing collaboration with some of the programs at the jail, I could respond quickly and on site. From the moment Nicole and I began talking, a sea of sorrow opened up for this mother. As she cried, she shared the fact that, midway through Sean's kindergarten year, he was already being seen by the school as a "problem"; fighting with peers and having major tantrums in class. She said that the school's idea of "intervention" was to suspend him and send him home. Nicole knew that this was not right and wanted to receive actual help for her son. She spoke of feeling helpless in jail, as she tried to parent "from the inside," and she was worried about the strain on her husband and mother, who were parenting all four of her children (who were 3, 5, 8, and 9 years old) on the outside. Nicole and her husband, Kevin, both African American, had been married for 14 years and were a strong family unit, even though both of them had previously been incarcerated. Nicole was willing to try therapy, although no one in her family had done so before, because she was desperate for help.

By the time I met Nicole, I had grown accustomed to the complexity and challenges of working with families who were directly affected by the trauma of incarceration. I had been working with the FIRST program since its inception 9 years earlier. The FIRST program, part of the Early Intervention

Services unit at UCSF Benioff Children's Hospital Oakland, is committed to serving the hardest-to-reach families—that is, those affected by substance abuse and incarceration and, often, those involved with multiple law enforcement systems, including the criminal justice and child welfare systems. Trauma in these families takes many forms—witnessing parental arrest, experiencing frequent disruptions of family relationships

and subsequent transient and unstable living circumstances, exposure to punitive or harsh treatment at the hands of law enforcement, and observing (or, even, being the victims of) violence in the community. Difficulties at home and at school are commonplace, and the need for repairing ruptured relationships is often critical.

In that first visit at Santa Rita County Jail, Nicole and I addressed Sean's birth history, early experiences, and the important "ports

Abstract

For many hard-to-reach families who have experienced trauma in part related to involvement with public welfare institutions, creating a trusting relationship is the critical first step to finding ports of entry for additional intervention. In particular, parents who have been incarcerated are often profiled and stigmatized by criminal justice and law enforcement systems, which view them only as criminals without seeing their strengths as caring parents. Using a case description, the authors highlight ways in which advocacy across systems and collaboration with a family partner formed a bridge for engagement and treatment.

¹ Throughout this article, "I" refers to Jackie Schalit, primary therapist. Rashawnda Lee-Hackett was the family partner involved, and Barbara Ivins was the consultant.

of entry” for thinking about the impact of his mother’s incarceration on him: what happened at the time of arrest, where he had been placed when his mother was incarcerated, what Sean had been told about what had happened to his mother, contact she had with him since her arrest, the challenge of parenting “from the inside,” and plans for re-entry and reunification with Sean. It was notable that, although Sean and his siblings had seen their mother arrested and were living with their grandmother and father, they had not been told anything about where she was. She talked to them on the phone regularly but did not want them to visit her or to know that she was incarcerated. I began to wonder about how confusing and scary it must have been for Sean and his siblings to watch their mother be arrested and then just “disappear.” Reunification was imminent as Nicole was going to be released in a few weeks, and she and I agreed that an important starting point for me would be meeting Sean and his dad, Kevin. I knew that Nicole was taking a leap of faith; she was inviting me—a stranger who was affiliated with the very systems that she and her family did not trust—into their lives. She would call Kevin and let him know that it was important to her that he meet with me.

During my subsequent meeting with Kevin, he described his son as being “like a girl” because Sean cried all the time, and he said that he was very surprised to hear that the school said Sean was hitting other children. When I asked Kevin about his thoughts as to why Sean was hitting, he explained that Sean’s behavior problems started only after Nicole was arrested. As he made the connection, it surprised him. He shared that he had not talked to the children about why their mom had left and had not told them where she was. Both he and Nicole had been incarcerated before, and they believed that their children were too young to know or talk about it. “Anyway,” he said, “no one wants to think about the bad times.” The parents’ decision to not tell Sean about where his mother was—although difficult to accept from my perspective—was not new to me; my experience working with families directly affected by incarceration had taught me that this is a frequent response, sometimes due to shame and stigma but often strongly supported in the family and in the community as a loving and protective act. This was clearly the case for Nicole and Kevin, who had thought carefully about this decision. Kevin’s willingness to meet with me upon Nicole’s request made a positive impression on me, and I noted to look for ways to engage him in treatment.

In the Early Intervention Services unit at UCSF Benioff Children’s Hospital Oakland the assessment process for families includes a 6-week period of observation, play-based

interactions, clinical interviewing and discussion, and trial intervention. The staff attempt to see the same child that caregivers and teachers see, and simultaneously assess—through structured and unstructured play and observations—the child’s developmental competencies and adaptive functioning in multiple settings (Lieberman & Van Horn, 2008). I was able to see Sean in multiple settings, including school and home. I met with his teacher and spent time with his caregivers, learning about Sean’s early years and his family’s history, trying to gather each person’s experience and perspective about Sean’s behavior and to put it into context. As I began to get to know Sean, my impression of him was of a little boy with developmental strengths—including good symbolic capacity, as shown by his eagerness to share his story through play (the story included police cars and people being taken to jail). He had a history of traumatic separations from his parents, and he seemed worried about keeping track of his mother, as evidenced by his constant clinginess when she returned home from her jail time. From a trauma and systems perspective (Lieberman & Van Horn, 2005), I saw four goals for intervention:

1. I would need to create a foundation of trust with the family in order to stay connected and offer treatment.
2. I would try to be a bridge during therapy and with the family between Sean’s internal world and the everyday struggles that marked his and his family’s experience by creating a narrative of the multiple and frequent relationship ruptures that were the hallmark of Sean’s trauma experiences.
3. I would serve as a liaison with all of the other community agencies and public systems with whom the family was involved.
4. I would work to keep both parents involved and engaged in services.

The First Year: Creating a Foundation of Trust and Facilitating Family Partner Intervention

MY EAGERNESS AND knowledge about ways to help Sean were no substitute for the many differences in race, class, privilege, and experience that were evident in my first meetings with the family, and potential impediments to moving forward. Thus, I knew that building a relationship with them would take time and would require me to demonstrate repeatedly through my actions and words that I truly understood them and their experiences (Ghosh-Ippen & Lewis, 2011). I needed to show them that I could see beyond the sur-



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The FIRST program has been committed to serving the hardest-to-reach families—those affected by substance abuse and incarceration and, often, those involved with multiple legal enforcement systems, including the criminal justice and child welfare systems.

face of a family that had a history of criminal convictions and conflict with most of the systems with which they had come into contact. Nicole aptly described her experience as if “the world was against them.” I would come to see that they were always in “fight” mode, and come to know that they were putting themselves out on a limb by reaching out for help to a system “outside” of their circle. Not only had they never received helpful support from outside their community, but—as I soon learned—they had actually been harmed on many levels by the very systems (e.g., criminal justice, child welfare, and the schools) that were supposed to help and protect them. Armed with this insight, I saw that this family’s uneasiness with me stemmed from their view that I was actually part of that outside community; and, I thought, their viewpoint made sense. As the first mental health person with whom they had been in contact, and as a White woman, I would need to prove myself and be careful to address the fear and hurt that my presence could unearth—that is, the belief that I represented yet another potentially unhelpful system of services.

After spending time with Sean in play and listening to his parents, I concluded that his difficulties were best explained as stemming from trauma as a result of (a) the multiple, abrupt separations from his parents because of their incarcerations and (b) the witnessing of his mother’s most recent arrest and sudden disappearance (Poehlmann, 2010). This was the second time that he had been separated from his mother. From a developmental and

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The assessment process for families includes a 6-week period of observation, play-based interactions, clinical interviewing and discussion, and trial intervention.

a therapeutic perspective, I was concerned that Sean had no way to understand these events, thus no way to feel assured that he had not caused them or that they would not happen again. He had no narrative or story to explain what happened and no way to manage the very big feelings that he was expressing through aggression and excessive crying when he was triggered by events, people, or feelings at school or at home. In focusing on Sean, I thought that I had developed a plan and that creating a narrative would promote change.

I consulted with Early Interventions Services family partner, Rashawnda Lee-Hackett, to help me think about the family's needs. Rashawnda had a different perspective from mine, gleaned from her experience as a previously incarcerated parent, the mother of a child with mental health challenges, and someone who had direct knowledge of Oakland "street life." She reminded me that the parents' not wanting to talk to Sean about their absence was rooted in their desire to protect him. "Go slow, and understand their perspective," she encouraged me. I realized that I was, in fact, rushing forward with my plan to "fix things." My sense of urgency to help the family make deep and lasting change and increase their developmental understanding of Sean's experience, and my wish to help them steer clear of additional legal difficulties, would be feelings that I would repeatedly wrestle with as I became aware of them in our work together. In addition

to my therapy visits with Sean and his family, Rashawnda also began providing family support to Nicole, by carefully sharing elements of her own story to help Nicole feel less alone in her struggles to interact with (from Nicole's perspective, "do battle with") various service systems (Ivins, Lee, & Reus, 2013).

Slowing down took the form of being more curious with Nicole, following her lead, listening to her, and trying to understand her beliefs and fears about being a mom and raising young African American children in East Oakland, California—an area saturated with trauma.² As the family grew to trust me over this first year, I began to learn more from Nicole, Kevin, and Rashawnda about the challenges and the values of street life.

The Second Year: Standing Shoulder to Shoulder—Complex Trauma Made Real

IN MY SECOND year of treatment with Sean and his family, I was to have direct experience with the challenges of street life that we had been discussing so much. Over the years, I had heard many stories from parents about violence in the home and in the community and about lack of protection and mistreatment by the very systems whose

supposed charge was public safety. I was about to learn more about the positive and negative sides of law enforcement and the criminal justice system—and the importance of being both an advocate across different systems of care and a "thread of continuity" to help mitigate more successfully the effects of family disruptions (Frame, Orfirer, & Ivins, 2004).

One Sunday night, Nicole called me, frantically, screaming, "They took the kids!" She described a scenario that was outside my own experience but not uncommon in Nicole's world. Given Kevin's previous criminal record, he could be stopped and searched at the police's discretion. On this most recent occasion Kevin had been chased by the police, run down, and, according to Nicole, "beaten up pretty bad." The police had brought him home, leaving him outside while they called an ambulance, questioned Nicole, and searched the house. The family was told about Kevin's condition, then witnessed it directly when the children were instructed to go outside where their aunt was waiting. Nicole was threatened that her children would be taken away if she did not tell them about her husband's alleged criminal activity. She pleaded with them and said she did not have any information. Kevin was arrested, taken to jail for attempting to flee, and later charged with child endangerment for what his children had been exposed to. Nicole did not feel safe in the home, and she went to stay with the children at a relative's home.

A few days later a child welfare worker called and requested that Nicole meet her at the house. The worker arrived with the police and a warrant to remove the children from an environment that they claimed was "unlivable" (e.g., garbage, dirty diapers). Sean and his siblings were abruptly removed. Rashawnda, having made several recent home visits, had never seen the house in the kind of disrepair that the police alleged, and Nicole believed that she had been set up by the police. As Nicole spoke about the story, she expressed a sense of despair about the criminal lifestyle that her husband led and the impact that it was having on the children and on their family. She was powerless in a law enforcement system that she said had profiled her family, and in which officials could use their power to justify "teaching Sean's parents a lesson" regardless of whether Nicole and Kevin had done anything to warrant such extreme punitive measures. I also felt powerless and at odds with the idea that a system mandated to protect could have such disregard for the impact of its ways on young children. In my opinion, both sides had played a role in the trauma that plagued this family, and Sean and his siblings were

² According to the Federal Bureau of Investigation's Preliminary Annual Crime Report (2011), 7,962 violent crimes and 126 murders occurred in Oakland in 2011, making it one of the 10 most dangerous cities in America (see http://os.cqpress.com/citycrime/2012/CityCrime2013_CityCrimeRateRankings.pdf)

casualties. I asked myself whether there was something I could do to make a difference.

In my mind, Nicole and Kevin had a history of breaking the law but were also caring, concerned parents. In the eyes of the law, they were profiled as a danger to their children and community by seemingly having trouble staying out of jail. Was there a way to reconcile these differences and collaborate across these two very different systems and points of view? Would advocating for Sean's parents in the criminal justice system create a bridge of developmentally informed understanding? Could this tactic—combined with a more direct trauma treatment approach—help Sean and promote a healthier lifestyle for the whole family?

Advocacy as a Bridge

MY JOB OF advocacy began full force after this incident. Advocacy became a way for me to bridge the family's experience with several different institutions, especially the criminal justice and child welfare systems. With the latter, I advocated to be able to see Sean directly, in the first hours after his removal to the county assessment center, where the children had been taken and were awaiting placement. When I arrived, Sean was playing, but with an intensity and frantic quality that suggested his level of anxiety. I talked with all of the children and let them know that their parents were safe and were thinking about them. I expressed sorrow that they had gone through such a scary experience. I gave them information about what was going to happen next. Sean surprised me by saying, "Just leave. I don't want to play with you . . . I don't want to be here." I felt deeply sad, thinking about the defenses that he needed to mobilize in order to survive yet another traumatic parental absence. I also was proud that he was able to tell me his truth. I talked to Nicole afterward and was able to inform her about how the kids were doing, which was a tremendous relief to her. She was feeling so helpless, traumatized, and worried about her children and about her husband, who was now back in jail.

I stayed in touch with the child welfare workers throughout the placement period. The children were placed with an aunt while the investigation through child welfare proceeded. They were eventually returned home to Nicole as in-home dependents with an open child welfare case. The family's ruptured relationship and subsequent repair became a focus of our treatment as we worked to (a) co-create a coherent narrative about what had happened and (b) find ways to promote predictability and routine that might help the children feel safe during this turbulent time (Lieberman & Van Horn, 2005). Kevin had been in jail for 3 months by

Slowing down took the form of being more curious with Nicole, following her lead, listening to her, and trying to understand her beliefs and fears about being a mom and raising young African American children in East Oakland, California—an area saturated with trauma.

this time, and Nicole and I would now have to work hard to keep everyone feeling that Kevin—despite his absence—was still part of the family and a vital part of our therapeutic work together. Whereas a year ago I was visiting Nicole, now I would be attempting to visit with Kevin at the jail, trying to help him stay connected to his family on the outside.

Partnering on Behalf of Sean

IN OUR PLAY sessions after Kevin's incarceration, Sean was showing me that he was confused about his dad's disappearance and that he believed his dad was never coming back. This belief lingered in Sean despite his mother's carefully explaining what had happened. Together, Nicole and I wondered whether it would be helpful for the children to visit Kevin in jail so that they could see for themselves that he really was OK. The decision to allow this was a departure from Nicole's previous adamant position about not wanting her children to even know when their parents were incarcerated, and it was a tribute to the fact that our work together allowed her to consider more flexible alternatives. I attended dependency court with Nicole and advocated on behalf of the family to both the attorneys and the judge, highlighting the positive parenting behavior that I had witnessed in Kevin. Because of Kevin's criminal activity, the judge had placed a stay-away order that effectively prevented the family from visiting Kevin in jail. In court, I shared my experiences with the "other side" of Kevin—the "Dad" in him—and tried to convey to the attorneys and the judge the children's worry about whether their father was okay, and the importance of managing that worry. Visiting parents in jail is a tricky and difficult decision for families, but it seemed that if Nicole wanted to take the children to jail to visit their dad, then it

should be an option available to them (San Francisco Children of Incarcerated Parents Partnership, 2005). The judge agreed to let the children visit their father but ordered that I attend the first visit and provide family therapy upon Kevin's release.

