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INFANTS IN THE MIDST OF TURMOIL

Enhancing Resilience In Mothers Of Infants

Workshop For Mothers And Infants In War Zones

By

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INTRODUCTION

War broke out on Israel's northern border in the summer of 2006. Within a few hours, the entire population of northern Israel numbering tens of thousands was being bombed by Katyusha rockets. This unexpected war came as a total shock to the population of the north, causing panic to both Jews and Arabs, as they were quite unprepared for it, both

physically and emotionally. Within a short time, the danger to citizens' lives became more and more apparent; the bombings increased and became more widespread.

The breakout of war at the height of the summer found the children of the north in the middle of their summer vacation, thus rendering parents unable to be assisted by facilities usually provided by schools, and every family had to quickly come up with its own solution for the sudden state of emergency. Meanwhile, damage to property and lives increased, and this included injury to children. Some families were forced to leave their homes and make their way to the center of the country, with a sense of uncertainty about the future. Others who did not have that option, were obliged to stay at home, but there were also families who chose to remain in the bombarded areas together with their children. This caused families and children to cope with extremely difficult situations, sometimes very dangerous ones.

Sahar, the mother of three children between the ages of four and nine, lives with her family in an Arab village which was also under constant attack. She describes what happened: "I went out to work every morning, I had no choice. My older son, aged 9, took care of his brother. I locked them

in the house so that they wouldn't wander around outdoors. Because our village doesn't have an air raid warning system, I phoned home every time I heard the siren in the town where I worked, and told the children to go into the protected room".

Simcha, a Jewish mother of two children aged 3 and 6, who works in the hospital, was bound by an Emergency Order requiring her to report each morning for work, like many others. The hospital had set up a babysitting facility for the children of employees, and Simcha arrived at work every morning after a twenty-minute drive under threat of Katyusha explosions. She was in her sixth month of pregnancy at the time. She says: "One morning, as I was driving with the children, I heard the air raid siren. I stopped the car at once, quickly took the children out of the car, and the three of us lay face down on the road next to the car, as per the instructions given by the media. I don't think the children really understood the danger we were in. I tried to make it into a game, even though I was almost paralyzed with fear. Of course it took me a long time to calm down".

The war lasted about a month. As it went on, many families were forced to move from one place to another, to find themselves a new place of refuge,

Contents

- 1 Kanotopsky: Enhancing resilience in mothers of infants workshop for mothers and infants in war zones
- 8 Editor's Perspective
- 10 Khamis-Zoabi: The Israeli-Palestinian conflict seen from the Arab young child's and parents' eyes
- 13 Guarino & Bassuk: Working with families experiencing homelessness: understanding trauma and its impact
- 23 From the Kauppi Campus

and many even decided to return home after an exhausting and confusing period spent wandering from place to place. This is what happened to the family of Gili, a mother of three living in a kibbutz in the north of Israel. "We left the kibbutz in a hurry the day after the war began, prepared to stay away from home for a few days. We went to stay with friends who live about half an hour away. The following morning, after a sleepless night during which the bombs were exploding there too, it was clear that we had to go further away. We went down to the south of Israel, and every few days, we went somewhere else. We were homeless. After two weeks of this, I was fed up and decided to go back home to the kibbutz. The kibbutz looked like a huge army camp, and the noise was unbearable: the blasts from the rockets coming from Lebanon, and the artillery fire from our army. But in spite of the chaos we had a routine. We were in our own home and that was the main thing, but when I think of it with hindsight, it was like a nightmare! I was in a constant state of anxiety about the children's safety. I was afraid something would happen to them and I knew that if it did, I would never forgive myself. But at the same time, at least we were at home, and a home is a home, it's a secure place".

When the war ended, life in the north returned to normal. The general population, and the parent population as part of it, was forced to function again as if nothing had happened. This meant an abrupt and instant transition, without any period of gradual adjustment, from the role of mothering during an emergency back to coping with a normal routine.

GROUP BACKGROUND:

The idea of planning a project involving mothers and infants after the war, emerged from two types of professional impressions:

1. Clinical meetings with parents made us realize that parental coping was very challenging and complex both during and after the war. However, within the maternal population, mothers of infants and small children constituted a unique group whose complex experiences should be considered separately. The complexity derives from a dual relationship existing on the part of

the adult world with infancy. On the one hand, the fact that the baby or the small child is at a pre-verbal developmental stage, lacking the ability to communicate freely, makes it difficult to understand his inner world, and makes it hard for the mother to identify the source of his distress.

On the other hand, a widely accepted concept maintains that infants are in such a preliminary stage of development that they lack the ability to absorb and understand the events of external reality. This approach is based on the idealization of the world of infants, according to which the baby functions according to its basic needs, and if these are provided, changes in the external reality will have minimal effect on the infant. Time and again, we come across statements that infants "do not understand", and if so, they do not feel or experience. We, as mental health professionals caring for babies are surprised to find that this line of thinking as expressed not only by laymen, but is also popular amongst professionals working in various therapeutic areas.

In his writings, Winnicott (1965) relates to the mother as the best expert in understanding her baby, and emphasizes the importance of empowering the maternal role in the development of the child, in comparison to the role of professionals. Indeed, many mothers, with their natural healthy intuition, clearly sense the baby's active ability to participate in the real world. Clinical experience indicates that difficult life experiences are liable to weaken the natural intuitive ability of the parent to "read" his or her baby, and thus create a misattunement between the two. If reality becomes difficult and causes acute stress, mothers find it harder to identify their babies' need and will be less available for them.

2. Meetings with community professionals (pediatricians, nurses at community clinics, nurses in baby clinics, managers of daycare centers, social workers) in the immediate period following the war, emphasized a few additional facts:

- Mothers express more stress in their daily routine.
- A great increase in referral of babies to pediatricians about symptoms worrying the mothers

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- Community professionals expressed lack of expertise in dealing with stressful events involving parents.

Clinical work in the first post-war months showed that many parents felt dissatisfied with the way they coped as parents during the war. As a result, they felt insecure about their ability to cope in similar situations in the future.

These understandings led us to plan a project for mothers of infants and young children to empower their maternal capabilities and expand their coping repertoire when faced with situations involving tension and stress. The aim was prevention, rather than treatment. At the sixth world congress of the WAIMH in Finland in 1996, Peter Fonagy spoke of prevention as the main target of infant psychotherapy. He appealed to society in general and to therapists and researchers in mental health, to invest in the welfare of babies. Clearly and concisely, he maintained that caring for the mental health of babies is the key to preventing emotional disorders throughout life. These words gave us the impetus to develop our own insights and to reach out to this specific group of mothers who experienced the war but did not suffer direct traumatic events and who were not diagnosed as post-traumatic.