An Unconventional Home Visit

ONE WEEK LATER, I met the family at the Santa Rita County Jail. While we waited in line, I talked about what the visit might be like, and Nicole told us what was going to happen. Sean's nervousness and worry took the form of fussiness and high activity, which I had seen before. The staff searched us, we passed through metal detectors, and then we walked down a long hallway, only to wait in yet another line outside the cell block. Time moved slowly as we listened to the stories of the other people waiting in line, such as women who were visiting their incarcerated boyfriends, and as we watched children crying. Suddenly, we heard loud noises and clanking. Nicole and the children started to become more animated and excited. The door to the visitation room opened and Kevin and the other inmates were behind glass, waiting, and the visitors filed in. Everyone seemed to know the drill; correction officers stood by silently.

The children found Kevin and released a flurry of questions.

"Dad, what's on your feet?"

"Dad, what are you wearing?"

"Your hair is so long!"

I sat back and watched him look at each of them intently and answer their questions. He then asked to speak to me and thanked me for coming and for supporting his family.

Being an advocate took the form of additional visits to the courtroom. A bench warrant was issued for Nicole's arrest due to her probation violation "as a result of police contact and child endangerment" at the raid when Kevin was arrested and the family's home was searched. I would return to court six more times and would make visits and calls to the public defender, talking about Nicole's unwavering commitment to her children and her importance in their lives. As a result, I was allowed a visit with Nicole in a holding cell after her re-arrest for the probation violation, and because of this, I was able to assure her that her children were safe with their grandmother and that my co-workers and I were all working on her behalf to reunite her with them. I maintained the continuity of the ongoing trauma work meant to help Sean manage his extreme worry about the whereabouts and permanence of his parents. A few weeks before Kevin would be released, I scheduled a visit to see him on my own. I stood in line again with the other eager visitors for a brief 20-minute phone session.

During that session, I asked him to think about re-entry and reunification with his children, and talked to him honestly about the importance of changing his lifestyle in order to protect his family (due to his criminal activity, he and his entire family had become a target). And I would acknowledge over and over to both parents that what had happened with the police—and the way things had happened in their family—was not okay and that I wanted to continue to share with the courts, probation, and law enforcement systems that Nicole and Kevin were more than just their criminal record—they were parents who were trying to keep their family together.

“Keeping It Real”

AS A RESULT of the advocacy, when Kevin was released from jail, the dependency court lifted the stay-away order and mandated that he participate in family therapy with our program; the court also stipulated that he attend additional sessions to explore and further understand his role as a father. This would be the beginning of a new stage of our work, and I focused on building a relationship based on trust and transparency. I was mindful that therapy was not a culturally sanctioned or familiar experience for Kevin and that being not just asked but ordered to attend added another layer of complexity. I used my knowledge of street slang and my ability to use “real talk” to engage Kevin in the therapeutic process (Ivins et al., 2013). When I talked about confidentiality in our very first collateral session, Kevin remarked, “Oh, I get it; you’re not a dry snitch” (someone who is an unnecessary snitch). I agreed that I was not a snitch and that if I ever felt that I needed to break confidentiality because of the mandates of my job, I would let him know. I also promised that I would share what was on my mind and work hard at “keeping it real.”


Keeping Kevin comfortably engaged in family therapy took the form of creating activities for the family to do together that he would enjoy as well. I learned that Kevin loved cooking; it was something that they all enjoyed doing together. In family sessions, we began a series of cooking activities that engaged everyone and provided opportunities for fun in a family that had suffered so many traumatic events. Embedded in this very real “kitchen therapy” (Fraiberg, Adelson, & Shapiro, 1975) were interventions related to safety and protection, co-regulation, negotiation, verbal exchange, and the support of developmental competencies.

The work with Sean and his family has ended with our program, because of Sean’s age. The work is far from over, but the family has made tremendous shifts in ways they interact with each other and with outside programs. Sean was finally placed in a therapeutic classroom and is making slow and steady progress at school. He has a new therapist at school and is doing better. There continue to be struggles related to basic survival and the pull toward doing whatever is necessary to make ends meet, but it has been 8 months with no arrests, and Sean’s parents have been able to have honest conversations about creating a different way of life for their family.

Lessons Learned

AS A THERAPIST, it is often challenging to hold onto hope and muster the energy to keep moving forward during work with families such as Sean’s, who have experienced unrelenting complex trauma. Standing shoulder to shoulder with a family through this process requires a complicated interweaving of relationship building, trauma-informed intervention, and advocacy. By accompanying the family to criminal court and by arranging visits to the children’s school, to the parents’ holding cells, and to the jail, I showed, through my actions, that this family was important to me, that their difficult experiences would not drive me away, and that I could see how much these two parents cared about their children. I demonstrated to law enforcement and the courts that I was able to appreciate their system mandates and paradigms while also holding another view of Nicole and Kevin—not as throw-away criminals but, rather, as concerned parents. I learned, through Sean’s family and their experiences, the reality of “street life,” the difficulty of staying out of trouble with the law, and the compromises for and against one’s best interest that parents of color—without a strong voice, advocacy, or support—must make when they do not have options or adequate legal representation.

In summary, the following lessons can be drawn from 2+ years of work that I did with Sean and his family:

1. It is important to slow down, resist the urge to “fix,” and meet the family at its particular level of need, demonstrating over and over the capacity to listen while learning from the family members about their points of view.
2. I was careful to be honest and transparent about what I was thinking with Sean’s family. I needed to “violate their expectations” about being profiled and mistreated by the very systems that are supposed to be about protection and help.
3. I used consultation and collaboration with our family partner to bridge the gap when I became frustrated or confused about the parents’ responses, and I used supervision to work through my own very strong feelings and responses to the ongoing trauma to which the family was exposed.
4. Advocacy was my lifeline to staying connected; it helped me break through the family’s institutional wariness that often clouded my relationship with them. This advocacy often took the form of being willing to accompany the family to court, jail, and school, and to reach out to teachers, judges, attorneys, probation officers, and child welfare workers.
5. I learned it is imperative that practitioners form working alliances with other systems that interface with children and families. Only through collaborations and partnerships with the law enforcement, criminal justice, and child welfare systems will family intervention workers be able to change systems so that they are more informed in relation to trauma and child development, more accountable for their methods and actions, and increasingly supportive to families. 

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Ghosts, Angels, and Sharks

One Family's Story of Healing and Growth

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Child First is an evidence-based home visiting model developed to prevent or diminish serious emotional disturbance, developmental and learning disabilities, and abuse and neglect (Lowell, Carter, Godoy, Paulicin, & Briggs-Gowan, 2011). The intervention is conducted in the home with the child, parents or other primary caregivers, and other family members. A team of a master's-level mental health/developmental clinician and a bachelor's-level care coordinator work together to support families with complex needs. The intervention operates simultaneously at multiple levels: helping parents understand typical developmental challenges and expectations and their child's unique processing abilities; helping parents understand the impact of trauma on their child and how this might be expressed in behavior; facilitating parental reflection on the meaning and feelings motivating a child's behavior; reframing a child's behavior; problem solving new strategies; and reflecting on the psychodynamic relationships among parent feelings, history, and the parental response to the child.

Circle of Security Parenting® (COS) is a DVD-based parent-education program offering the core components of the COS protocol. The program presents video examples of both secure and problematic parent-child interactions and healthy options in caregiving, and animated graphics designed to clarify principles central to COS. COS integrates decades of attachment research into an accessible step-by-step process for use in group settings, home visitation, or individual counseling.

Baby Leanne was referred to Child First by Child Protective Services (CPS) as an "urgent referral" when she was 5 months old. CPS cited concerns about the parents' ability to provide safety for the baby and inadequate parenting as a reason for referral and

involvement. At the time of the referral, the parents had been married for 8 months and their relationship was somewhat strained and unstable. The mother, Jen, 21 years old, and father, Mike, 20 years old, were struggling to function as a married couple, maintain adequate housing and employment, and adjust to their new roles as parents. From the beginning, the assigned Child First team could see how much Jen and Mike aspired to give their daughter a healthy and positive childhood, which the team soon came to discover neither parent had experienced.

Both Jen and Mike came into the Child First program with their own individual trauma histories, their own set of "ghosts" and "angels" in the nursery. "Ghosts in the

nursery," a concept well known in infant mental health, is described as "the visitors of unremembered past of the parents" (Fraiberg, Adelson, & Shapiro, 1975, p. 387). Parents will unconsciously experience their children, particularly in infancy, through the lens of their ghosts, thus continuing the transmission of "child maltreatment from one generation to the next". Lieberman, Padrón, Van Horn, and Harris (2005) offered "angels in the nursery" as an intervention to uncover the "growth-promoting forces in the lives of traumatized parents,"; arguing that this intervention "is as vital to the work of

Abstract

In this article, the authors tell the story of one family's journey toward healing using the Child First home visiting and Circle of Security Parenting interventions. Parents with complex trauma histories frequently float through services for years looking for guidance to help them address their struggles. Often, these services do not offer interventions with a trauma frame or address the significance of the parental role. The authors highlight how programs can enhance their efforts with families by mindfully integrating models of treatment and parent education in ways that are sensitive to parental trauma. They also discuss important home visiting model components that elicit success.

psychotherapy as is the interpretation and exorcizing of ghosts” (p. 504).

Parental Trauma and Its Impact

MIKE’S GHOSTS INCLUDED his absentee father and a mother who had limited availability for her son because of her own mental illness. Mike identified his maternal grandmother as an angel, someone who provided him with nurturing care that had a lasting impact. Jen identified her own father as her angel. But Jen’s father had a pattern of choosing his girlfriends’ needs over his daughter’s needs, so using Jen’s angel as a resource for promoting growth proved to be difficult.

It was the presence of Jen’s ghosts that most profoundly impacted her. As the relationship between Jen and the team strengthened, the team grew to understand how Jen’s early trauma had shaped her beliefs about herself and her identity as a mother and wife. Much of the Child First focus involved holding these elements of Jen’s and Mike’s past in the present, as a point of reflection and as a way to understand their presentation as parents. The team struggled to be mindful of the parents’ pasts, especially when Jen and Mike’s behaviors called into question their abilities to parent their daughter.

Jen’s maternal identity was formed and reinforced by her ghosts and the conditions set upon her by her angel. Jen was haunted by the experience of her own mother’s abandonment of her when she was 2 years old and her subsequent placement into the foster care system. In order to protect herself from the past trauma, Jen developed a defensive persona that she displayed to the world as angry, controlling, and unlovable. She had worked to address her difficulties through numerous anger management interventions and individual therapy, but the approaches failed to acknowledge the presence of her early trauma and the profound impact it had on her sense of self and her ability to sustain relationships. Jen became accustomed to using her angry persona as a shield, a strategy to ensure that no one would hurt her again. The intervention thus presented this challenge: How could the team help Jen explore her past trauma and its impact on her role as a mother in a way that would not threaten her sense of safety? The team held this question in mind as they worked with Jen to shape the pace and the intensity of the work.

During the second home visit, Jen reported to the team that she struggled with the lack of control she had regarding her relationship with her daughter. She reported anxious feelings because she did not know what the relationship with her daughter was going to be like. Jen acknowledged in that

visit that not being in control of the relationship was very difficult for her. Jen’s need to control all aspects of her life quickly became evident. During visits Jen would report that she was “in charge”; she felt that one of her roles in life was to make sure that everyone else was following the rules, including her daughter. With Leanne, Jen defined the relationship by her terms, which often meant restricting the relationship so that Leanne did not have an opportunity to reject Jen first. The team interpreted Jen’s controlling behaviors as a response to her experience of abandonment and the unpredictable life that followed. Jen needed control to mitigate her trauma; she exercised control to create the stability she had never experienced.

Exploring the Work Through Reflective Supervision

DURING THAT SECOND visit, Jen reported that her daughter no longer liked the sound of her singing voice. Initially the team’s response was to provide an alternative perspective, but because Jen believed that the parent–child relationship was filled with rejection, she could not tolerate an alternative view. During the work with the family Jen would often refer to Leanne as a “monster,” and described her as “manipulative” and “picking favorites” when the baby wanted to go to her dad. The Child First team struggled with these negative attributions and relied heavily on supervision to process their reactions to Jen’s behaviors. The reflective supervision the team received throughout the course of the family’s treatment focused heavily on countertransference, the impact of this countertransference on the work, and self-regulation during intense sessions with family, which were frequent. Whereas the clinician relied on support to interpret and understand Jen’s negative projections, Jen’s internal representations of herself, and the implications of these for the baby, the care coordinator’s supervision often focused more on building self-regulation skills and mindful practice—because some of Jen’s behaviors and statements were very triggering. Both team members understood the opportunity to use their relationship with the family to model self-regulation and also to facilitate reflective capacities in both caregivers.

The clinician and the care coordinator also struggled with Jen’s insistence on Leanne’s need to be independent and the methods Jen used to nurture independence in her daughter. Processing these feelings in reflective supervision opened up a port to a different understanding of Jen’s behaviors that were initially viewed negatively. In reflective supervision, the clinician and the care coordinator began to see Jen’s desire



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Jen discussed her childhood and eventually revisited the day of her mother’s abandonment...she had been living with powerfully vivid images of the last time she saw her mother.

to support independence as a survival skill. Jen’s behaviors toward the child, which were first seen as “mean,” took on new meaning once the team could see them as a reflection of Jen’s view of the world. She was preparing Leanne for a challenging future that she assumed would come to fruition based on her own past experiences, which were bathed in trauma and loss.

Getting Worse Before Getting Better

IN THE FIRST 6 months of work with the family, Jen called CPS on herself three times, requesting that they remove Leanne from her care. The team interpreted Jen’s desperate acts as attempts to protect Leanne from her ghosts. In the first few visits with Jen and Mike, Jen would talk about wanting to be a “good mom” and behave differently than her parents, but these desires were not enough to keep the ghosts at bay. When Jen became overwhelmed by the stress of life and began to sense a loss of control, she was forced to protect herself by increasing her aggression, rejecting relationships, and pushing the scariest relationship of all, her relationship with Leanne, as far away as possible.

Jen had never been given the opportunity to acknowledge that her experience as a child had in many ways left her feeling like a wounded little girl. The work with Jen toward acknowledging and respecting the little girl

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With Mike and Leanne living apart from Jen, there was space for the team to encourage and foster the bond between Mike and the baby.

inside of her did not come until 8 months into the intervention. There had been so much turmoil in Jen and Mike's relationship that moving the work forward had become very challenging. It was at this time that the clinician began to meet with Jen and Mike separately, on a weekly basis, to help them both process their past trauma and its impact on their parental roles.

Initially, these sessions with Jen were an opportunity for her to vent her frustrations with Mike and with how Leanne's emerging toddler behaviors challenged her. Jen's emotional energy was concentrated on her anger and resentment of the bond between Leanne and Mike. The clinician began to guide the sessions toward more reflection on Jen's trauma. Through these sessions Jen discussed her childhood and eventually revisited the day of her mother's abandonment. She had a profound awareness of its magnitude at the time, and for 19 years after, Jen had been living with powerfully vivid images of the last time she saw her mother. During the session when Jen returned to that painful day, she curled into a fetal position and cried intensely. This experience was a pivotal moment for healing the little girl inside of Jen, exorcising the ghosts, and starting the work of becoming the mother she wanted to be. But moving forward would not happen for several more months.

Following the session in which the little girl within was revealed, Jen began to unravel. The pain of exposure and loss of her defensive strategies left her unable to cope. Jen began to plan an escape from her life as a wife and mother. In the week following the session, Jen

called hotels to find a place to stay, paying up the rent months in advance so that Mike and Leanne would be taken care of, and keeping cash in her pocket, ready to run.

In the following 3 months Jen pushed Mike and Leanne away, stating that she needed to be alone. Ultimately, rather than move out, she asked Mike to leave and to take Leanne with him, and so Mike and baby moved in with Mike's grandmother. During these 3 months Jen maintained phone contact, but she limited her parenting time with her daughter. In these months when Jen and Mike did interact, there would often be violence. Jen's aggression was heightened as she tried to protect herself from the pain of acknowledging her trauma and its impact.

While Jen was living apart from Mike and Leanne, the Child First team continued to work with them in separate sessions. This period for Jen was about grieving for her childhood and reconceptualizing her role as a mother. When she was parenting Leanne and the team was able to work with the mother-baby dyad, patterns of avoidance emerged. Jen limited her interactions with Leanne and emphasized her perceived rejection from the baby. When asked to reflect on her feelings about being a mother, Jen would say that by "just by being present" she was already "100% better" than her mom had ever been.

Although it was challenging for Mike and the team to watch Jen's rejection of Leanne during this difficult time, it became a port of entry for the clinician to introduce to Jen an alternative definition of *mother*. The clinician began to slowly wonder with Jen what it would be like if Jen were to offer emotional presence for Leanne in addition to physical

presence. Jen's first instinct was to push back against the clinician; the concept of an emotionally present mother was so different from the role she had defined through her trauma lens that it was difficult for her to entertain the possibility on her own.

The engagement with this family had been burdened with changes in family living dynamics, crises, and ruptures. At times the work seemed so uncertain. But the team had built a relationship with both parents that allowed the clinician to gently challenge Jen and begin to chip away at her previous definition of motherhood. With the defenses created by the ghosts diminished, there was now capacity for Jen to participate in reflective processing. Jen's desire to be "a good mom" now had space to grow. Jen allowed the clinician to guide her to new thinking about motherhood, and her definition of the role began to evolve. Jen was able to acknowledge the importance of emotional availability in her role as a mother and, more important, she began to believe herself capable of that role.

Although this break in the relationship was difficult for the family, it provided a safe space for Mike to acknowledge and reflect on his past. The team was able to use Mike's positive childhood experiences with his grandmother to enhance his natural instincts and support his relationship with Leanne. The team understood that the strength of the father-daughter bond was a painful trigger for Jen, and early on in the work the team both consciously and unconsciously limited the emphasis on the bond as a way to protect Jen. But with Mike and Leanne living apart from Jen, there was space for the team to encourage and foster the bond between Mike and the baby. Mike delighted in Leanne's language development, supported and encouraged her exploration, and welcomed her coming to him. While Jen continued to struggle, the team wondered with Mike about the possibility of Mike parenting Leanne on his own. But Mike expressed a strong commitment to Jen and their shared desire to create the family they had never known, and this kept him waiting for Jen to heal.

Mike's nurturing foundation allowed him to process the Child First interventions and begin to integrate them into his parenting, but like Jen, he also carried a painful past. Mike's father had died when he was very young, and Mike reported no memories of him. His mother had suffered from significant mental health issues that left her unable to parent; as a result, Mike was raised by his maternal grandmother. In the individual sessions with the clinician, Mike shared that for much of his life he struggled with explosive anger and sadness. In his late adolescence he decided that he did not like his explosive patterns of expressing strong emotions, so he

learned to bury his emotions. The clinician worked with Mike to help him consider the parallels between his caregiver's struggles with holding strong emotions and his own struggles to hold Leanne and her emotions. The clinician also worked with Mike to understand how his pattern of suppressing emotions when confronted with Jen's anger had resulted in his taking on the role of the victim in their hostile relationship.

As a strategy for suppressing his anger and sadness, like many young men, Mike retreated into video games, which offered a safe place for him to "check out." His retreat into this realm restricted his presence for Jen and Leanne and became a significant source of resentment and frustration for Jen, further straining their relationship. As the clinician began to explore with Mike the reasons behind his tendencies to retreat from and suppress strong emotions, he began to see that he had other options for managing these emotions. He also began to learn how he could support Leanne's emotions, and as Jen's anger diminished as a result of her own work, Mike found ways to safely express himself in their relationship.

A Roadmap for Moving Forward

THROUGHOUT JEN and Mike's conflicts and separations, they both continued to articulate a desire to create the family they had never experienced. With this common ambition, they were able to return to each other after a 3-month separation, during which they had engaged individually and at times jointly with the Child First team. The transition back to living together and coparenting was an adjustment, and Jen's defenses initially reappeared, but the team continued the work both jointly and individually to foster their gains and acknowledge the struggles.

It was at this stage of the work that the team brought in COS and its "shark music" concept—music that sounds like the theme music from the movie *Jaws*—which helped both parents understand the impact of each of their past traumas on their roles as parents. For parents, shark music may appear when a child has a need and requires a response that is safe, but feels dangerous for the parent (Powell, Cooper, Hoffman, & Marvin, 2013). In Mike's case, shark music was triggered when Leanne expressed strong emotions, and Mike would struggle with being present with such strong emotional expressions. Mike's response to COS was immediately positive and prolific. He was able to see Leanne on the "circle" and identify her needs as they were presented. It was incredibly important for him to be able to support Leanne's expressions of anger and sadness differently than they had been supported for him as a child.

Initially for Jen, COS threatened her defenses. Jen originally rejected the notion of shark music, saying she did not feel she had any. But as the defensive stance diminished, she came to understand, as she expressed it, that when it came to the relationship with her daughter, "everything was shark music." That is, the mere presence of her infant daughter and the existence of the dyadic relationship was in itself a trigger for Jen—because of the work Child First had facilitated around Jen's early experience of abandonment, this feeling was easily put into context. Using COS, the team was able to help Jen see that she didn't have to be mean in order to be strong. Much of the work involved supporting the parents in making the connection between shark music and their ghosts. As they better understood those connections, the team focused more on helping them understand each other's shark music and how they could help each other using these COS constructs.

Critical Model Elements That Supported the Work

THE CHILD FIRST model incorporates several interventions to support the complex needs of families while unearthing and fostering their strengths. The model includes a comprehensive trauma-informed assessment process, an integrated teaming approach, and flexible application of the core interventions based on the ongoing assessment of the families' evolving needs. The emphasis on reflective and responsive supervision and both individual and team supervision allows staff safe spaces to process their individual experiences and unique feelings about their work with families.

Critical in the structure of the model is the trauma-informed, two-pronged approach: teaming and integration of care coordination and clinical intervention. Although the primary responsibility for the interventions lies with the clinician, reflective, trauma-informed training is central to the care coordinator intervention. The shared perspective deepens the work and supports the team's ability to understand and process family needs. This duality and common understanding of the families' struggles and strengths helps enhance engagement and inform the intervention.

This duality was reflected in the way care coordinator connected Mike to fatherhood supports. Early in its work, the team noted that Mike's confidence was frequently diminished by Jen in her need to maintain control of the relationship. The care coordinator connected Mike with a father's support group that met Mike's critical needs: support and encouragement in his role as a father. Mike's experience with the group was positive and empowering; the

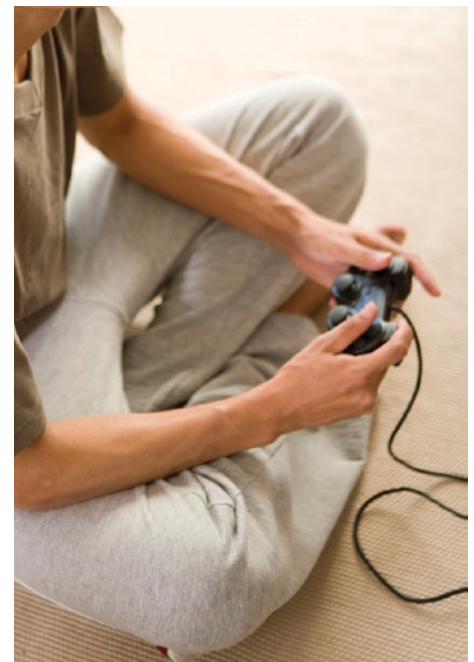


Photo: ©iStockphoto.com/TAGSTOCK1

As a strategy for suppressing his anger and sadness, like many young men, Mike retreated into video games, which offered a safe place for him to "check out."

experience enhanced his identity as a father and supported his integration of the COS roadmap for understanding his daughter's needs and ways to respond to them. With these supports, Mike developed a level of confidence and certainty about his parenting

Learn More

CHILD FIRST HOME VISITING

www.childfirst.com

Child First, an evidence-based home visiting program developed in Connecticut, is designed to serve vulnerable families with complex challenges and needs. The program uses a psychodynamic approach, grounded in the principals of child-parent psychotherapy (CPP). Child First clinicians and clinical directors participate in formal CPP training to ensure that the intervention responds to families who have experienced past or present trauma that impacts family relationships with a trauma-informed approach.

CIRCLE OF SECURITY PARENTING

www.circleofsecurity.org

Circle of Security Parenting is a DVD-based parent education program that provides parents with a roadmap for understanding and meeting their children's developmental and emotional needs.

that began to yield an even stronger bond with his daughter.


A core element of the Child First intervention is creating a “holding environment” for the families when their ability to cope with and manage their stress is compromised. The experience of being “held” is a first for many parents, and one that both supports their emotional development and models for them a way of being in relationship with their children. Critical in the holding intervention is the team’s pacing and patience, both supported by the model’s flexible time line and the fluidity of the interventions. Because the model’s time line allowed for Jen to first experience “being held” in the pain of her past trauma, she was then able to feel safe in processing it. Child First’s continued work with Mike helped him recognize the significance of having difficult emotions supported, an experience lacking in his own childhood. The model’s flexibility, which allows for responsive modifications in response to the chaotic and unpredictable lives of families, enhances engagement and improves outcomes.

Family Follow-Up: 1 Year Later

ONE YEAR AFTER closing services with the family, Mike, Jen, and Leanne are doing well. Early on in their time with Child First, Jen struggled to maintain school attendance while navigating through the remnants of her trauma. Mike had been

unable to maintain consistent employment, distracted by his unconscious search to fill the voids left from his own childhood. At the 1-year follow-up, Jen has completed her associate’s degree and Mike has just been promoted to department manager in his place of work.

Jen and Mike are continuing to build the family for Leanne that they had never experienced themselves. Jen describes her relationship with Leanne as positive, expressing pride in her ability to support Leanne’s emotional development and secure in sharing the parental relationship with Mike. In her words, “It’s okay that Leanne has a strong bond with her dad, because she has a strong bond with me, too.” When Jen does feel overwhelmed with her role as a mother, she references COS: “I have my shark music, but I understand how to put it in perspective so I can meet her needs.” With support from Jen, Mike reports that he has uncovered his potential as a father and husband. He acknowledges how much the family has grown in the past year; “It’s hard to believe that we were there when I see where we are now,” he says. Even in the midst of challenges, Jen and Mike maintained their shared desire to do the hard work that would transform their family. Their willingness and commitment was evidenced by their level of engagement, which was pivotal to the success of the intervention. Jen and Mike

acknowledge they still experience challenges raising their daughter, but they also report knowing how to work together to overcome these challenges. 

FLORA MURPHY, LCSW, is a Child First clinician at Wheeler Clinic, Plainville, CT, and uses a trauma-informed psychodynamic approach to working with families who have complex needs. Prior to working in early childhood, Flora connected adolescents in the foster care system with their biological families, which gave her profound insight into the long-term and negative consequences of not intervening early with a trauma-informed, dyadic approach. Flora is currently working toward her IMH-E through the Connecticut Association for Infant Mental Health.

MELISSA MENDEZ, LCSW, IMH-E, is associate director of Early Childhood Services and Child First clinical director at Wheeler Clinic, Plainville, CT. Melissa attended the University of Michigan for graduate studies in clinical social work and child development and started her career as an Early Head Start infant mental health specialist in Michigan. Currently, Melissa serves as vice president of the Connecticut Association for Infant Mental Health and works to support the growth of the infant mental health workforce in Connecticut.

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Mothering in a Foreign Land: Who Holds the Mother?

Supporting Immigrant Families With Infants and Young Children

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After I¹ had worked with immigrant families, especially families with infants and young children, for a few years, I noticed common themes emerging in my relationships with families. The complexity of being an immigrant in the United States resonated as a central aspect in the context of these relationships.

As an immigrant myself, it was not hard to be aware of how it felt to be in that position in a new country. However, being an immigrant is a particular experience, impacted by many variables. Those who work with immigrant families most often address concerns related to basic needs, priorities such as housing, food, child care, and medical insurance, especially in the context of immigration status. The ways in which immigration and cultural displacement affect motherhood are not commonly addressed, yet becoming a mother in an adoptive land may have a meaningful impact on how women experience their maternity and relate to their newborns. Immigrant mothers, with few networks of support, face acculturation stress, language and cultural barriers, and additional challenges. How immigrant women understand and disclose difficulties related to these issues, as well as to critical concerns such as domestic violence and maternal depression, must be assessed and addressed

by professionals involved in the care of this population.

During the year I worked as a family specialist for Project DULCE (Developmental Understanding and Legal Collaboration for Everyone; see box Project DULCE), I had the privilege of meeting families from all over the world who came to the United States from different backgrounds and with diverse motivations for immigration. Families of newborns came to Boston Medical Center for care from Bolivia, Brazil, Cape Verde, Congo, Dominican Republic, Guinea, Haiti, Israel, Kenya, Mexico, Morocco, Nigeria, Peru, Puerto Rico, Rwanda, Trinidad, and Uganda, among other countries. As part of Project DULCE, I received training in infant development, family dynamics, and legal benefits pertaining to immigrant families from an experienced team of pediatricians, attorneys, and a child development specialist. I received ongoing supervision and benefited enormously from the support of my primary supervisor, Margot Kaplan-Sanoff, who “held

me in her mind” (Fonagy, 1996) while I dealt with complex, multifaceted family situations.

The following case illustrates a situation that arose in the context of my work with the Project DULCE intervention group. A woman became a mother for the first time in a foreign country, with no network of support aside from a few friends, the health care professionals at Boston Medical Center, and the support provided by Project DULCE staff.

Isabel emigrated from a little town in Africa, where following the tribe’s traditions was

Abstract

Becoming a mother in a foreign land can be challenging and demanding for immigrant women and their families, and also for the professionals who support these families. In addition to the typical demands associated with raising a newborn, mothers who are immigrants confront other issues that professionals must keep in mind: a unique understanding of child development, culture differences and displacement, immigration status, acculturation stress, language as an emotional connection to the newborn, mental health, family structure, and networks of support.

¹ Throughout this article, “I” refers to M. Carolina Velasco-Hodgson.

of utmost importance. Isabel came to the United States on a scholarship; she is a skilled musician and a smart woman. Soon after she arrived, however, she became ill and was unable to continue her studies and fulfill the responsibilities of her scholarship. She lost her scholarship funding, which started a spiral of circumstances that she could not overcome. During this time, she got pregnant by the man she loved, Jules. When Jules found out Isabel was pregnant, he asked her to discontinue the pregnancy, but she decided against it and continued with the pregnancy on her own, without a partner, career, money, or strong networks of support in this new country. Despite his mother facing all of these concerns, Jeremiah was born full-term and healthy.