Each group was composed of 5-7 mother-baby dyads and two therapists. The presence of the baby/infant was a precondition for participation in the group. Each group consisted of 10-12 sessions. After 6 sessions each dyad was videotaped separately for 10-15 minutes. Mother and therapists watched the video together and discussed it.

The groups were held in Kiryat Shmonah and in Tzfat, two towns that were heavily bombarded during the war. Kiryat Shmona has a long history of years of constant bombardment and a great number of the mothers in the groups were born and brought up in war-like life.

GROUP PROCEDURE PROCEEDED ALONG TWO CENTRAL LINES

1) Group discussion
Expressing feelings, tensions and fears, sharing personal conflicts with the group, was the first goal. It brought about an immediate relief of guilt feelings, of shame, and feelings of anger with themselves and their children. Group discussion facilitated the mentalization process (Fonagy 1991) and enabled the mother to think of the infant as a separate entity, person with intentions and thoughts of its own.

In this process, special emphasis was placed on maintaining a balance between discussing mothers' stresses and babies' needs. Many times, this procedure brought about an immediate change in mother-baby interaction followed by a growing sense of mutual enjoyment.

S., an orthodox-religious young woman, shares with the group great emotional difficulties she encountered during her pregnancy. She met her husband through a matchmaker and was married soon afterwards. The pregnancy that immediately followed, was actually a period of building the relationship. The couple had a hard time adapting simultaneously to the pregnancy and to each other. "I was constantly thinking about intimacy, pregnancy and divorce, all at the same time".

Z., who comes from a completely different background, immediately joins in, and tells the group of the great tension between her and her spouse during her pregnancy. This tension heightened her anxiety and made her fearful of the life awaiting her, "bringing up a child on her own". This dialogue between these two very different women, created a very special intimacy that affected the rest. Lying between the mothers, the two babies found a common interest in the same toy. The therapists make note of this parallel joint experience between the two mothers and the two babies. The group watches quietly. The mothers are watching contentedly, smiling.

2. OBSERVING AND WATCHING THE INFANTS

The ability to watch a baby seemed to be a main component in strengthening the emotional resilience of mothers of babies. The maternal role requires the ability to observe the other as a separate entity. Jessica Benjamin (2005) discusses the importance of mutual recognition in the development of a mother-baby relationship. In this developing relationship between these two partners, there is also a third partner, not necessarily an additional person or anything tangible, but rather an organizing principle that allows the relationship to become recognized and mutual. The existence of a third person creates an intersubjective symbolic space. As the infant grows, the mother is the one who must represent the wish for that third, for the idea that organizes the relationship. Thus, the mother keeps simultaneously the desire for her own subjectivity, her awareness of her child's needs, and the empathetic knowledge of her child's experience.

We felt that observation can become a facilitating tool both for the acquisition of mutual recognition and the process of mentalization.

In groups composed of dyads, there are expanded possibilities for observation:

Mother observes her infant
Mother observes other infants
Mother observes other mother-infant dyads.

In our groups, we chose to add another aspect of observation. Halfway through the sessions, every mother-baby dyad was video-taped for 10-15 minutes in free play, after which mother and therapists watched the videotape together. This allowed for another aspect of observation:

Mother observes herself and her baby

In her work, Susan McDonough uses this technique of filming the family and joint observation with the therapist as part of therapeutic intervention. She notes that by means of such observation of the interaction, the parents become more aware both of the positive interactive behaviors that we, as therapists, want to encourage, improve and expand, and the interactions that are less enjoyable or suitable that need to be redirected, changed or disposed of. Observation by means of videos also allows parents

to take notice of what they say to the child and how they say it.

AIMS OF THE GROUPS:

Preventive work with mothers

- 1) To facilitate and improve mothers' **ability to observe** their children
- 2) To identify **behavioral characteristics** that are indicative of existing stress in adults and children
- 3) to identify **coping patterns** in anxiety states
- 4) To learn how to acquire **self-relaxation and self-regulation** in anxiety states

In presenting the work with our groups, we chose to focus on a number of issues:

- 1) The significance of the **infants' presence** in the sessions
- 2) The importance of **observation** in developing emotional resilience
- 3) **Daily pressures** vis-à-vis the pressures of wartime
- 4) The role of the **therapists**

1. SIGNIFICANCE OF THE INFANT'S PRESENCE IN THE SESSIONS

The actual presence of the baby in therapy with mothers has been used to develop a new line of therapeutic thought. Today different approaches of dyadic parent-infant therapy are becoming more and more familiar (Watillon 1993; Lieberman & Pawl, 1993).

At first, most mothers questioned our request for babies to be present, but soon realized the great advantage of it.

The significance of the baby's presence could be divided into two parts:

THE ADVANTAGE FOR THE DYAD:

The baby's presence gives a special quality to the issues raised in the room, and is a central component in the emotional processes mothers go through in the group. Very frequently, anxiety expressed by the mother brought about an immediate special reaction of the infant. These were powerful situations, usually causing great excitement and making the maternal insight more acute. Every

time this happened, the mothers were astonished by the amazing sensitive ability displayed by these non-verbal babies.

T. shares with the group a dilemma she had about the choice of day care for her daughter. She tells the group how hard this decision is for her since it could mean a lot for her daughter. She has to make a choice between the voice of professionals recommending that she should be transferred to a group of older children and her inner voice that advises her to keep her daughter in a small, protected, warmer day care. As she tells her story she begins to show stressful reactions, her voice starts to shake, her body becomes tense and she looks nervous. She expresses an extreme sense of "there's no way out" and finds it difficult to be attentive to the comforting that other mothers are trying to give.

All of a sudden, the little girl crawls over to her mother, climbs into her arms, and becomes irritable and agitated, causing the mother to stop talking and to direct her full attention to her. Mother takes out a bottle and begins to feed the baby. The therapists note that the baby was drawn into the mother's distress. The mother, however, seemed to be comforted from her own distress by taking care of her daughter. The dyad detaches from the group and become more involved with one another. The therapists describe the story to the group and reflect the stress that is created by situations in which the mother has to make a choice. They turn to the mother and talk about the pain that arose, and reflect the parallel process formed between the mother's distress and that of the baby.