Because they leave behind the familiar and face the challenge of adapting to a new culture, immigrant individuals and families are often considered one of the most vulnerable groups (Beckerman & Corbett, 2008; Noroña, 2011; Tummala-Narra, 2004). The process of immigration is not a uniform phenomenon, as people emigrate for many reasons—in response to political, ethnic, religious, cultural, or economic crises, or for the opportunity for better life circumstances (Segal, 2012).

Such was the case for Isabel. She already had a good life in her country of origin; she had the support of her family, she was an accomplished musician, she had a bachelor's degree, and she was starting to search for a job when this exciting opportunity to study abroad presented

itself. She told me that she could not resist the idea of challenging herself, going out of her comfort zone and trying something new. She won the scholarship and travelled to the United States searching for new opportunities in her field of expertise, in addition to the adventure and increased personal freedom that emigration offered.

Isabel's immigration can be considered an easy one—it was planned, voluntary, economically supported, documented, and safe; and Isabel can be considered a privileged immigrant—she had a scholarship to study what she loved, and many positive expectations regarding her move to the United States.

Pérez-Foster (2001) provided a guideline for clinicians who work with immigrants and Segal (2002) proposed a framework for understanding the immigration experience, dividing it into processes that can be clustered in three time frames:

BEFORE MIGRATION:

- Conditions, status, and experience in the home country
- Reasons for leaving home country

DURING MIGRATION:

- Transition to country of immigration (including emigration)

AFTER MIGRATION:

- Response to the immigration process
- Adjustment to the receiving country life-style and culture
- Implications for human services

Using this framework to break down the immigrant experience into before, during, and after, professionals can gain a deeper understanding of the particular issues involved in each case. With this greater awareness of the complexity of a particular individual or family situation, the professional is more likely to prioritize the family's needs and concerns and give appropriate support (see box Working With Immigrant Families).

I was an immigrant and had personally experienced the immigration process myself, but many of the families enrolled in Project DULCE experienced courses of immigration different than mine. Families from diverse countries shared their history, perceptions, and emotions with me, and I listened to their stories in a nonjudgmental way and without being predisposed toward certain topics or answers. Noroña (2011) acknowledged that immigrant clinicians can facilitate cultural transition and can serve as cultural brokers. “By offering their clinical skills, linguistic abilities, and knowledge gained from their own immigrant experience, clinicians have the opportunity to help bridge cultural gaps” (Noroña, 2011, p. 7).

Most immigrants experience what is commonly referred to as “culture shock.” Professionals in the medical or mental health fields better know the experience as *acculturative stress* (Berry, 1997). This stress arises when the individual who has immigrated tries to balance differences between the new dominant culture and the culture of origin (Beckerman & Corbett, 2008). The stress is experienced differently among individuals, but when it increases and the individual experiences a “sense of loss, disassociation, flashbacks or nightmares about separation from homeland or family of origin, they have symptoms that may be consistent with those of posttraumatic stress disorder” (Beckerman & Corbett, 2008, p. 66). Many researchers refer to this constellation of behaviors as *immigration trauma* (Pérez-Foster, 2001). Moreover, the effects of migration are felt not only by the family members who emigrate but also by those who remain behind at home; there may be emotional repercussions such as increased depressive symptoms and feelings of loneliness due to separation from loved ones (Silver, 2011), and these effects may create additional concerns for the immigrants.

In addition to all the stresses she experienced related to the immigration itself, Isabel lost her scholarship, got pregnant, and decided to continue the pregnancy on her own. Becoming a mother even under the most ideal circumstances can impact a women's life profoundly; for Isabel, it was doubly stressful.

PROJECT DULCE

Project DULCE (Developmental Understanding and Legal Collaboration for Everyone) combines strategies from two powerful models: Healthy Steps, a relationship-based model of care located in pediatric primary care that in more than 20 years has demonstrated that pediatric primary care is an accessible, universal, timely, and nonstigmatizing point of entry for families with very young children to ask questions and receive information on child and family development; and the Medical Legal Partnership (MLP), a program that provides legal advocacy and services for families needing assistance with nutritional benefits, housing supports, electricity and heat shut-off protection, and educational placement for children with special needs to prevent or alleviate the parental stress often associated with child abuse. In DULCE, MLP brings together pediatricians, child development specialists, and legal advocates to engage in structured collaboration on behalf of vulnerable families who experience barriers to such care and services that, in many instances, could be eliminated through legal advocacy.

Project DULCE uses a patient-centered medical home model, offering interventions in the pediatric primary care setting during regularly scheduled well-child visits. Family specialists are trained by MLP | Boston to identify the legal and social needs that may affect a child's health and development and to take action by helping the family advocate for themselves or by referring them to an appropriate public health, legal, or social service agency or resource (including MLP | Boston). In this project caregivers of newborns were recruited in the pediatric primary care clinic at Boston Medical Center at the time of their new baby's first visits. Families were randomly assigned to either the intervention or control group after informed consent. Intervention families met with the Project DULCE family specialist in conjunction with their pediatric clinician at all routine well-child visits. They were offered child development screening and screening for adult risk and protective factors, home visits, and telephone check-ins, depending on the needs of the family, for the first 6 months of the baby's life.

One's cultural identity is closely connected to one's native language. Some of the mourning that happens during immigration is related to the loss of the native language use and the challenge of adapting to the new language and to particular ways of expressing emotions in the new culture. Mothers are usually seen as responsible for raising their children and passing on their culture; for immigrants, there are high stakes involved: A child's future level of proficiency in a mother tongue is sometimes associated with that child's authenticity as a member of the ethnic group (Tummala-Narra, 2004).

It was hard for Isabel to talk to her son in her mother tongue. She was the only person she knew who knew the language, and she would get very emotional and nostalgic when speaking. But when she spoke in her native language, she felt different and like an outsider; she thought she would adapt more easily if she spoke only English.

WORKING WITH IMMIGRANT FAMILIES

Suggestions for professionals when working with immigrant families include:

1. **Be curious and ask.** All individuals are different, even when they come from the same country or city. If you are sensitive and respectful, any question will be well received by families.
2. **If you are afraid, they will be, too.** You will need to address delicate topics like immigration, domestic violence, or mental health. Even when it can be difficult and talking about those issues can open a Pandora's box, you need to be confident in your tone and strong enough to listen to whatever they need to disclose.
3. **Accept and support relative dependence to accomplish independence.** Some families will need you more than you are used to when they are facing a new culture. This does not mean that they will depend on you forever; you just need to support them intensely for a short period of time until they are strong enough to navigate the new system.
4. **Your role may be to "mother" a new mother in a foreign land.** Try to make some space for the mother to open up and allow professionals to "hold" her as a mother. No one is perfect; if mothers believe they need to accomplish a "scientific motherhood" (Apple, 1995), their anxiety and fears will keep them from reaching for a professional's help.

However, given the positive effects on children of language use in the expression of emotions and feelings and recall of memories (Pavlenko, 2005) and because her language could be a bridge to connect her with her newborn, I encouraged Isabel to speak to Jeremiah in her mother tongue.

North American culture is often described as individualistic, in contrast to non-Western cultures that are described as more community oriented, in which there is more collective and intergenerational family involvement (Beckerman & Corbett, 2008). Western-based psychological theories place significant value on the individual mother's role in helping her child to achieve a strong sense of autonomy and independence. Therefore, "conceptions of the psychologically healthy mother-child relationship are challenged in the case of immigration, in which the mother typically struggles with culturally divergent values of parenting and with her disconnection to either her parental figures or cultural representations" (Tummala-Narra, 2004, p. 172). Specialists working with mothers in a foreign land must address the role of the often-missing extended family in child rearing.

During our meetings, Isabel would regularly describe precisely what her mother would say, do, or think in a particular situation around Jeremiah's care.

Because this tended to be the way in which Isabel would reflect on her "angels" (Lieberman, Padron, Van Horn, & Harris, 2005) in relationship to her son, I encouraged her to consider how her mother would handle different situations. We also discussed her home community's norms, values, and rituals, and explored ways in which Isabel could bring some of her cultural background, which was such a strong "holding environment" for her relationship with her son, into her new life.

Jeremiah was a happy, responsive, robust baby. Isabel was also a happy and very warm young woman, but she looked tired and was very skinny. Isabel was open during early well-child visits, but also she seemed reserved and sometimes ashamed of sharing some aspects of her personal story. Her perception of herself had changed; she no longer felt connected to the woman she had been in her country of origin, and she felt that she was letting everyone down. Isabel was an outsider, mothering alone and burdened with the belief that she had squandered all the dreams she had while she was growing up and was disappointing her family, especially her father.

During a home visit, which was offered to all Project DULCE families but which was



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Being an immigrant is a particular experience, impacted by many variables.

particularly critical here because of the family's complex situation and unstable housing arrangements, Isabel opened up. She discussed her immigration situation and shared the complexity of her financial situation. After these first meetings in the pediatric office and at her home, I realized that this family had many needs, but food, income, and housing insecurity were the most immediate concerns. Isabel and I started working to connect the family with the community agencies and resources that could assist them during this time and for the long term. My colleagues and I decided to request legal assistance to help them with their unstable immigration situation.

I was interested in the lives of the families I worked with and how child-rearing practices were different in their countries of origin; conducting home visits and meeting the family in their own environment helped me connect more closely with them. My own accent when speaking English placed me in a position similar to theirs—of not being perfect, of also being an outsider—which may have helped them feel less inadequate and more comfortable with their own imperfections. Even with the language barrier, we built our communication on other cues that helped us connect to and trust each other. I used humor, for example, as one such tool in my interventions.

Isabel said that my way of pronouncing some words in her language was very similar to the one used by farmers in one of the cities near her home, so every time she was feeling down I would pronounce these words and the emotional climate would change.

Isabel and Jeremiah continued coming to the well child visits and requested my assistance when connecting to community resources. After a few months Isabel felt more empowered to connect to the other resources her family needed.

One day, however, I received a call in which Isabel's voice was agitated and she sounded desperate. Jeremiah had been crying all weekend, and she had tried "everything": holding him, singing to him, rocking him, but nothing seemed to work. She didn't understand why and didn't know what else to do to calm him down. She told me that she was on her way to the hospital and asked for my help. I realized that this mother needed someone who could understand the complexities of being an immigrant mother.

I met them in the hospital lobby and observed that both Isabel and Jeremiah looked exhausted. As we sat and talked, Isabel provided a detailed description of what had happened during the weekend and Jeremiah's unusual behavior. While she was talking about her son and his uncommon display of emotion, I observed that her own behavior was similar to her son's: She was agitated, her speaking speed increased, and she almost lost her breath while talking. She held Jeremiah more rigidly than usual, and she kept moving him from one arm to the other, changing positions rapidly. I thought about what the dyad might have experienced during the days before Jeremiah's

The effects of migration are felt not only by the family members who emigrate but also by those who remain behind at home.

inconsolable crying started. I wondered if this infant's behavior could be his way of experiencing and expressing his mother's emotional state. After I empathized with Isabel's feelings and explored possible explanations for Jeremiah's unusual behavior, I asked what had happened before Saturday.

The parent-child dyad is exquisitely synchronized, especially during the first months of life. Infants and very young children need a parent to be their protector (Fraiberg, 1959), to provide them with the resources to overcome danger before they develop their own inner resources. A newborn's ability to regulate anxieties is deeply embedded in basic aspects of the parent-child interaction. When parents, regardless of the context of their crisis, are able to maintain an impression of both a physical and emotional holding

environment, then the child experiences a psychic stability and the regularity of felt experience. Mothers can be an anxiety buffer for children, and this has been clearly seen in immigrant children (Pérez-Foster, 2001).

A mother must feel emotionally secure herself in order to focus herself on her duties of child rearing. Becoming a mother activates a woman's own attachment needs; Winnicott (1987) said that a mother needs someone else holding her, so she can hold her baby. She needs "another mother," someone else who can be present emotionally, providing safety and helping her alleviate the worries she has on her mind (Dio Bleichmar, 2005). A mother's partner can play this role during the first months of baby's life, but mothers without partners must seek other avenues of support. This is a real challenge for immigrant mothers who lack social networks.

Sitting beside Isabel and Jeremiah, I observed that he was crying and she was almost crying as well. They sat in this tearful state for a few minutes, and I started to ask open-ended questions about what had happened in the days before his crying behavior began. Isabel's eyes opened wide and she said, "I had a big fight with Jeremiah's father over the phone on Friday." They had been arguing because Jules didn't want to help her out financially; also during that call, Isabel discovered that Jules had

MENTAL HEALTH
IN INFANTS:

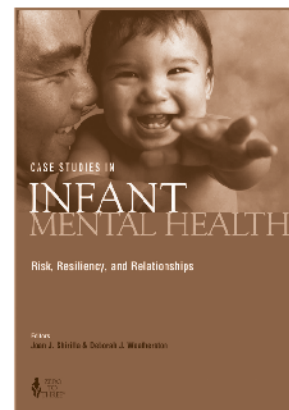
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Case Studies in Infant Mental Health *Risk, Resiliency, and Relationships*

JOAN J. SHIRILLA and DEBORAH J. WEATHERSTON,
Editors

This comprehensive reference book details 12 real-life case studies when health, developmental, or learning problems occur in infants and very young children. Widely praised as a "must" for all students and practitioners in the field of infant mental health, this book serves as an outstanding source of methods and techniques of clinical intervention. Each case study includes a full description of the child and family, discusses the supervision and consultation that supported the specialist, and includes self-reflection questions for the reader.

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another partner. I sat with Isabel for a couple of minutes without saying anything, remembering that she had always reported that Jeremiah was an easygoing baby, very happy and easy to console. I asked her if this intense crying had ever happened at any other time in the past; she said it hadn't.

This confirmed my sense that this baby was experiencing his mother's intense anxiety about her interaction with his father; he was expressing his upset the only way he knew how, with intense crying. And Isabel was not just concerned about her baby's crying, she also was worried about how her family back home would respond to Jules's abandonment of her and the baby, and, ultimately, about her and her son's future in this country as immigrants.

Even psychologically healthy mother-child relationships are challenged by immigration. Mothers struggle with culturally divergent values of parenting and with their disconnection from their parental figures or their cultural representations of parenting values. Winnicott's (1960) notion of "good enough" parenting required an understanding of broader cultural parameters of mothering than the ones considered in a Western psychological formulation (Tummala-Narra, 2004). It is therefore critical for professionals working with diverse populations to be culturally sensitive and open to different sets of knowledge. Recently, the Irving Harris Foundation Professional Development Network Tenets Working Group developed and published the Diversity-Informed Infant Mental Health Tenets (Seymour, Thomas, & Noroña, 2012) that may help professionals and institutions working with diverse population, including immigrants (see box Diversity-Informed Infant Mental Health Tenets).

Because Isabel was so anxious about the baby and so preoccupied, I suggested that it might be a good idea for Jeremiah to be seen by his pediatrician to rule out any medical concerns. Isabel really needed a doctor to tell her that her baby was doing fine. After she agreed and made an appointment, she seemed calmer, her respiration frequency was lower, she stopped talking with short breaths, and she was able to sit down with her baby without moving him all the time. While we were waiting for the appointment, I spoke about how infants can be highly attuned to their mothers' emotional state and told Isabel that even when mothers try to hide the words related to those emotions, babies feel them. Isabel looked at me and said, "Ohhh, now I understand why he was so upset and fussy."

Isabel is an intelligent and empathic woman; she was eager to learn about parenting, and we had built a relationship based

DIVERSITY-INFORMED INFANT MENTAL HEALTH TENETS

Recently, the Irving Harris Foundation Professional Development Network Tenets Working Group developed and published the *Diversity-Informed Infant Mental Health Tenets*, which may help professionals and institutions working with diverse populations including immigrants.

1. Self-awareness leads to better services for families.
2. Champion children's rights globally.
3. Work to acknowledge privilege and combat discrimination.
4. Recognize and respect nondominant bodies of knowledge.
5. Honor diverse family structure.
6. Understand that language can be used to hurt or heal.
7. Support families in their preferred language.
8. Allocate resources to systems change.
9. Make space and open pathways for diverse professionals.
10. Advance policy that supports all families.

Source: Seymour, M., Thomas, K., & Noroña, C. R. (2012). Infant mental health professional development. *Zero to Three*, 33(2), 13–22.

on mutual respect for one another. She was open to listening to new ideas, even when her levels of anxiety were making it hard for her to reflect on the situation. Yet Isabel had the capacity to digest the short sentences I offered and to make the connections that helped her visualize other ways of thinking about the situation.

Even though Isabel had realized how the events of that argument had spiraled out of control and impacted the baby, we decided to follow through with the doctor's appointment just to make sure there was nothing going on that could affect Jeremiah's physical health. The pediatrician confirmed that the baby was healthy and doing great. After the appointment we sat for a while to talk about Isabel's current situation and ways she could cope during this stressful time.

Isabel and Jeremiah didn't show up for a follow-up appointments, and for 2 weeks I could not reach Isabel, when she suddenly called and requested an urgent meeting. Isabel had found that her immigration status was in jeopardy. She was struggling and very anxious, and although I suggested she talk with a therapist and maybe reach out for extra support, she was afraid of sharing her

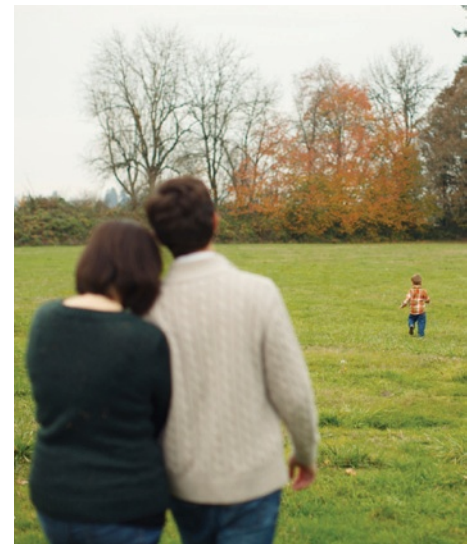


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Western-based psychological theories place significant value on the individual mother's role in helping her child to achieve a strong sense of autonomy and independence.

difficulties with anyone. Afterward, Isabel shared what had been going on in her mind during those difficult weeks: She had been concerned about how she would be treated if she revealed her emotions; she was afraid that she was not going to be seen as a good mother for Jeremiah and that maybe her baby was going to be taken away from her.

We worked very hard to connect to the supports the family needed but it was not easy due to Isabel's financial instability and her now unstable immigration status. One day, after waiting for a meeting at a community agency and finding out they could not take her case, she just looked at me and said, "What am I gonna do?" She was shaking and looked hopeless. I sat by her side and when she was about to cry, she disclosed she was very tired, she couldn't find the strength to continue, she loved her son more than anything in the world but she couldn't see any way out. Upon hearing this revelation, I conducted a risk assessment and developed a verbal contract with Isabel. She agreed to go home to a friend's house and the next day she finally agreed to a psychiatric evaluation.

Learn More

HEALTHY STEPS
www.healthysteps.org

MEDICAL LEGAL PARTNERSHIP
www.medical-legalpartnership.org

PROJECT DULCE
www.bmc.org/Project-DULCE.htm

Isabel, Jeremiah, and I spent an entire day between the psychiatric offices and the hospital emergency department. During that time Isabel was scared and overwhelmed by the many administrative questions and different professionals exploring her mental status. Isabel's worst fear was losing her baby; she reported that Jeremiah was her strength and the reason why she didn't give up on herself. During this stressful day, Isabel and Jeremiah were together all the time, and Isabel was able to gather some internal strength to sing to him, play with him, and feed him as on any regular day. Her love for her child and her fear of losing him, coupled with the strength of her relationship with me, her family specialist, and a fellow immigrant, held her through her crisis. Isabel started on medication and was assigned to a therapist.

Throughout this crisis, I turned to my Project DULCE team for both concrete suggestions about how to support the family with their basic needs despite the mother's changing immigration status and for clinical supervision. As an immigrant myself, I was closely aligned with this mother and baby. At times I felt like a "grandmother" to them, providing that holding environment for them while my supervisor provided a holding environment for me.

On a follow-up appointment Jeremiah was growing well and still smiling with shiny eyes, and Isabel was starting to show some hope for the future. Isabel has continued to receive the care she needs as she works to get connected to services that can provide stability for her family, stability that will mother Isabel so she can mother Jeremiah in their adopted land. 🌱

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Breaking the Cycle

Supporting Parent–Child Relationships Through the “Parents Interacting With Infants” Intervention

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Tamika, a young African American mother, reluctantly walks into the room to join other mothers for a new parent–child group. She is mandated to be here. As someone who’s grown up in the child welfare system, this is one more hoop to jump through, one more place she has to be. She is very pregnant, tired, and heavy with ambivalence about her pregnancy, having to be in this group, and life in general. Her eyes are sad and dull. It is obvious that she does not want to be here. A moment later, a beautiful 2½-year old girl arrives with one of the case managers. Imani’s eyes light up at a promise for attention and play as she notices us, the group facilitators, and the toys and books in the room. Imani is so hungry for play, reading, talking, and singing. As the group begins, mothers are asked to sit with their children. It is only at this point we realize that Tamika is Imani’s mother. There is no connection, little interaction between the mother and the daughter. Throughout the group, Imani joins other parent–child dyads or tries to engage us, while Tamika prefers to spend her time sitting on the chair at the end of the room, blaming her belly for her inability to play.

Recent research has confirmed that relationships are essential for all children. Brazelton and Greenspan (2000) believed that ongoing consistent, nurturing relationship is one of “the irreducible needs of children” (p. 53). Only in the context of a relationship can a child survive, learn, and grow. The quality of the relationship between the child and his caregiver determines what the child learns about the world and about himself. Will the child learn to feel safe and secure, that he is worth responding to, or will he learn that his needs and wants are not important and that there is no one to count on? Will the child learn that interactions with adults are pleasant and rewarding, that adults make him feel respected, important, and understood, or will he learn to be fearful, anxious, and passive and to curb his curiosity? Most of this learning happens in the first years of a child’s life. These years

are particularly important because they provide the foundation, the framework, for every domain of human development. The development of self-regulation, self-esteem, and self-confidence—the ability to form healthy and secure relationships with others, to experience and express a wide range of emotions, and to explore the environments—is rooted in the child’s first relationships.

The early experiences and first relationships shape the development of the brain, the only organ that changes in response to experience after birth. Specific neurological patterns are formed in the brain in response to the type of care the child receives. Evidence shows that sensitive and responsive caregiving affects the development of the brain in positive ways. Perpetual lack of such essential experiences is stressful for infants and toddlers and damages brain architecture. In fact, researchers are able to find

measurable differences in gray matter volume in infants affected by toxic stress starting at 5 months old (Hanson et al., 2013).

Abstract

The Parents Interacting With Infants (PIWI) intervention is designed to support parents in developing their capacity to create positive, sensitive, and engaging interactions with their infants and toddlers. These interactions, as indicated by research, are essential for healthy brain development and overall well-being, yet they are particularly challenging for young mothers who have not had nurturing experiences growing up. Through a series of facilitated groups, teen mothers exiting the foster care system in inner-city Milwaukee demonstrated a new interest in and sincere engagement with their baby, as well as an increase in parental capacity around understanding their child’s cues and preferences and the importance of relationship and play in supporting their child’s development. The authors found the PIWI intervention particularly relevant to populations challenged by poverty, domestic violence, trauma, substance abuse, mental illness, and many other stressors.

PHOTO: LINDA J. STEINER



The first years of a child's life provide the foundation for self-regulation, self-esteem, and self-confidence.

Many adults who have faced trauma, abuse, or neglect have tremendous difficulties creating positive, consistent, and sensitive relationships with their babies because they have not experienced such relationships growing up. As they become parents, there is no foundation for them to draw on to build the nurturing relationships with their babies; thus, it becomes essential for professionals to foster the process of parent and child falling in love with each other.

When working with populations challenged by poverty, domestic violence, substance abuse, mental illness, incarceration, and many other stressors, professionals (e.g., case managers, home visitors, child care teachers, nurses, and child welfare workers) are often at loss deciding which fire to put out first. Brandt (2013) pointed out that the professional's greatest responsibility is to support and foster the "serve-and-return" interactions between an infant and her caregiver—a process that is fundamental for proper neural wiring of the brain.

The Pyramid Model

IN LINE with the latest discoveries, the Center on Social and Emotional Foundations for Early Learning developed the Pyramid Model framework, an evidence-based prevention intervention model to promote social and emotional

competence in infants and young children. This framework is grounded on the notion that optimal development is only possible within nurturing and supportive relationships (see Figure 1). Wisconsin is one of the many states implementing the Pyramid Model throughout its early childhood systems.

The Parents Interacting With Infants (PIWI) intervention, developed by Tweety J. Yates, is a component of the Pyramid Model that specifically addresses the parent's relationship with the infant or toddler (McCollum, Gooler, Appl, & Yates, 2001). PIWI recognizes the critical value that parent-child interactions have in a child's development. Children's development is enhanced when parents recognize and act on their own important roles in supporting their children's developmental agendas. The goal of PIWI is to increase parental competence, confidence, and mutual enjoyment. In other words, PIWI supports the parent's capacity to engage in "serve-and-return" interactions.

PIWI offers an opportunity to break a cycle of intergenerational relational dysfunction and increase the capacity of parents to connect with their infants and young children. SaintA, one of the largest providers of family-centered care and education services and the leader of trauma-informed care in the state of Wisconsin, recognized the need to provide

supports to young parents who are aging out of their foster care system. As part of the innovative practices, they selected the PIWI framework and partnered with the Wisconsin Alliance for Infant Mental Health to offer a series of parent-infant groups.

There are other mothers and babies in the room besides Tamika. They are all teens raised in a foster care system with a shared goal to be a better parent than they had growing up. The room is set with age-appropriate toys and activities inviting parents and children to play together. There is also a quiet area with books, pillows, and cozy blankets. After our introductions and discussion of the group's focus, parents are encouraged to play with and observe their child in different play areas. At this point, we realize that we lost the mothers. Instead of exploring the room and playing with their children, they are off in a corner looking at their phones or talking to each other. The children are delighted to explore and play with us and seem perfectly content to be entertained and held by two strangers. We fumble through the free-play portion of the group and pull everyone back to the large-group activity and closing. There is a noticeable change in the mothers' engagement when it comes to singing familiar children's songs.

Figure 1. The Pyramid Model Framework



After the group, during our debriefing, we realize that, although mothers are comfortable doing something they are familiar with (like singing well-known songs), their inability to play and disengagement with their babies may not be stemming from lack of interest or love but rather from lack of knowledge and experience. How do you play with your baby when no one really played with you when you were one?

All learning happens in the context of relationship, and learning to connect with a baby is not different. We embraced Jeree Pawl's concept, "How you are is as important as what you do." We knew that before we could help the mothers to discover and love their babies, we needed to fall in love with the mothers and make them feel safe, secure, competent, and appreciated. We scaled back and adjusted our goals and expectations. As a framework, PIWI both offers group structure (see box SaintA Parents Interacting With Infants Group Schedule) and allows for flexibility. Thus, we were able to intentionally create time and space to build relationships with the mothers. We decided to start each group by sharing common parenting challenges and providing information on key parenting concepts and practices. We talked about infant cues, emotions, behaviors, and what they might mean—behaviors as a way

to communicate and connect. We discussed the joys and many challenges of raising babies and toddlers. Through these honest and sincere conversations, we were able to build a foundation of trust that allowed us to facilitate and coach the relationships between the mothers and their babies.

Before every group, as we set up and prepare, we notice our worries and anxieties. Will the mothers come back? Will they be able to be present? Will they connect, share, play, participate? We are relieved when they make it; we know it is a big effort for both the SaintA staff and the mothers to join us weekly—yet here they are. Imani leaps in, followed by Tamika. She runs to the large cardboard box with cutout openings. She gets in and hides. We are ready—we know this is an opportunity to help Tamika notice her child's invitation to play. We demonstrate and invite Tamika to try playing with Imani. By now, Tamika knows us; she feels safe and appreciated. She sees our faces light up when she and

her daughter walk in. She is wanted here. We compliment her on the beautiful game she creates with Imani. Over the next several sessions, we see Tamika becoming more at ease with toys and books and more natural in her interactions with Imani. We also notice that Imani is more selective and prefers to spend time with her mother during the groups. With time, we can see and feel the joy in their relationship grow. There is connection, and there is love.

The main focus of the PIWI intervention is on the parent–child relationship. The PIWI framework identifies a number of dyadic strategies—specific behaviors that adults engage in to establish and maintain responsive, supportive, and positive interactions (see box Parents Interacting With Infants Dyadic Strategies). PIWI facilitators use concrete strategies to enhance, expand, and foster these dyadic strategies. They help parents build their skills by using *triadic* strategies (see box Parents Interacting With Infants Triadic

PARENTS INTERACTING WITH INFANTS DYADIC STRATEGIES

Dyadic strategies are behaviors parents engage in to establish and maintain responsive, supportive, and positive interactions. These strategies increase the number of "serve-and-return" interactions between an infant and her parent.

Set the Stage for Interaction

- Position self and child so that mutual gaze and joint attention are possible.
- Provide objects and events appropriate to child's development and understanding.
- Physically support child, if necessary, to allow interaction with others and objects.

Maintain Child's Interest and Attention

- Establish yourself as an interesting and interested partner.
- Maintain a warm, encouraging manner.
- Provide clear emotional cues.
- Use novelty and exaggeration to capture interest.
- Be sensitive and responsive to the child's emotional expression.
- Regulate pace in relation to the child's mood and emotional cues.
- Recruit the child's attention when unengaged or unfocused.
- Introduce new focus or activity when needed.

Establish Reciprocal Roles (Turn Taking)

- Respond to the child's initiations.
- Establish predictable interaction routines (e.g., I take a turn, you take a turn).
- Provide time for the child to take a turn.
- Let the child know that a response is expected . . . then wait.
- Imitate . . . then wait.

Match and Follow

- Observe, interpret, and then join the child by matching his focus of attention or interests.
- Follow the child's lead.
- Comment on the child's activities and interests.

Support and Scaffold Learning

- Elaborate on the child's communicative attempts.
- Add new actions or elements to established interaction routines.
- Balance support (e.g., suggestions, demonstration) with expectations and opportunities for independence.
- Pose "dilemmas" for the child to solve.

(Adapted from: Center on Social and Emotional Foundations for Early Learning. (n.d. a). *Handout 3: Dyadic strategies*. Retrieved from <http://csefel.vanderbilt.edu/resources/piwi/PIWI%20Handouts%20PDFs/Handout%203%20-%20Dyadic%20Strategies.pdf>

SAINTA PARENTS INTERACTING WITH INFANTS GROUP SCHEDULE

Greetings and Welcome 25 min

Arrival

Informal conversations/key parenting concepts with the mothers

Group Discussion 15 min

Hello Song

Sharing

Introduce developmental observation topic

The "guess"

Parent–Child Play/Observation Time 35 min

Closing Discussion 20 min

Songs and rhymes

Sharing what happened

Carry over to home

Good-bye Song

Facilitators Debriefing and Note Writing 60 min



The Parents Interacting With Infants (PIWI) intervention supports parents in creating positive, sensitive, and engaging interactions with their infants and toddlers.