They emphasize the important place the mother has in containing and consoling, whatever choice she makes. At the following session, T. shares with the group that she has decided to listen to her inner voice. She sounds proud of herself. It seemed that bringing up her dilemma with the group and making the connection between her distress and that of her baby, gave her an insight that facilitated her decision. In addition, the process gave her a sense of empowerment and increased her confidence in her ability to make decisions as a responsible mother. In another group, S. expresses

her disappointment that her seven month-old baby son does not show any particular preference for her, and relates to other female family members, her mother and her sister, the same way. She describes how she yearns to "be special" for her baby, and how painful this situation is for her. The group starts asking her questions, S. is quiet, finds it hard to talk. A minute later, she starts crying. The baby climbs into her lap and clings to her. The mother is overtaken by emotion, and the therapist addresses the non-verbal "speech" by which the baby expressed his special relationship with his mother.

THE ADVANTAGE FOR THE GROUP:

The baby's presence was important for two reasons

1. Observation of the babies as a group, with the guidance of the therapists, created a wide space for the individuals in the group. The mothers could move within the group between being involved and active to a more distant role of watching and observing
2. The intensifying formative process in the group of the mothers brought about a parallel process within the group of babies. Many a time one could see an inner circle of babies within an outer circle of mothers. The experience of gaining strength by being a part of a group, made it clear for the mothers that their babies were actually experiencing a similar experience. They realized that the babies, too, were a group in their own right. As a result, they found it easier to move about individual watching their own baby or other babies, and at the same time, observing them as a separate group.

In one of the sessions, the subject of discussion was maternal competence. H, who was born in Kiryat Shmonah, and often raises the subject of her childhood in the shadow of Katyusha explosions, became very agitated about the topic of competence. She raises many doubts about how she functions as a mother, and asks the group to strengthen her as a "mother who knows". The group tries to understand why she finds this issue so distressing. The mother begins to talk about her traumatic first experience as a mother – A birth to a premature baby, lengthy hospitalization and the anxiety from which she suffered regarding the baby's survival. She

describes herself as an “over-protective” mother, associating this with the traumatic birth. She gathers up her baby into her arms while talking, and suddenly becomes restless and has breathing difficulties. The therapist goes over to her, holds her physically, and guides her how to breathe and relax. The group watches quietly. What they see is “a mother holding a mother holding a baby”. H. calms down helped by the support and reinforcement she receives from the group. The therapists address the group and reflect upon what H. and the group went through. They ask H. to say what she feels. “I know I can. I am a good mother”. The group echoes her words. The atmosphere is very calm. Meanwhile, the group of infants in the inner circle are undergoing a similar process. The calm exuded by the mothers has an immediate impact on the babies.

This process shows how the group of mothers undergoes a reinforcing experience that develops into calmness and self-empowerment. This experience is instantly transmitted to the babies, separately to each baby, and together as a group that is self-contained and forming a single voice. The mothers identified this parallel process, and the group is unanimous regarding the shared insight about their babies’ sensitive ability to understand and internalize emotional states on a complex level.

2. THE IMPORTANCE OF OBSERVATION

Observation, was found to be of great significance in facilitating group process. During the course of the sessions, mothers underwent an important in their ability to watch and observe. However, from the beginning on, we saw striking differences between mothers in their ability to be an observer. Mothers under high levels of pressure, were limited and rigid in their ability to adjust to the role of an observer. They showed this inability in all the various observations (observing her baby, other babies, dyads, and videotapes of her own dyad).

Our last group meeting, was a group of single mothers all referred to us by the social welfare department. Social workers described these women as coping with difficult life situations. In this group, the atmosphere was highly-strung and often the topics brought up

were surprisingly extreme.

L. arrives with her 15 month-old daughter. She describes her difficult separation from her spouse after a period of extreme violence during her pregnancy. She tells her story in a very restraint and distant manner. As L. is telling her story, her daughter is wandering around the room. She does not play with the toys and is constantly on the move. All of a sudden, she approaches a baby playing peacefully on the mat, and pulls his hair. This aggressive behavior repeats itself again and again. The mother’s reaction is very minimal, saying “no, don’t”, but doing nothing else. A few minutes later, the toddler tries climbing up on the mats piled in the corner of the room. Again, we witness the lack of an appropriate response by the mother. The mother seemed incapable of relating and reacting although she was clearly watching her daughter. The therapists had to intervene directly to ensure the safety of her daughter and that of the other children.

In this group, we found that the mothers had a much lower ability for observation and watching. The ongoing experience of stress seemed to create a state where the mothers had a diminished ability to observe their children. Prof. Claude Shem Tov (2005) from New York relates to this phenomenon in therapeutic intervention with young children and their parents after 9/11. He maintains that mothers who have undergone a threatening traumatic experience, be it single or ongoing, behave in a survival mode that causes a decrease in responsiveness level. These mothers are not really available for their babies.

This group of high pressured mothers enabled us to experience together with them the amazing ability to change. Surprisingly enough, we saw a significant change after watching a video of themselves with their baby. A joint observation of them interacting with their child, enabled insights, that were an expression of their yearning to be “good mothers”. Watching the video with a mother figure who is attentive and watchful of positive maternal behaviors, created a gentle ambience that allowed the mothers to let go to some extent of the survival mode, and expand their ability to observe.

L. is the mother of Y. a 2 year old toddler. Y. moves around always holding a bottle in his mouth, biting it with his teeth, hands free to play. In the video watched by the mother and the therapists, Y. can be seen walking around the room, looking around, exploring. Suddenly he approaches his mother and lays down on her lap. He puts his hand down under his mother’s dress, reaches her breast, and starts playing with her nipple. L. explains that Y. Is constantly doing this; she does not remember since when, but does not consider it anything unusual. The therapist inquires about the period of infancy and nursing. L. suddenly becomes agitated, raising her voice: “I don’t know, I never thought about it but maybe it has to do with the way he stopped nursing”. She tells a horrifying story, how her spouse, after their separation, broke into her home while she was nursing, and kidnapped her 8 month old baby straight from her breast. L. did not see her baby for the following 3 months until the police found his hiding place and returned the baby home. “There was no weaning. He was literally torn from my breast. Could this be the reason he always wants a nipple in his mouth, and holds on to my nipple so that it won’t be taken away from him?”. This was a very inspiring and moving insight for L. She never had the chance to think of this event until she became the observer of the scene. The stories related by L. and by the other participants showed us that mothers can be helped to improve their own observation ability and become more attentive to their children’s distress.

3. DAILY PRESSURES VIS-À-VIS THE PRESSURES OF WARTIME

Will coping with daily stress situations prepare mothers to cope with wartime?

In our first groups, maternal coping with the war took a more central place, but despite this, mothers showed a marked preference to bring up topics from their daily routine. In almost all the following groups, bringing up issues having to do with war-time was less welcomed. Mothers were more eager to use the group experience as a source of support for every-day stresses and tensions. There are a

number of reasons for this:

- The time that had passed since the war.
- Many of the mothers had been pregnant during the war, which meant that at time of war, they were dealing with a fantasmatic baby, not a real one.
- The presence of the baby in the room was a constant reminder to present coping and the need to find solutions to existing dilemmas
- Most mothers in our groups were mothers of firstborn. Many women see this as a cause of constant stress, lacking a sense of confidence, and concerned about their ability to fulfill this role. They need support in their present life which is often experienced as dramatic and intense in itself.

Our conclusion is that coping with stressful daily situations efficiently, could strengthen emotional resilience amongst mothers of infants. Focusing exclusively on stressful war-related situations was perceived as being too threatening. In order to preserve the stability of the maternal role, mothers tend to make a split between routine time and wartime, and do not see the connection between the coping processes in the two types of situations. Our impression was that over-focusing on wartime situations would be less efficient than focusing on the routine situations. Indeed, it enabled the mothers to internalize and exercise efficiently individual coping styles so that it will be available in intense stressful situations.

The situations involving daily tensions that were raised during group discussions included coping with illness, of mother or child, traumatic birth, home accidents, car accident, father's unemployment, parent going abroad, etc. The therapists helped each participant identify her personal emotional resources and coping options. For example, Y. learns that what she is comfortable with is letting herself have a dialogue with herself in stressful situations before doing something. This enables her to organize her thoughts and thus, regulate the behavior of her baby in a better manner. E. tells how touch and movement relaxes her. The therapists indicate how often she uses this style when taking care of her baby too, and they reinforce her ability to find a joint organizing and regulating pattern for herself and her daughter.

One of the sessions begins with R. saying: "I have no resources of my own to cope with stress situations, I always need someone else's help. She finds the courage to share something very painful for the first time. She tells the group of fears she has at night, linking this to her childhood when she was exposed to shelling for years on end. She recalls a scene from her early childhood, a night of air raid sirens and Katyushas, her father carrying her down to the bomb shelter. The group expresses empathy, asks questions, giving her a sense of understanding and caring. R. is concerned that as a result of her personal history, she has become an over-anxious mother. The group calms her fears, and they relate to nighttime as a symbol of loneliness, saying that being afraid at night indicates fear of being alone. The therapists repeat her opening sentence and suggest that she reframe it thus: "The emotional resource I use for coping with stress situations is to be helped by someone else". They encourage her to relate to this as her strength, her special style, rather than relating to it as a weakness.

4. THE ROLE OF THE THERAPISTS

A central aspect of the group process is the relationship between the group and the therapists. In an article about the ambivalence of mothers towards babies and infants, Leon Hoffman (2003) describes the unique processes that develop in groups of mothers and babies. He maintains that positive transference to the therapist and to the setting takes place as a result of the regular weekly meetings in which a sort of family atmosphere is created. He mentions that positive transference is reminiscent of Stern's concept of "the good grandmother transference" when the young mother, as a result of the motherhood constellation, searches for a maternal image who appreciates, supports, helps, teaches and admires her.

Hoffman emphasizes that since these groups are not therapeutic, the therapist must bear in mind that transference is not supposed to be worked through, as in therapy. Special attention should be paid to dealing appropriately with negative transference.

In her psychotherapeutic work with parents and infants, Tessa Baradon (2002) describes the complex role of the therapist in dyadic work. Although these groups were not therapeutic, we used her thinking in to understand processes between the mothers and therapists. On the one hand, the therapist is a clinical observer of everything happening between the mother and the baby. She attempts to identify the mental models of being with the other, that evolve in the interaction. On the other hand, the therapist is also involved in the actual emotional dialogue between the parent and the infant in the room. The presence of the baby intensifies the countertransference issues for the therapist.

G. is sitting on the mat with her baby daughter, aged 5 months. She does not place her on the mat because she is not happy with the cleanliness, and is afraid that her baby will become infected. G. holds her child on her knee in such a way that is almost impossible for the baby to watch the surroundings. In spite of this, the baby makes constant efforts to follow the other babies and infants moving around freely on the mat.

G. starts talking about her difficulty in coping with her own mother who lives with them. She describes how critical her mother is towards her, and her desire to move away with her child to another apartment. G's stress is intense, I listen to the content, but instead of empathizing with her, the therapist feels angry at her. She is actually identifying with the little baby who rather than being held by her mother, is tied down by the restricted position she is in, preventing her from looking out at the world around her. The therapist goes back to listening to G.'s talk, but finds herself blaming G. for the relationship with her mother. To complicate matters, for a moment, the therapist also identifies with the grandmother, who is experiencing her daughter's incompetent and negative motherhood.

Hoffman considers the role of the therapist as one that detects and identifies difficulties, and chooses the appropriate interventions in order to encourage group discussion about occurring events. From this aspect, the different dyads help one another and learn from each other. For

example, in one of the groups, one of the mothers says to another: "Why do you carry your baby in your arms all the time? Put him on the mat". Intervention of this sort is often more effective when it comes from one of the participants, rather than from the therapist, yet it is significant that it is said via the containment supplied by the therapist. In addition, when the therapist addresses one of the mothers, she is actually addressing all the others. Mothers sometime quote something previously said to another mother. In practice, interaction between the therapist and any participant, can have an effect on all the others.

A frequent phenomenon in groups of mothers is expecting to receive clear directions as to how to cope "correctly", a kind of professional prescription. This expectation is linked to the basic anxiety that accompanies many mothers regarding their ability to best withstand complex maternal situations. The ability of the therapists to take a widespread role, listening, containing, directing, guiding, advising, supporting, each in its own time, has a powerful impact on a group dealing with stress.

CONCLUSION

Preventive work is a main objective in psychological encounters with contemporary parenthood. Post-modern parenthood has created new complexities that were unfamiliar in previous generations. Many more parents nowadays seek the help of mental health professionals in order to use parental potential to its full. The work described in this paper is the result of many encounters with parental coping at war and its aftermath. We hope the work described here will encourage more professionals to indulge in this important mission of helping parents bring up healthier children although reality is complex.

We are grateful to all those mothers from the north of Israel who gave us the opportunity to be their partners in strengthening and reinforcing their emotional resilience in a process of bringing up children in a complex reality. We all pray and hope that

these and all other mothers and babies will have the chance to bring up their children in an atmosphere of peace and unity between nations.

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EDITOR'S PERSPECTIVE

Once, nobody knew that infants react to violence, wars, disaster. Today, we know that infants experience post traumatic stress and we know what the signs of post traumatic stress disorder are in the early years. We even know and teach the basic principles of treatment. Still, traumas vary in nature, as well as in extent and WAIMH, as a world organization devoted to the mental health of infants and young children has a role in defining guidelines for assessment and treatment when different kinds of traumas have occurred within the first three years of life.