PARENTS INTERACTING WITH INFANTS TRIADIC STRATEGIES

Triadic strategies are behaviors Parents Interacting With Infants facilitators use to support parent use of Dyadic Strategies. These strategies foster parent's ability to engage in "serve-and-return" interactions between an infant and her caregiver.

1. Establish Dyadic Context

Elements of the environment are arranged or rearranged to increase the probability of developmentally matched, mutually enjoyable parent-child interaction.

2. Affirm Parenting Competence

Developmentally supportive interactions are warmly recognized and expanded on, as are characteristics of child competence.

3. Focus Attention

Facilitators comment on, expand on, or question aspects of the interaction to draw the parent's attention to particular competencies or actions in self or child.

4. Provide Developmental Information

Information about the child's development is given by verbally labeling or interpreting the child's social-emotional, cognitive, language, and motor abilities within the context of play and interaction.

5. Model

Dyadic interaction roles are momentarily taken on by the facilitator.

6. Suggest

Facilitator provides parent with specific suggestions to try with child.

Adapted from Center on Social and Emotional Foundations for Early Learning. (n.d. b) *Handout 5: Triadic Strategies*. Retrieved from <http://csefel.vanderbilt.edu/resources/piwi/PIWI%20Handouts%20PDFs/Handout%205%20-%20Triadic%20Strategies.pdf>

Strategies). Many professionals who work with parents and young children naturally use these strategies, but PIWI emphasizes the intentional use of the triadic strategies so that professionals can become more purposeful and more aware of their own influences on the relationship. PIWI facilitators are trained to consider every situation from the parent and child's point of view to figure out which strategy might be the most appropriate and supportive. It is the facilitator's responsibility to find the balance of how much support will be helpful without taking over or undermining the natural competence that parents have.

Finding the right strategy is not always simple. Knowing and understanding each dyad is essential in providing the right level and kind of support. It is important for the facilitators to wait and observe the interaction before jumping in with help. Fighting the urge to assist, a pull to pick up a baby, is tremendously difficult. Once again, the wisdom of Jeree Pawl (1998) comes to the rescue: "Don't just do something—stand there!"

We make time to meet and debrief after every group. We rehash the beautiful moments of connection that we notice with all the mothers and their children. There is different energy in the room. There is eagerness to play, explore, be silly, and be joyful. We hear the warm words mothers say to their babies as they master crawling through the tunnel or figure out how to

press a button to see an animal pop out. Tamika is on the floor with Imani. The ever-growing belly is no longer a barrier or excuse for not playing. They read books, they bang on the drums, they color—they are together! After every group, we write notes, simple handwritten evidence of the new relationship. We thank each mother for coming and describe to them exactly what we saw during their play time. If someone has to miss our group, we send a note anyway, telling the parent that we missed having them and that we hope to see them next time.

Capturing the Power of the Moment

WHEN INITIALLY EXPLORING the best way to evaluate the effectiveness of the intervention, we realized that what we needed to capture is the power of the moment. The compilation of many moments is what creates change. If we could get a mother and a child to truly connect, even if for a moment, and the mother was rewarded with a special look or special touch from her child, she would be more likely to repeat her interaction to get that response again. Thus, our job was to facilitate the creation of that initial moment of connection and to build the mother's capacity to create more of such moments. Through this process of increased parental responsiveness, "serve-and-return" will unfold.

We were intentional in deciding not to do a baseline assessment, as we thought it might negatively affect the development of our relationship with the young mothers if they felt they were going to be judged by their responses. Instead, we chose to use a retrospective survey at the end of our last session. We asked the mothers to self-assess their behaviors and attitudes, thinking back to the first group and now, at the end of the last group, using three simple statements. The table below summarizes the evaluation results (see Table 1).

All mothers indicated better understanding of their baby's cues and increased time focused on playing with their little ones after the six group sessions. The mothers' responses to the

Table 1. Evaluation Results

1		2		3		4		5									
Hardly Ever		Once in a while		Sometimes		Usually		Most of the time									
Before the series												After the series					
1	2	3	4	5	Avg.	Learning objective						1	2	3	4	5	Avg.
0	0	3	1	4	4.13	I spend time focused on watching and playing with my baby/child.						0	0	0	1	7	4.88
0	0	4	0	4	4.00	I understand my baby's/child's cues.						0	0	0	1	7	4.88
0	0	2	1	5	4.38	I know what he/she likes and know how to help him/her explore new things.						0	0	0	1	7	4.88

open-ended questions continue to tell a story of growth in awareness, competence, confidence, and mutual enjoyment. When asked to share two things they have tried or noticed as a result of participating in the PIWI groups, the mothers reported the following:

- I learned that my son is smarter than I think, and he enjoys new things.
- I play with my baby more, and I try new things with her.
- Let her explore things on her own.
- Giving my kids 15–30 minutes to just focus on them. Look for their cues.

For more examples of mothers' feedback, see the box *In Their Voices*.

In addition, the mothers shared with us that they had been taking advantage of “little free libraries” in the neighborhood to get books for their babies, and one mother had signed up for a library “Mommy and Me” group to be able to continue to devote play time with her children after our sessions had ended. Another noticeable change was in the way mothers dressed from the first to the final group. In the first sessions, many of the mothers arrived for group “dressed up,” as if trying to impress the professionals in the room. As the groups progressed, they wore more comfortable clothing coming in, prepared to get on the floor and into the sensory play space. They knew we were seeing “them” and not judging by appearance.

Maternal self-perceptions and comments, as well as our own observations, showed an increased sense of competence in parenting, a key factor in positive parenting (Jones & Prinz, 2005). As summarized by Deković et al. (2010), parents who trust in their ability to parent and who demonstrate parental confidence are warmer; more responsive and accepting toward the child; use less harsh discipline; and are less hostile, inconsistent,



PHOTO: LINDA J. STEINER

Parents Interacting With Infants facilitators consider every situation from the parent's and child's point of view to figure out the most appropriate and supportive strategy.

and intrusive. Parents who lack a sense of competence and confidence not only show parenting that was less adequate but also tend to withdraw from interactions with the child and give up addressing child problem behaviors altogether.

It is late on a warm summer night. One of the SaintA staffers is on duty, patrolling the transitional living facility. She is concerned about the noises coming out of one of the apartments. She knows she needs to intervene and be fully prepared for confrontation. As she comes closer to check, what she sees is both surprising and stunning to her. It is not a party, a TV, or music turned up to an unaccepted volume setting. It is Tamika playing and giggling with her new baby boy. This is the same mother who, just a few months ago, was not sure whether she was going to keep the baby or place him for adoption. This is the same mother who was disconnected and uninvolved. This mother is able to love, find joy, and create the beautiful moments of connection with her son that are so essential for his well-being.

Strengthening Parent–Child Relationships

THE PARENT–CHILD DYAD is at the center of the PIWI intervention, which has the main goal of helping parents experience confidence, develop competence, and create mutual enjoyment—*joie de vivre*. Although this comes naturally to many, some parents struggle with the true connection, especially if they had a lack of consistent and nurturing relationships growing up.

The ability to be patient and flexible, the ability to let go of any preconceived plans on how the group should go, and the ability to

meet the dyad exactly where they are become instrumental to making this intervention successful. PIWI facilitators need to be aware that they might be facing initial resistance and might be turned off by lack of interaction and level of disengagement between the parent and the baby. Understanding and intentional use of triadic strategies is helpful and organizing, and yet, before any strategies come relationships. Showing kindness and respect, admiring the babies, and complimenting on any glimpses of connection come first.

Learn More

CENTER ON THE SOCIAL AND EMOTIONAL FOUNDATIONS FOR EARLY LEARNING

<http://csefel.vanderbilt.edu/resources/training-piwi.html>

Young Moms Learn How to Be Mothers SAINTA

www.st-al.org/2013/09/10/young-moms-learn-how-to-be-mothers

Home Visiting UWM–MILWAUKEE CHILD WELFARE PARTNERSHIP

<http://www4.uwm.edu/mcwp/programs/home-visiting.cfm>

WISCONSIN PYRAMID MODEL FOR SOCIAL EMOTIONAL COMPETENCE

www.collaboratingpartners.com/social-emotional-competence-sefel-pyramid.php

NATIONAL CENTER ON THE DEVELOPING CHILD, HARVARD UNIVERSITY

<http://developingchild.harvard.edu>

In Their Voices

Mothers shared their reflections on what they liked most about the groups:

“I like that we had time to play with our children, and I got to learn new things about her (my daughter).”

“I liked that I learned new things about babies that I didn't know.”

“They taught us how to focus more on our children. It makes me more aware and a better parent.”

“It benefits both of us; we learned how to interact more, and I learned the signs when she doesn't want to be bothered, and about different things she wants to do.”

We strongly believe that the PIWI framework applies to very diverse groups of parents, including those with trauma histories. In fact, it might be particularly relevant to the populations that experienced disruptions in relationships growing up.

It takes a community to raise a child, and it takes a community of professionals to implement a successful intervention strategy. This project would not be possible without the financial support of the Wisconsin Children's Trust Fund and the dedication of competent and visionary SaintA staff. However, our deepest appreciation and admiration goes to the mothers: the mothers who came consistently to the groups; who trusted us to try new things; who were able to share their worries, struggles, and successes

of motherhood; the mothers who sincerely wanted to be different from the mothers they had growing up, and we have good evidence to believe that they will be. ♡

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STACI SONTOSKI has been in the child abuse prevention/family support field for more than 20 years. Her direct service work has included home visitation and case management on an intensive basis for families with young children screened out of Child Protective Services and development and facilitation of different parenting programs with families of diverse populations. She currently works to support programs through professional development and technical assistance as the family support professional development manager through the University of Wisconsin—Milwaukee Helen Bader School of Social Welfare, Milwaukee Child Welfare Partnership.

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Tell Me A Story

A Literacy-Based Intervention to Help Children, Early Care Providers, and Parents Talk About Difficult Topics

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The Tell Me a Story (TMAS) practitioner, an early childhood education provider, gathers the 3- and 4-year-old children together for circle time to read a special story. She looks over at her colleague, confirming that they are ready to begin, and then quietly makes eye contact with each of the children that surround her. She places her hand on the back of a wiggling child to calm him and introduces the storybook, When Sophie Gets Angry—Really, Really Angry... (Bang, 1999).

While reading, the TMAS practitioner points out objects and encourages children to identify them: boat, puzzle, painting, house, mommy, sister. As the story unfolds, the children learn that Sophie really does get angry! When Sophie “roars” in anger, the TMAS practitioner asks the children to make a big “roar” and praises them for repeating it with gusto. With each exclamatory word from Sophie, the TMAS practitioner explains the meaning of the word and joins the children enthusiastically in repeating it.

“Roar! Explode! Pabam!”

Jayden settles in to his space and calls out excitedly,

“I yell when I’m angry too!”

The TMAS practitioner nods and repeats Jayden’s statement and then asks the other children to raise their hands if they have ever felt like yelling like Sophie. A small sea of hands shoots up into the air. She and Jayden cast a knowing glance at one another—everyone feels like yelling sometimes. Remembering an important tenet of TMAS—learn from the children—she asks if anyone ever gets really, really angry? And, what makes them so angry? The children nod their heads vigorously.

“It makes me angry when I can’t play police with my cousins because my mom won’t let me!” says Ayana.

The mental health consultant (MHC) asks Ayana what she does when she gets angry. Ayana replies,

“Sometimes I yell like Sophie, but Mommy gets mad and yells at me.”

The MHC nods while taking a mental note of each child’s response. She asks again if the children ever get really, really angry.

“It makes me mad when Grandma says I have to go to school when I want to stay at home and play with my baby brother, Joey,” says Michael, crossing his arms for emphasis.

The TMAS practitioner tells Michael that she understands how that could make him angry, and then looks around the circle for other children who have thoughts to share. One by one, she empathizes with each of the children who offer their experiences, pointing out common themes, and taking time to invite the quieter children to talk. She returns to the book.

“Let’s see what Sophie does,” she says.

In the story, Sophie begins to feel a little better after climbing a tree. Four-year-old Abby raises her hand and says,

“I don’t have a tree, but I hug my pillow really hard!” Abby squeezes her arms tightly around her pretend pillow.

The TMAS practitioner recalls a conversation with the MHC and her supervisor in which they talked about the importance of giving

children opportunities to come up with their own solutions for managing difficult situations. She decides that she will call on the children’s strengths rather than telling them what to do when they get angry and invites the children to problem-solve together.

She asks, “What helps you to feel better when you feel angry?”

The development of social, emotional, and self-regulatory competencies in young children is crucial for both their current and later development (Easterbrooks, Bartlett, Beeghly,

Abstract

The use of storytelling and discussion about difficult topics naturally lends itself to early skill development in both social-emotional and academic (i.e., emergent literacy) domains. In this article, the authors present initial information on the efficacy and feasibility of Tell Me A Story (TMAS), a program focused on supporting early childhood providers (e.g., infant and early childhood mental health consultants [MHCs], teachers, home visitors, family service providers, early intervention staff) in becoming skillful leaders of thoughtful conversations on social-emotional issues through book reading.



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Infants organize their emotional systems around social experiences with adults.

& Thompson, 2012). There is increasing evidence that social and emotional domains are essential not only to emotional health, but also to learning across language and cognitive developmental domains (Ayoub & Fischer, 2006). The current literature supports the notion that children's capacity to both experience and understand powerful emotions, and to be able to have and competently manage conversations about these emotions, represents important developmental competencies (Gilliom, Shaw, Beck, Schonberg, & Lukon, 2002; Gross & Thompson, 2007). Children become competent in these areas largely through interactions with their parents and other important adults (e.g., grandparents, child care providers, home visitors). Infants organize their emotional systems around social experiences with adults, rely heavily on help from attuned caregivers to manage their internal states (Tronick, 2010), and continue to need some regulatory support as toddlers and preschoolers (Beeghly, Fuentes, Liu, Delonis, & Tronick, 2011). Young children reference caregivers' emotional responses to situations and enlist them to achieve their social goals (Calkins & Hill, 2007; Campos & Stenberg, 1981; Saarni, 2010). Later, they gain emotion understanding directly from conversations with parents and other caregivers about their feelings (Shipman & Zeman, 1999, 2001). These skills in turn support pro-social behavior, empathy, social competence, and positive psychological adjustment (Cook, Greenberg, & Kusche, 1994; Denham, Renwick-DeBardi, & Hewes, 1994; Schultz, Izard, Ackerman, & Youngstrom, 2001).

Similarly, language and literacy are vehicles for learning competent emotional expression. A number of studies (Ayoub,

Vallotton, & Mastergeorge, 2011; Denham, Zoller, & Couchoud, 1994; Dunsmore & Karn, 2001; Taumpopeau & Ruffman, 2006) have shown that language-rich environments (e.g., exposure to vocabulary, verbalizations, and book reading) are positively associated with children's ability to talk about and understand their own feelings and others' emotional experiences, as well as to engage in successful peer interactions. For example, Ayoub and her colleagues found that children's language skills at 24 months old predicted their ability to self-regulate at 36 months old (Ayoub et al., 2011). In another study, Dunsmore and Karn (2001) found that preschoolers' knowledge of emotions was highest when their mothers used and highly valued emotion language.