Infants in societies in chronic conflict with periods of violent exacerbation

Infants, parents and therapists who live where conflict is chronic and where nations are at war, face daily and complex issues, regardless of their political points of view. In the regional conference held in Ako, Israel last September, WAIMH provided the setting for a high level, professional and respectful dialogue for countries in conflict. In this issue of *The Signal*, we feature summaries of our Arab and Israeli colleagues' presentations about their personal and professional experiences as clinicians in an extremely complex geo-political context. The dialogue in Ako did not change the reality, but engendered the recognition of mutual feelings of fear and insecurity, embedded in the history of these two countries. The regional conference gave Arabic and Israeli clinicians the opportunity to explore therapeutic experiences in face of chronic conflict and communicate with one another "at home." Important to note, few could have travelled to one of our world conferences. WAIMH did not take a political stance, but, quite the opposite, set the stage for parties in conflict to reflect on their mutual suffering and ways to deal with it.

As a mental health professional in a society in war, I personally believe WAIMH has a special role in facilitating communication between all parties who wish to enter into a reflective conversation. This is the first step towards mutual recognition, the opposite of alienation that allows killing.

Four years ago, Sam Tyano and I had the opportunity to organize an Israeli-Palestinian Infant Mental Health Training Course, having in mind that the process itself could serve as a mediator of mutual recognition. The setting was three overnight week-ends at a hotel in East Jerusalem for a 48 hours of training. The participants included 14 Palestinians from Bethlehem, Ramallah, Naplus, and East Jerusalem and 14 Israelis from West Jerusalem. All of them were community child mental health professionals. The explicit goal was to increase basic knowledge about core concepts of psychopathology in infancy, early detection, diagnosis, assessment and therapeutic principles, and specific diagnostic classifications.

We started with formal sharing of knowledge on the first week-end and, by the third one, discussed clinical cases of mutual interest and concern, enabling the gradual building of trusting relationships within the group. Gradually, through talking about the impact of the war on our little patients and their parents, we started to talk about its impact on ourselves as therapists and individuals. We started as a "group of Israelis" and "group of Palestinians." We ended as individuals who knew each one's names. The realization that this process can happen in spite of the ongoing war, is what re-installed hope that hate can be overcome.

Sharing professional/neutral knowledge was the context that facilitated joint sharing of heavy, affect-loaded experiences. Humorous,

mutual jokes became "politically correct". This training experience taught us how to talk with one another, even in the midst of violent conflicts. Discussion also enabled us to see how each is both the victim and the aggressor. There was no more split between we, the good ones, the victims and they, the bad ones, the aggressors.

Mutual recognition enables the start of re-humanization. Through discussion, we may not perceive the other as an anonymous member of "the enemy group," but as an individual with capacities for kindness, intelligence, humor and similar wishes for life, growth and love. Political solutions are found when, and only when, each side wants to find them. This phase usually comes after each side is filled with suffering. As we know, suffering is the "best" trigger for therapy and change. Each mental health professional's own suffering can be channeled into a motivational force to help mutually recognize and re-humanize, at a personal level. This is the first requisite for ending the killing and starting the reconciliation process. Facilitating the re-humanization process is, I think, our primary role as mental health professionals who work and live in conflicted areas...

Several months after the regional conference in Ako and the infant mental health training that brought Israeli and Palestinian clinicians together, Haiti experienced the worst natural disaster in its history where hundreds of thousands of people were killed or maimed. Many, many infants and young children were traumatized. They lost their families in the earthquake and are now orphans. What follows is an important question, "How can WAIMH offer its expertise to help infants and their families in massive, natural catastrophes?"

Infants in massive natural catastrophes

Detection and treatment of infants and families who have been traumatized, is, nowadays, a common practice in Western infant mental health units. Still, when we hear about mass-level disasters, where thousands of infants have survived the catastrophe, but are left orphaned and/or are surrounded by helpless, poor, uneducated and overwhelmed adults, who are themselves in need of leadership, our knowledge needs to be translated for action on a mass level. The Haiti earthquake is a tragic example of such a situation and the WAIMH board is now in the process of considering developing WAIMH guidelines for dealing with the trauma in Haiti. The first step might be to draw on the experiences that WAIMH members have had in responding to trauma in different areas of the world where mass disasters have occurred. Then we might try to contact the WHO and ONU people who are in Haiti and ask how we can help at implementing these guidelines on a practical ground.

Here are the first reports we have collected, more are on their way. *WAIMH members, Sally Stinson and Debbie Weatherston* (Michigan Association for Infant Mental Health, Southgate, Michigan, dweatherston@mi-aimh.org) wrote: " We have two thoughts about concrete help for caregivers of babies orphaned in Haiti and cared for in groups. 1. Baby Stages wheels information about social and emotional development has been translated into French by

Antoine. Because Haitians speak French, the translation could be used with child care staff to guide and support their knowledge and care of very young children. 2. The use of soft muslin to wrap a baby securely, to carry the baby, to hold, to feed, to comfort and contain. We might make the muslin wraps available to those who have the tremendous task of comforting babies who have been born to trauma and, metaphorically, offering comfort to the caregivers, too, in the course of training. Perhaps a foundation would fund WAIMH to offer a supportive, guiding presence to caregivers through training, using the information from the wheels and soft muslin to hold babies securely.

Beulah Warren (Sydney, Australia) further clarifies: The wrapping is what we encourage parents of premature babies to use in the early weeks and months. It is also useful for any newborn who has had a difficult birth or hospital experience. No doubt it would be useful for the little ones either born or soon to be born in Haiti. For receiving the drawings that demonstrate this specific kind of swaddling, please address either of us: lookes@ozemail.com.au (Beulah) and stinson@iamtgc.net (Sally).

An additional idea came from *Elisabeth Tuters* (The Hincks-Dellcrest Centre, Toronto, Ontario): Learning Through Play (LTP), An international early intervention program for infants, children and their families.

The aim of LTP is to support parents in their ability to stimulate healthy child development. The method consists of two pictorial Calendars (birth to three, and three to six) that depict the successive stages of child development, along with brief descriptions of simple play activities that show parents what they can do to promote healthy development. The LTP Calendars are low-literacy, multicultural materials that have been culturally interpreted to ensure widespread acceptability. To date they have been translated into over 20 different languages.

Canadian International Development Agency is showing interest in using LTP in the reconstruction of Haiti. LTP has already been translated into Creole and re-illustrated for Haitians. Child Psychiatrist, Lynne Jones, with the International Medical Corps, is already in Haiti, promoting LTP. Their site is: <http://www.hincksdellcrest.org>

This is just a beginning. More reports are on their way, such as Marie Rose Moro who is preparing a description of what the Physicians without Borders, have already accomplished in Haiti specifically, and more generally in disasters areas.