Extrapolating from the scientific literature, as well as from our own research and experience in the Family Connections Mental Health Consultation and Professional Development Project (FCMHC; Beardslee, Avery, Ayoub, & Watts, 2009; Beardslee, Ayoub, Avery, Watts, & O'Carroll, 2010), we take the position that children gain a better understanding of their own feelings and how to regulate them when they have the opportunity to discuss literature that involves characters that respond appropriately to emotional situations. By *difficult matters*, we mean two different things: (a) issues and feelings that would be hard for anyone to talk about and (b) troubling incidents that arise in the community but do not tend to be discussed in early childhood settings or at home. Unfortunately, discussion of negative emotions and difficult matters seldom is addressed through curricular materials that promote the appropriate ways of engaging children in such dialogue.

A limited number of books for young children raise content related to difficult topics and the management of negative emotions. As a result, caregivers may lack critical resources when young children want to talk about harder topics (e.g., a mother who is too sad to get out of bed, an uncle who has gone to prison, a death in the family). In turn, young children have fewer strategies for participating in these important conversations. Without raising these painful issues in a safe and captivating way, young children may not have the means to practice expressing their feelings honestly and appropriately, nor to engage in thoughtful problem-solving.

History of the TMAS Approach

TMAS, A LITERACY-BASED intervention for supporting young children in the successful expression of their feelings and actions related to difficult topics, was developed from observations of circle time in early care settings. We realized what

a tremendous opportunity circle time presented, particularly for dealing systematically with topics that are difficult, as well as for very positive celebrations of children's feelings. We also noticed that it was hard for caregivers to respond to young children when they brought up difficult issues. We saw providers and family workers avoiding topics with their young charges, including parental sadness, anger, worry, exclusion, grief, and anxiety due to situations that included adult conflict, violence, and trauma. In response, we felt a need to interject opportunities for children to acknowledge their positive identities, to celebrate the skills that they have to cope with everyday issues, and to enhance their capacities for handling difficult situations and emotions.

TMAS was developed first in the context of delivering a preventive, system-wide mental health consultation and professional development system, the FCMHC. FCMHC was based on the work of Beardslee and colleagues in developing and implementing preventive interventions for families with parental depression. Crucial to that work was helping children and parents discuss difficult matters that previously had been un-discussable (Beardslee, 2002). Our work in developing and implementing mental health consultation and providing trainings for early care providers using the FCMHC model is described in further detail elsewhere (Beardslee et al., 2009; Beardslee et al., 2010).

The TMAS Program

OUR APPROACH DEVELOPED OVER several years through an interactive iterative partnership approach with a series of Early Head Start and Head Start programs. Initially, the TMAS work was done in the classroom by FCMHC MHCs. The MHCs also delivered the professional development component of TMAS to staff as part of the regular in-service offerings in their programs. Having skilled MHCs working with staff, families, and children provided support and reassurance for all that, if difficult topics were raised, they could be dealt with in competent ways. Through this process, we developed a series of TMAS professional workshops that include nine 2-hour trainings: three focused on using books, for providers or home visitors; three focused on engaging parents, for all staff; and three focused on understanding and working with families from different cultures.

In addition, we developed a series of training workshops for teachers, home visitors, family service providers, and MHCs (see box Tell Me a Story Workshop Modules). We adapted these workshops for use with parents in a way that mirrored the work with children and their providers. The TMAS

materials now comprise a set of Short Papers (see Learn More box), Lessons Learned (see box Tell Me a Story Lessons Learned), and Workshop Guides (Boston Children's Hospital, n.d.).

TELL ME A STORY WORKSHOP MODULES

The Tell Me a Story Workshops are designed to build skills by first encouraging participants to gain understanding of key concepts and then providing the opportunity to reflect on what those concepts bring to the participants' own program and work.

MODULE I

Introduction to Workshops for Teachers:

- Workshop One: Strategies for Talking With Children About Difficult Issues
- Workshop Two: Getting the Most out of Circle Time
- Workshop Three: Using the Tell Me a Story Book Guides

Introduction to Book Guides:

- Book Guide: *When Sophie Gets Angry—Really, Really, Angry...*
- Book Guide: *Jamaica Tag-Along*
- Book Guide: *When My Mom Is Sad*
- Book Guide: *Only You*
- Book Guide: *Knuffle Bunny Too*
- Book Guide: *Quinito's Neighborhood*

MODULE II

Introduction to Workshops for Families:

- Workshop One: Ways to Engage Families by Using Tell Me A Story in Your Classroom
- Workshop Two: Ways to Engage Families by Using Tell Me A Story in Your Center
- Workshop Three: Teachers and Parents Working Together: Delivering a Tell Me A Story Workshop to Parents

MODULE III

Introduction to Workshops Addressing Dual-Language Communities:

- Workshop One: Engaging Families Across Language and Culture
- Workshop Two: Engaging Dual-Language Learners in HS Preschool Classrooms
- Workshop Three: Creating Programs to Partner With Immigrant Parents

And we have learned that workshop leader preparation is key to a successful event. That preparation includes many levels, such as:

- Personal preparation to ready oneself to be fully present
- Preparation to review and reflect on the content and our own responses to the material
- Preparation of the materials and work space
- Knowledge of the participants, the community, or both

The TMAS program not only provides the vehicle for discussing difficult matters, but also builds enduring partnerships that are collaborative, interactive, and lead to the development of strengths and competence in children, parents, and staff while maintaining a focus on literacy. We have found TMAS to be a useful way to connect with providers, children, and families from the very beginning of a professional relationship. For example, we often use TMAS in the early stages of the mental health consultation process with early childhood programs. As an individual identified with expertise in social, emotional, and behavioral issues, the MHC naturally draws interest from providers, parents, and children about difficult subjects and how to handle them and, in this context, TMAS is a particularly helpful tool in the MHC's repertoire.

In a number of early care programs, we were able to form alliances by first partnering with staff around challenging matters that had arisen in the community and which had proved difficult to discuss. These typically involved episodes of community or family violence. We selected difficult topics that represented issues that were directly relevant to the community and, in this way, supported successful coping and problem-solving strategies around real issues that were relevant to the program. We learned repeatedly that crisis has to be seen as an opportunity.

We also found that it is often easier for adults to support children when the issues are distanced a bit, as they are in a storybook, rather than beginning with the feelings of the individuals involved. This approach opened the door to discussion by staff, children, and parents in a way that was sensitive to their fears and anxiety. It allowed some testing of feelings and ideas through fictional characters, and protected individuals from exposing their own feelings prematurely. Through TMAS, topics that relate to crises and tension in families and communities, including violence, anger, loss, and sadness, can be brought to the attentions of the listeners in a way that is manageable for all.

Implementing TMAS

IMPLEMENTING TMAS in early care settings occurs in phases. It is important that the adult presenting TMAS ("the TMAS practitioner") is familiar with the providers and children in each setting where the intervention will take place. For example, if the TMAS work is to be presented by an MHC in an early care and education program, the MHC begins by spending time in classrooms first. We found that early care providers who had an existing, ongoing relationship with the MHC that was built on trust were more likely to benefit from a mutual learning experience than if a relationship between the MHC and the provider had not been forged previously.

Second, while the TMAS practitioner is immersed in spending ongoing time in selected classrooms, the practitioner also dedicates time to training the center staff by presenting the modules for TMAS on a regular basis until the staff is comfortable with the TMAS process. Center-wide trainings conducted by the TMAS practitioner and developed with leadership help both set the tone for a culture that is responsive to the difficult emotional issues that arise in the lives of children and families and support the delivery of the TMAS program in classrooms and at home. Parent workshops may be held simultaneously or may begin when classroom implementation is in place. By receiving training while simultaneously participating in classroom readings, both early care providers and parents have reported feeling better equipped to address the social-emotional topics raised by the stories.

Third, we select classrooms on the basis of the early care providers' level of readiness to address social-emotional behaviors of children. Providers receive support so that they are prepared to talk about both positive and negative emotions, and they also are encouraged to show an interest in their own skill development and self-reflective capacities. After engaging in the training modules together, early care providers, the center director, and the TMAS practitioner develop a TMAS reading schedule. Generally, TMAS practitioners offer the program activities at least once a week for 3 weeks in a row, preferably on the same day of the week for consistency, and with the same book being read several times.

Overall, staff and parents found the approach safe and feasible to use in each of the six Early Head Start/Head Start programs where it was first implemented. In addition, MHCs encouraged far more discussion of emotional themes during TMAS circle sessions when compared to conventional circle time sessions in the same programs based on raters' reviews of videotape. Children used significantly more

TELL ME A STORY LESSONS LEARNED

Developing the Tell Me a Story (TMAS) Materials has provided us with many experiences from which to learn. The following is an effort to share some of the lessons we have learned from working with early childhood professionals trying to affect positive change in creating a more expressive environment in their classrooms and programs.

1. **A commitment to change requires leadership and collaboration to make circle time flourish.** TMAS materials are designed to focus on the early care providers facilitating circle time. That support has more impact when supervisors and program directors are engaged in improving the expressive environment.
2. **Early care providers and supervisors plan and implement the steps to be taken in order to target circle time as an activity for improvement.** Setting a variety of short-term and long-term goals based on the unique needs and strengths of each classroom and to acknowledge all levels of growth and success goes a long way to making TMAS a success.
3. **Early care providers benefit from additional opportunities to discuss integrating books with social-emotional themes at circle time with team members, a supervisor, or a mentor.** Self-reflection and shared

reflection build professional competence. Investing time in regular meetings to this purpose enhances the meaningful change in practice.

4. **It is important from the beginning to plan to incorporate high quality, culturally relevant books with social-emotional themes into the classroom curriculum.** High quality, culturally relevant children's books about emotions and social situations are an important investment. Children express themselves at different rates and in different ways. The more books shared, the greater the chance of building child engagement, professional skills, and confidence.
5. **Children are the best guides in this process.** The children are truly the greatest guides in improving TMAS. They let us know their preferences to stories or characters, and to social and emotional themes, through their conversations, play, and interactions.
6. **It is useful to think of the TMAS work with parents and children as mirroring one another.** When parents also have opportunities to learn TMAS and to use books to engage children at home, the impact of the work in the classrooms is magnified.

vocabulary related to their feelings in circle sessions compared to conventional circle time sessions. These findings were present both when MHCs and providers prompted the children and when they did not (Ayoub, Bartlett, & Beardslee, 2014). These initial study results offered confirmation that the TMAS intervention facilitates providers' and MHCs' discussions about difficult social-emotional themes with children, helps children discuss their feelings on sensitive topics and plan responsive actions, and encourages children to express their feelings in a comfortable setting.

How Do We Do It? Training to Deliver of the Components of TMAS

We begin with a series of interactive workshops, each about 90 minutes in length, to provide the basis for early care providers to think about developing an emotionally expressive space for children. Workshops are designed to allow participants working collaboratively with one another to gain understanding of key concepts—strategies

for talking to children about difficult issues, getting the most out of circle time, and using the TMAS book guides. Grounding in the basic concepts of the importance of social-emotional growth is critical. Consequently, many programs will precede this professional development series with a session like the one found in the FCHMC materials, entitled "Supporting Social-Emotional Growth" (Training Module 3). The workshops are experiential and provide an opportunity for participants to reflect on what the concepts presented bring to each person's and program's work. They are presented in order because each builds on what has been learned previously.

After providers have experienced the three-session module, they are ready for the implementation of TMAS. As previously noted, it is helpful for early care providers to have a role model for this work. An MHC is often a good candidate for the job, and we have found evidence of success using this model (Beardslee et al., 2009; Beardslee et al., 2010). However, TMAS is a flexible

system, and variations have been used effectively such as having master teachers, family service providers, home visitors, early intervention staff, and other well-trained early childhood professionals filling the role of the TMAS practitioner.

One choice that programs will want to make is whether or not to offer parallel parent workshops. In programs where parents are actively engaged, where there is an interest in bringing parents into the classroom with their children, and where there is a desire to extend the work in the classroom to other settings, such as the home, this can be an especially effective approach. The TMAS materials include workshops for parents, as well as extensive guidance for workshop leaders working with staff and parents (Boston Children's Hospital, n.d.).

Once providers are ready to begin doing the work of TMAS, the following general principles and guidelines apply:

- During the first and second session, the TMAS practitioner pays particular attention to circle time, as well as behaviors before, after, and during circle time; book choice; attachment; cultural relevance; conversations and interactions during story time; and transitions.
- After the second or third session, and as a result of consultation and discussions with providers, providers select a book and topic with the help of the TMAS practitioner. This book could be selected in response to an overall social-emotional theme in the classroom or a recent crisis. The TMAS practitioner discusses the providers' expectations such as what the providers would like to get out of TMAS and what the possibilities are for outreach and applying it across their curriculum.
- The TMAS practitioner makes adaptations to the book and reviews both possible activities and information for the providers to offer in the lesson plans.
- Repetitive reading
 - The reading of the story occurs three or four separate times, with each reading taking place once or twice a week. Repetition of the book is supported in that students, providers, and the classroom as a whole forms relationships with the story that grow and develop with each reading.
 - Repetitive readings of the story are important because:
 - Reading the same story multiple times allows children and staff to develop the relationships and attachments they are forming with the story;

- Every time the classroom reads the story they discover a detail or idea;
- The story is actually different each time, as the reader and listener are slightly changed;
- It models the importance of consistency and follow-up during classroom time;
- An increased comfort level and a sense of normalization are established as the story and topic are addressed on a weekly basis.
- Different activities that meet the classroom's needs typically occur before and after the story time (e.g., breathing exercises, science and art projects, puppets, role playing, gross motor, and music activities). Providers participate in the discussions and join the class on the rug.
- The early care providers are then trained through modeling and consultation in how to read social-emotional books that invite in conversations that may be challenging in order to continue TMAS once the TMAS practitioner moves to the next classroom.
- After the children have gone home, the TMAS practitioner provides consultation following each TMAS reading to debrief and process the reading of the story, the conversations that took place, and any challenges or feelings that came up within themselves as a result of the story. (See the Learn More box for examples of books that can be used.)

Case Examples of TMAS

HERE WE OFFER TWO examples of our work with children, providers, and parents using TMAS with *When Sophie Gets Angry—Really, Really Angry...* (Bang, 1999).

Example 1: A Challenging Classroom

The MHC walked into the toddler classroom for her second day with eight 2-year-olds. According to the lead teacher, many children had experienced serious loss, family trauma, and community violence, and had “issues with attachment.” The children often engaged in kicking, throwing chairs, biting, spitting, or hitting when frustrated.

The early care providers felt that having a large number of traumatized children in the classroom was disorganizing. Following the principles of TMAS, the MHC made sure to validate their feelings, while also helping them to identify ways in which the children had shown resilience and developed strategies to meet their needs, albeit not the most desirable strategies. The next day the providers and the MHC sat on the rug with the children and engaged everyone in story time.



PHOTO: KIVI STREET STUDIOS

Language and literacy are vehicles for learning competent emotional expression.

It was interesting that the children who exhibited the most challenging behaviors in the classroom were the most active participants in discussion. The children called out phrases from the story and showed their angry faces. They pretended to climb the tree with Sophie and made little bird “tweet tweet” noises and began to extinguish her anger. The providers smiled with pride as the children sat attentively and connected to the story. The discussion, so rich with words and noises, took up all of circle time. They read the story again the next week, as the MHC explained this would allow for opportunities to go more deeply into the story and into how children could cope with “big” feelings, with the children themselves leading the way.