Whoever is interested in contributing to the elaboration of WAIMH guidelines for dealing with Infants after mass-scale disasters, please email to WAIMH office (info@waimh.org). We will work on it at the coming conference in Leipzig and in the months that follow.

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The Israeli-Palestinian conflict seen from the Arab young child's and parents' eyes...

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Invited address presented at the
WAIMH
Regional Conference, Akko, Israel,
September 2009

INTRODUCTION

Simple, direct questions, asked by Israeli Arab children, reflect best the complexity of the unique problems to which Arab children are confronted in times of exacerbation of the Israeli-Palestinian conflict:

Example 1: During the July 2006 war on Lebanon, when Hizballah missiles reached Arab towns and villages, and killed 19 Arab residents, A 4 year-old boy asked : *“Why is Nasrallah throwing missiles at us? Doesn't he know that we are Arabs? Could it be Israel throwing missiles at us and blaming Nasrallah?”*

Example 2: During the “Cast Lead” operation against the Gaza Strip, a boy of 4.5 years of age asked his mother: *“Why doesn't Israel kill you or Dad or Grandmother? Why does it only kill us, little children?”*.

Example 3: When hearing the explosion of fireworks at a wedding, a 3.5 year-old boy asked: *“Is Israel attacking us?”*.

Example 4: A 4 year old Bedouin boy told his nursery teacher: *“The Palestinians throw stones, but Israel protects us from them”*.

We all learned from D.W. Winnicott's saying: “See not the child by himself, but in the whole context”. In order to understand the uniqueness of the Israeli Arab child during Israeli-Arab wars, I will try to relate, as a whole, the historical, religious, cultural and social context together with the media by which the child grew up in

and was affected from, while at the same time emphasizing the factors of psychological resilience and stamina.

“Not the blazing isolated moment, with no before or after, but the whole flaming life at each moment” (T.S. Eliot)

I. THE STATUS OF THE ARAB COMMUNITY IN ISRAEL IN THE HISTORICAL, MEDIA, RELIGIOUS, CULTURAL, AND SOCIETAL CONTEXTS

1. HISTORICAL CONTEXT

Arabs in Israel are in a very unique situation. They are Israeli citizens, as well as Palestinians, and at times of exacerbation of the Israeli-Palestinian conflict they are put in a conflicted situation, laden with feelings of confusion, perplexity and frustration. A certain stream among Israeli Arabs considers the situation to be conflicting, charged, confusing, perplexing and frustrating.

A second stream maintains that this situation is supposed to be ideal because they are Israelis experiencing all the Israeli events for better and for worse and that their interest lies in seeing Israel prosperous and in peace. At the same time, since they are also part of the Palestinian people (almost any Arab family in Israel has a first or second degree kinship tie with people living in neighboring countries, Lebanon, Syria, Jordan, Egypt, The West Bank and Gaza Strip), they say “We want it to be good for both, our people and our country.” But, I am sorry to say, this is not a widespread notion, especially among politicians. Israel's discriminatory attitude against its own Arab population, with suspiciousness and exaggerated security concerns (e.g. at the airport) on the one hand, and the backlash of the Arab leadership in Israel on the other hand, lead to establishing and strengthening the first stream and weakening the second one. Thus a dialectical expanse is derived between

the Jewish and Arab populations, reinforcing in turn the Israeli authorities' suspiciousness. This has been an ongoing chronic vicious cycle for many years.

Just like war always awakens the collective traumatic anxiety and memories of the Holocaust among Jews (a trauma that is very much present in the everyday life, in peaceful times as well), so it is for the Arab-Palestinians in Israel. War raises *their* collective traumatic anxiety and memory of the “Nakba”. I am not comparing the Nakba with the Holocaust which was the most horrible episode in recent human history. I am only giving a tangible example that should be better understood and recognized: in terms of emotional impact, the core feeling of insecurity is shared by both people. Therefore, the term “transfer of Arabs”, used by some Israeli Jews, raises among Arab adults a very strong existential threat which is transmitted to the children, like the fear of being exterminated is transmitted from one generation to the other among Jews in general, and more specifically in Israel.

2. THE IMPACT OF THE MEDIA

We live in the “electronic media revolution” era. This revolution has far stronger impact in the Arab world than it has in developed countries such as Israel, because media has become a major means of entertainment among Arab populations, as it bypasses the high level of illiteracy, low reading rates (average of 1.25 hours per year in the Arab world, and 6 hours per year in Israel) and lack of enriching cultural activities. A 22% rating is usually considered as maximal. But when MBC1 broadcasted the Ramadan series “Bab el Hara” that rating jumped in the Arab world, including the Arab sector in Israel, to an unprecedented 80%. In addition, the Arab population in Israel is exposed more to media originating from Arab countries than to the local Israeli one. These channels conquered a hefty place in the hearts and minds of every

household member in normal times (in between wars), and formed a continuum in belonging to the Arab nation starting with language, culture, music and religion... This is true for the adults as well as for the children:

A 5 years and half boy from Nazareth who usually watches children programs in Arabic, broadcasted from Arabic TV stations, and is thrilled by these programs. He asks his mother "Whom are we friends with?", "Where can we travel to?", "I want to go to Jeddah?", "I want to buy games such as those on TV and play like the kids there, they speak the same language I do, and have games that I like too." (It is important to mention here that this particular child, like other children of his age in the Arab sector in Israel, has not yet been exposed to the Hebrew language, nor to Jewish children, in spite of the closeness of the Arabic neighborhood to the Jewish one in Nazareth).

At times of war, the extent of the media impact is multiplied. The war reaches directly every home. All the Jews are recruited to the army and most Arabs show their alliance to the other side – the adversary. Shocking and horrible images that should never be broadcast in an enlightened society are shown on TV screens. Children are exposed to all of it, without restrictions nor explanations. Parents are most often unaware of their children's feelings, and therefore do not use "home censorship". As a result, children watching those images are "flooded" with violent, threatening and anxiety-provoking information, and left alone with raw emotions.

This became prominent during the war on Gaza where the media exposure was completely unrestrained and most of the broadcasted pictures were of dead small children. The public at large, including children, was inundated with images of children, infants and women who were killed by IDF shelling. Some of the children concluded that "Israel is killing children". In the fantasy world of a child (where the sense of reality, space and time is different from that of an adult, thus allowing him to give different interpretations to events that do not go in line with reality and, at times, even intensify them far beyond), it is understandably possible that the broadcasted anxiety turns into a real and personal one. The horror and fear were transferred from the TV

screen directly into their hearts and minds.