After lunch on that first day of TMAS, as the children were getting ready for naptime, a child who had been identified as particularly difficult to settle down approached the MHC. He asked her if he could see the Sophie book and the MHC gave it to him. He sat on the floor and looked through each page, running his fingertips over the pictures as he turned the pages. He took the book to his cot and opened the book. Gently, he put his head on the page and fell asleep.

In a follow-up discussion with the providers, the MHC reviewed the day's activities. They talked at length about TMAS, how the children—even those who usually were not able to sit still—were able to remain engaged with the story. They made a plan to continue the multiple readings of the story and added into the curriculum a time for follow-up activities in the classroom. For the first time in quite a while, the providers felt a sense of competence.

Example 2: A Grandmother's Dilemma

A woman who is well-known in the community and is the guardian of two of her grandchildren, who are in the early care and

education program, approached the MHC in the resource room, checking in as she did regularly during early morning parent drop-in times. She reached out her hand and touched the MHC's hand, thanking her for reading “The Sophie Book” to her granddaughter, and for teaching her that it is okay to be angry. She said that her granddaughter tended to get very upset and, without a way to communicate or understand what she was feeling, she picked at her skin as a way to cope. Now, the grandmother reported, the girl walks around the house stomping her feet, telling her grandmother that she is angry like Sophie, giving them a chance to figure out the problem together before the girl could begin to hurt herself. She stopped picking at her skin, and her ability to let her grandmother know about her feelings and to talk about the things that upset her was improving, as was their time together at home.

Two weeks later, the MHC facilitated a parent workshop on communicating with children. The grandmother was in attendance and shared a story. Her granddaughter thought that she was angry with her for taking too long to get dressed. She was disturbed that her granddaughter thought this when she hadn't felt angry. The MHC described the child's behavior—stomping her feet—to reflect on how the granddaughter has learned to show she is angry, and asked the grandmother what she did when she was angry. The grandmother said that she uses a frustrated tone of voice and stomps out of the room. The MHC reflected on the similarities between Sophie's behavior and the grandmother's. The grandmother began to cry as her feelings about the morning's events shifted from anger and confusion to amazement at how perceptive children were about adults' emotional states. Her granddaughter was right—she had been angry.

PHOTO COURTESY OF POLKSON BAND HEAD START PROGRAM



Children used significantly more vocabulary related to their feelings in circle sessions compared to conventional circle time sessions.

The MHC invited the grandmother to a workshop on TMAS and gave her a copy of the Sophie book to read with her granddaughter. The grandmother commented that reading the book was less intimidating than trying to have a direct conversation. The next week she attended a morning coffee group and reflected on a conversation she had with her granddaughter at the dinner table after reading the book together. They had talked about how to handle hard feelings. For the first time, the grandmother felt she could address the anger in their house openly, working to repair and recover after conflict arose at home.

The primary goal of getting early care providers to talk to one another and to the children they serve often involves providers talking about their own enjoyment of reading and their use of reading to both relax and learn. These discussions are one important focus in the training modules and in the classroom demonstrations. Overall, we emphasize key principles for individual practice in both formal training and demonstration in the classroom, such as:

- Choose the book carefully and read it ahead of time;
- Include consideration of group size and how to make it work—whole class, small group, and individual session.
- In general, when reading the book and leading a discussion, draw attention to illustrations, especially facial expressions of the characters.

- Use your voice, body language, and facial expressions to keep children engaged.

In addition, early childhood programs work with families from diverse backgrounds, and considering the cultural and educational background of the parent and family is critical. For example, parents who speak English as a second language may not be comfortable reading in English. Or, families may be fluent in speaking their native language, but not in reading it. Moreover, if parents have difficulty reading on their own, they may be hesitant to try to read to their child. Sensitivity to these issues is important, and the TMAS process may be varied or adapted to meet families' needs. To support early care providers' work with diverse families, we have incorporated culture and language throughout the TMAS materials, including one of the modules (see box Tell Me a Story Workshop Modules, Module 3) and a Short Paper (see Learn More box, Short Paper Six). Further, all FCHMC and TMAS materials are available in both English and Spanish.

Additional principles of TMAS apply to classroom management:

- Recognize that all staff in the room should work as a team to support circle time.
- Understand that productive conversations require practice and encouragement; model for the children the behaviors you would like to see such as being focused on the book and the

discussion, directing attention to the child who is speaking, and reminding the others not to interrupt; make sure a variety of children speak, and be prepared for some of the children to remain quiet.

- Use open-ended questions to help stimulate the conversation. "What did you like about this book? What was your favorite part?" Using questions collectively in the group encourages listening, as well as discussion. Doing it in dyads (e.g., parent-child, home visitor-child) inspires useful dialogues about coping with social-emotional challenges and supports positive interactions between adults and children while simultaneously supporting young children's literacy skills.

For us, what began as a simple search for developmentally appropriate picture books on social-emotional topics led to the discovery of a gap in training and skills for providers and parents about how to have discussions with children about difficult topics. While many fine picture books exist, none address the fact that, often times, adults are very unclear about how to have a discussion about difficult topics and may need support in getting such communication started. We also found that, although a few books describe parental depression, none are designed to help very young children understand this experience. As a result, we wrote *When My Mom Is Sad* (Avery & Beardslee, 2009) to offer reflections on how children of depressed parents may feel. In addition, we developed TMAS Book Guides (Avery, Beardslee, Ayoub, Callejas, & Watts, 2012) to offer providers and parents templates for sharing books on social-emotional topics effectively and for extending the book to activities and dialogue that promote emotional expressiveness and support positive self-regulation. The TMAS workshops were developed to enhance providers', and then parents', efforts to make both school and home places in which children feel safe talking about their feelings.

In some programs, involvement in reading became an exciting center-wide activity. In one case, after an incident of community violence, an early childhood MHC (who had worked at a site for 3 years creating a safe and supportive environment) held a conversation not just about the trauma following the event, but also about other violent experiences in the community. Parent workshops and community outreach were key components of this work. Over 3 years, many opportunities for parents to meet in informal and formal workshop settings including coffee groups, open houses, resource fairs, and consultation services, promoted engagement. Social service supervisors, the mental health supervisor,

and the TMAS practitioner created a workshop series for all caregivers and children in the community using TMAS as a way to share stories of strength, resilience, and overcoming adversity (this work was supported by Boston Community Partnerships and by the Massachusetts Department of Early Education and Care).

In other cases, stories were presented first and then families shared their own experiences. For example, one program organized TMAS around *When Sophie Gets Angry—Really, Really Angry....* The work focused on the plot, and on Sophie, her family, Sophie's feeling, coping strategies, a connection with a little girl who is angry, and how both adults and children can recognize and deal with these powerful feelings. Some children talked about Sophie and were enthusiastic about imitating the sounds of her anger. When the book was read with both parents and children, several parents smiled as they exchanged and acknowledged what happens when Sophie gets angry. Following the book reading, there was a lively conversation with children and parents about how children could find ways to let their families know they were angry and also do it in a safe way. Parents talked about how they would read the book again at home. Several parents commented that they now had a way to open the conversation about difficult feelings in a way that engaged their child rather than criticized them. Other family members commented on what they do when they get angry. At the end, each family was given their own copy of the book to read at home. Children became very enthusiastic and made model volcanoes in class out of papier-mâché and painted them to express what Sophie was feeling. Formal evaluation suggested that this had been quite a positive experience. This center-wide activity opened up larger discussions, with several parents asking the MHC how to continue the work.

Adapting TMAS for Home Visitation

The same principles that we offer for TMAS in the classroom can be applied for use during home visits. The advantage to offering TMAS in the home is that the home visitor can simultaneously engage the child and work with the parent. In order to engage in a successful TMAS session with a parent and child, it is important to prepare the parent for the process. Using materials from the parent workshop with the individual family members in the home is the first step. Often it is helpful for the parent to help select the first book. Parents may have different comfort levels and skills with reading to their children, and demonstration by the home visitor is important.

The Importance of Sharing Our Stories

BEING WILLING TO hear others' stories is essential for both adults and young children. Inevitably our experience has been that parents, early care providers, and children have stories to tell about the adversities that affect their lives. Yet, many early care providers and leaders do not feel equipped to respond to children or their families when difficult emotions surface as a result of traumatic experiences. Verbal skill building and social-emotional or self-regulatory competence are two of the most important developmental tasks of children between 2 and 6 years old. These two developmental domains are affected by trauma and adversity in negative ways (Ayoub, Bartlett, & Swartz, 2014). Encouraging literacy through meaningful verbal exchange while enhancing emotional expressiveness and self-regulation has tremendous joint value for the child and adult involved. It is a program that supports adults to be prepared to listen genuinely to difficult stories, to encourage their expression, and to model and promote appropriate responses related to emotional expressiveness and positive self-regulatory skills in children. TMAS also provides a system of professional development for parents and early care providers that improves their confidence and competence in engaging in this process.

When literacy and social-emotional development are addressed together in one intervention, it can change the nature of the verbal and emotional exchange and build positive attachment and trust between the important adults in each child's life. This is accomplished through TMAS by making explicit to young children that there is a way to talk about difficult matters in a safe and healthy way by planning ahead, by providing intentional information that is helpful about what a difficult situation might be, by linking general information to the specific experiences in the lives of the participants, and by offering a safe and active way to help children practice the skills that they need to talk about and to regulate their actions when difficult issues arise. In our work, we have implemented TMAS within the context of mental health consultation using the FCMHC model. Although TMAS has been available as a free-standing intervention, and has been used as such by a number of early childhood programs, the presence of an organized model of mental health consultation and training does serve to support its full implementation. The ongoing presence of an MHC in early childhood classrooms, as described in the FCHMC model (Beardslee et al., 2009; Beardslee et al., 2010), allows trust to develop between providers and the MHC, MHC and children, MHC

and parents, and among the providers themselves. Sometimes, the presence of the MHC helps providers to engage in discussions with each other that would not ordinarily take place.

In our overall work with both TMAS and FCHMC, several major themes have emerged. The first is the value of self-reflection and

Learn More

Tell Me a Story Short Papers

In an effort to provide selected supportive materials, we have included the following short papers, originally part of the Family Connections Mental Health Consultation and Professional Development Project materials. These papers, and other resources can be retrieved from www.childrenshospital.org/clinician-resources/family-connections/for-professionals/short-papers-for-staff

SHORT PAPER ONE: Better Parent Communication: What Do I Say When a Parent Tells Me Something Difficult?

SHORT PAPER TWO: Better Communication With Children: Responding to Challenging Subjects

SHORT PAPER THREE: Parenting, Depression, and Hope: Reaching Out to Families Facing Adversity

SHORT PAPER FOUR: Foster Resilience in Families Coping With Depression: Practical Ways Head Start Staff Can Help Families Build on Their Power to Cope

SHORT PAPER FIVE: Understanding Depression Across Cultures

SHORT PAPER SIX: Communicating Across Language and Culture: How Do I Reach out to Parents Who Are Immigrants?

SHORT PAPER SEVEN: Encouraging an Expressive Environment: Supportive Communication From the Inside Out

SHORT PAPER EIGHT: Self-Reflection and Shared Reflection as Professional Tools

Books that can be used to talk with children include the following:

WHEN MY MOM IS SAD

M. Avery, C. Ayoub, W. Beardslee, & C. Watts (2012)

Family Connections Project Materials, (2nd ed.). The Early Childhood Learning & Knowledge Center, Office for Head Start, <http://eclkc.ohs.acf.hhs.gov/hslc>

WHEN SOPHIE GETS ANGRY—REALLY, REALLY ANGRY

M. Bang (2004). New York, NY: Scholastic Paperbacks.

QUINITO'S NEIGHBORHOOD/EL VECINDARIO DE QUINITO

I. Cumpiano, J. Ramirez (Illustrator) (2009) New York, NY: Childrens Book Press.

self-understanding. The use of the same book repetitively, so that it can be seen in different ways by children and by parents, offers a tremendous opportunity for self-reflection and shared-reflection. More generally, the purpose of the professional development series is to have early care providers reflect on their experiences individually and in a shared way; second, they are asked to think about how reflection combined with knowledge and shared purpose can improve their practice. In our direct work with staff and parents, we encourage keeping journals, reflecting, and remembering. In the training of mental health professionals, self-reflection and self-understanding are critically important; they comprise a crucial dimension of continuous improvement. This is true in related mental health depression programs as well (Beardslee, 1998).

A second key dimension of TMAS is self-care. Whenever we talk about adversities, trauma, and the difficult emotions they engender, we must make sure that the adults are taking care of themselves. Our MHCs are able to emphasize this through professional development and direct consultation with providers, and with support for parents. Each component is tailored to fit the needs of providers and programs. These approaches help build trust and often lead to conversations with adults that support their own mental health.

What is very difficult to talk about is unexpected, episodic, terrifying community violence, and yet talking about that has proved absolutely essential in our program. To be able to both help others and have credibility in talking about difficult matters, one has to talk about the most painful of issues. In one center, an alliance was built only after the MHC was able to help the center deal with a murder-suicide that occurred in the community. In the original work in FCMHC, shots being fired in the community when the children were out on a walk provided the occasion for a center-wide meeting to talk about community violence and how the children would be protected. MHCs used TMAS to begin a conversation about the children's reactions to the incident, as well as a way to support early care providers in talking to the children and their parents about their feelings of fear and lack of safety. They then were able to work both with children in the classroom

to increase feelings for safety and with families to engage in dialogue and act on joint plans to improve safety in the center.

We believe that being concerned about language, literacy, and narrative (stories) is an essential part of practice in early childhood settings. Our experience has been that there is great enthusiasm when, with careful preparation, books about difficult matters are read with children, and when early care providers are given opportunities for conversations and professional development about difficult matters. TMAS has been a highly useful program for accomplishing these aims. §

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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
Acculturative Stress	Acculturative stress, commonly referred to as “culture shock,” arises when a person tries to balance differences between the new dominant culture and the one from the country of origin. [Find it in Velasco-Hodgson & Kaplan-Sanoff, page 25]
Child–Parent Psychotherapy (CPP)	Child–Parent Psychotherapy (CPP) is an evidence-based treatment for children from birth to 6 years old who have been exposed to interpersonal violence and multiple traumatic events. [Find it in Moore & Osofsky, page 9]
Circle of Security Parenting®	Circle of Security Parenting® is a parent education program offering the core components of the Circle of Security® protocol through video examples of secure and problematic parent–child interaction, healthy options in caregiving, and animated graphics designed to clarify principles central to COS. Circle of Security Parenting integrates decades of attachment research in an accessible step-by-step process for use in group settings, home visitation, or individual counseling. [Find it in Murphy & Mendez, page 20]
Patient Navigation	Patient navigation, a tool that can be used to help address the needs of underserved families, was first developed as an approach to improving care for the underserved by Dr. Harold Freeman in the 1990s (Freeman, 2013). Initially developed to address disparities in cancer care among inner city adults in Harlem, patient navigation has become an integrated part of many cancer programs across the U.S. [Find it in Blenner, Fernández, Giron, Grossman, & Augustyn, page 4]
The Pyramid Model	The Center on Social and Emotional Foundations for Early Learning (CSEFEL) developed the Pyramid Model framework to promote social and emotional competence in infants and young children. This framework is grounded on the notion that optimal development is only possible within nurturing and supportive relationships. [Find it in Nenide & Sontoski, page 31].

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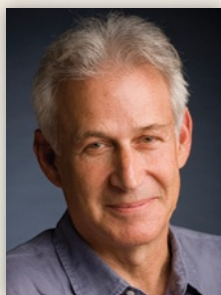
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