3. THE IMPACT OF RELIGION

Try to imagine the conflict taking place in the mind of a child who sees on TV the image of a killed child, of his own age, presented as "shahid" (martyr), together with the sentence "Allah Akbar" (God is great)... He may very well think that what happened was a good and acceptable thing...

Religion is highly ranked in the Arab world and has great influence among the three religious groups in the Arab world, meaning Christian, Druze, and especially Islam with its majority followers. All channels broadcast the prayers of the "Mua'zzin" (call for prayer) 5 times a day, all year round. Everyone, including little children, is hitched to the special broadcasts during the entire month of Ramadan. There are no less than 30 channels specializing in the Qur'an (Holy Islam Book) and it is no different when it comes to internet sites, radio or the print press.

Religion is taught at school and every village has several mosques. It is an intrinsic part of the Arab child's environment.

Religion could have been a positive factor if it had been placed into trustworthy hands, with the humane aspect of religion in mind. Faith has indeed always played an important role in coping with distress. The problem starts when religion is used by political groups, and violence is made legitimate "in the name of God".

Christian Arabs also stumble over tedious contrasts on the national level. For instance, Christianity views Judaism as its inspiration, but the Arab Christian finds himself in conflict with Judaism and Jews on the national, daily level...

Islam adopts the major concepts and stories embedded in Judaism and in Christianity' even exaggeratingly so at times. "David", for example, is a king in Christianity and Judaism, but in Islam he has been upgraded to the status of a real "Prophet". On the other hand, the "Magen David", symbol of the State of Israel, drawn on Israeli tanks and planes, has become a symbol of hostility among the Arabs!

At the same time, the Arab child sees the Star of David on the national flag hoisted on top of his school and local authority buildings, on the side of ambulances and on top of hospitals.

So much confusion for the young child's mind, unseen by the adults surrounding him, who are not even aware of all these intrinsic contradictions...

4. THE IMPACT OF CULTURE

The Western common view about "good enough" parenting is that it is the parents' task to be sensitive, attentive, and protective to their children at all times. In times of war, their duty is to protect them physically as well as emotionally and to provide them with an atmosphere of safety and calm, in spite of the turmoil outside.

The Arab concept of "good enough" parenting is different, because the valued concepts are authority and collectivity. The individual's characteristics and needs are much less valued, if ever. Therefore, the community, including the parents, do not consider the child as an individual with specific and sometimes, unique needs and characteristics, but as a "piece" of the community "puzzle". Since individual psychological needs are not valued, the Arab community does not invest in becoming trained in psychology, and the lack of knowledge, at times outright ignorance, is the rule in most Arab communities. More often than not, no one pays attention nor thinks about what may take place in the child's mind, in times of peace as well as in times of war. The Arab community is "adult-oriented", children are not considered as having their specific ways of understanding and behaving, and a young child is supposed to regulate by himself his negative emotions, and not to make his parents feel shameful. A child with behavior problems, is very quickly labeled as a "bad child", and the idea his/her behaviors may reflect emotional distress and not evilness, is often very foreign to parents. They will most often blame the child, which, in turn, can only make things worse.

5. THE SOCIETAL CONTEXT

Regular daily life in between the war times: The Israeli Arab child and his family, especially those who

live in mixed Arab and Jewish cities, breathe the same air, shop at the same shopping malls, visit the same parks and children play with the same games (but not together). At times, there is even a business partnership, meetings at restaurants, visits to the Jewish dentist or to the General Hospital. They depend on the same police and same authorities. Living in a mixed community influences the dressing and behavior codes, house designs and furniture. Israeli Arabs most often speak Hebrew fluently (most Jews do not speak Arabic), and often insert Hebrew words in their daily talks in Arabic. The fate of the Israeli Arab society is very much dependent on the fate of the Israeli Jewish one, in all domains, for the good and the bad.

The problem lies in the coherence of their identity. What is the inner emotional experience of any Arab boy and his family that accompanies this daily conduct? What do they really feel while at the shopping center? While walking along the main street of a Jewish city? Or when they need an official figure, such as a doctor, a police officer, a clerk at the income tax office or at the national security office?

I believe that the crystallizing identity is extremely ambivalent, with feelings of belonging as well as alienation. The recent Arab-Israeli movie "Adgami" has vividly illustrated this complex dialectic and fragile equilibrium.

Life during war: When the conflict between Israel (where the child lives as a citizen) and its Arab neighbors (his brothers) becomes violent, this fragile equilibrium is disrupted. Not only their internal conflict gets intensified, but their physical safety is endangered. Ironically, in most Arab towns and villages there are no shelters, no warning sirens, and not enough security officials. They face, from their Jewish neighbors, an increased suspiciousness of collaborating with the enemy, and a blaming message from their Palestinian brothers as collaborators with their enemy. This, in addition to the physical threat, can lead only to intense negative emotions and identity confusion. Their loneliness is intensified by their unique in-between position: as opposite to the Palestinian and Jewish populations who are "only" physically threatened, the Israeli Arabs feel threatened in their physical as well as in their emotional integrity.

The children, from their youngest age, experience this reality to a large extent "through the eyes of their parents". Hence, the child follows suit, becoming confused and his level of internal coherence weakening even to a greater measure than the adults around him.

II. COLLECTIVE RESILIENCE

Collective resilience is the coping mechanism the community activates in times of stress in order to strengthen individuals. It is based on three main components: leadership, shared beliefs system, and societal cohesion. War is a strong factor in stimulating societal cohesion, feelings of national belongings, and gathering around the leaders.

These three factors are problematic among the Arab minority in Israel in times of war: They do not identify with statements made by the official leadership of the country, nor with the Jews' feeling of increased cohesion in face of the bad enemy. The Jews have a common enemy, but for the Arab-Israelis there is no such shared enemy. They even have difficulty identifying and defining the enemy. They can neither rely on their own leaders, whose leadership is mainly civil, traditional, not duly organized and even tempestuous at times.

Some solve the problem by putting aside their internal conflicts, thus keeping a neutral stance, and worry only about the physical threat, when it becomes close. Others identify with the war and the Israeli State, experience much anger and blame directed at their neighbor "the enemy" and fear physical injury. Others feel identification with the Arab nation, based either on religion or national solidarity, and have an intense desire to see Israel defeated in the war. A fourth group finds itself in a personal dilemma that worsens at the time of war ("the Israeli in me is shooting at the Palestinian in me and vice versa").

As a result of all these processes, the collective identity weakens, with varying prominence of the components mentioned above, and at times there is conflict between the national, religious and civil components which turns the experience into "a minority within a minority within a minority". For the child, the situation is totally confusing: on the one hand, the Israeli

government distributes gas masks to Arab children and on the other, soldiers demolish their Palestinian relatives' houses. The army is simultaneously a protective and threatening figure, leaving the child confused and disorganized. Whom is he supposed to love and to go to for protection? This disorganizing experience is shared by the adults as well, magnifying the children's. No wonder why the children turn to regressive coping mechanisms.

III. THE ROLE OF THERAPISTS IN THE COMPLEX REALITY

During war, therapists, Jewish and Arab, find themselves in a state of stress and anxiety, as being part of the community. They are faced with physical dangers while trying to get to the clinic, may even have to look for a shelter if there is an alarm, and may not be able to return home in time. The Arab therapist, who most often works in a Jewish clinical setting, is exposed not only to the same physical threats as his or her Jewish colleague, but to being torn between his professional and personal loyalties. They are asked to be able to live in an emotional "split": in the morning, they treat Arabs and Jews alike, while in the evening, they shed off their professional neutralism and their loyalty is shifted back to their own Arabic family and / or society. Therefore, when considering treatment options for the Arab-Israeli child at times of war, we must bring all the above mentioned into account and see their impact on the specific child and parents, as well as on the therapist.

The lack of awareness of the Arab community to the psychological impact of the war on their children, may explain the very low rate of referrals to clinics. Parents do not make the connection between their child's behavior and the surrounding events, especially in times of war. An additional explanation could be that Arab parents are reluctant to open up and show their weaknesses to Israeli-based health settings. Finally, generally speaking, the Israeli government has not yet corrected the discriminative lack of psychological and mental health services provided to Israeli Arabs. Time has come to conduct studies that will show how the above described phenomena impact Israeli Arab young children over time.

Working With Families Experiencing Homelessness: Understanding Trauma and Its Impact

By

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Bassuk,

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Natural disasters often result in homelessness. The trauma associated with the loss of home, safety, and a sense of security have a significant impact on how children and adults think, feel, behave, cope, and relate to others. Understanding trauma and its impact is essential to providing quality care to families who are experiencing homelessness. Becoming “trauma-informed” requires that service providers tailor their services to meet the unique needs of trauma survivors and avoid additional harm. In this article the authors explore the impact of trauma on families experiencing homelessness in the United States, and identify concrete strategies that can be used to address these families’ needs.

Homelessness is a devastating experience that significantly impacts the health and well-being of adults and children. Families with children comprise 34% of the homeless population and this number is growing (U.S. Department of Housing and Urban Development, 2007). In the United States, one in every 50 children experience homelessness—approximately 1.5 million children (The National Center on Family Homelessness, 2009). Forty-two percent of children who are homeless are less than 6 years old (Burt et al., 1999, 2000). Families enter the homeless service system because of various factors that include lack of affordable housing,

unemployment, limited access to resources and supports, health and mental health issues, and experiences of violence. Eighty-four percent of families experiencing homelessness are female-headed (U.S. Department of Housing and Urban Development, 2007). The typical sheltered family is comprised of a mother in her late twenties with two children (Burt et al., 2000).

The prevalence of traumatic stress in the lives of families who are homeless is extraordinarily high. Often these families have experienced ongoing trauma in the form of childhood abuse and neglect, domestic violence, and community violence, as well as the trauma associated with poverty and the loss of home, safety, and sense of security. These experiences have a significant impact on how children and adults think, feel, behave, relate to others, and cope. Traumatized families have a unique set of needs and require tailored services. In this article we explore the impact of trauma on homeless women and children and describe concrete strategies and promising practices that can be used in a variety of community-based settings to address their needs.

WHAT ARE THE EXPERIENCES OF MOTHERS AND CHILDREN WHO ARE HOMELESS?

Alice is a 26-year-old woman who lives in a shelter with her daughter, Sarah, and son, Matthew. Alice’s exposure to violence began in childhood, when her father hit her frequently. In adulthood, soon after she was married, Alice’s husband was imprisoned for theft. After his release, the marriage became violent. Over the course of 3 years, Alice left her husband 15 times.

The violence in Alice’s life is a common story among homeless families. Mothers who are homeless frequently have significant histories of interpersonal violence. Traumatic events such as childhood physical and sexual abuse, family separation, and domestic violence in adulthood take a severe toll on families, often increasing their risk of experiencing additional traumatic life events (see box Defining Trauma). For these families, becoming homeless adds another layer of traumatic stress.

DEFINING TRAUMA

WHAT MAKES AN EXPERIENCE TRAUMATIC?

- Involves a threat to one’s physical or emotional well-being.
- Is an overwhelming experience.
- Results in intense feelings of fear and lack of control
- Leaves people feeling helpless.
- Changes the way a person understands himself/herself, the world, and others.

TRAUMA IN THE LIVES OF HOMELESS MOTHERS

Rates of violence among homeless women are extremely high (Bassuk et al., 1996; Browne & Bassuk, 1997; D'Ercole & Struening, 1990; Wood, Valdez, Hayashi, & Shen, 1990). Bassuk et al. (1996) documented that 92% of homeless mothers had experienced some form of physical or sexual assault over the course of their lives, mostly in familial or intimate relationships. During childhood, 43% of homeless women reported being sexually molested, usually by multiple perpetrators (Bassuk et al., 1996). Violence continues into adulthood with 63% of homeless mothers reporting severe physical assault by an intimate male partner (Browne & Bassuk, 1997).

While growing up, nearly half of homeless mothers lived outside of their homes at some point and 20% spent time in foster care (Bassuk, Buckner, et al., 1997). Disrupted attachments, whether they are due to abuse and neglect or family separations, have a significant impact on future relationships, emotional health, use of social supports, and development of coping skills. Homeless mothers who enter adulthood without the skills necessary to manage stress are considerably more vulnerable to the destructive impact of violence and poverty, and subsequent experiences of homelessness and other traumatic stressors (Bassuk, Perloff, & Dawson, 2001).

In addition to childhood and adult experiences of violence, researchers have found that being homeless is itself traumatic (Goodman, Saxe, & Harvey, 1991). First, homelessness adds an additional layer of vulnerability and deprivation that may increase a family's risk for continued exposure to various forms of violence. Second, the process of becoming homeless involves the loss of belongings, community, and sense of safety. Third, living in shelters is isolating and can lead to a loss personal control (Goodman et al., 1991). Homelessness can also trigger symptoms associated with past traumatic stressors that may hinder a family's ability to move back into stable housing (Goodman et al., 1991).

TRAUMA IN THE LIVES OF CHILDREN WHO ARE HOMELESS

Children who are homeless often live in chaotic and unsafe environments where there is frequent exposure to various forms of violence, including domestic violence, physical and sexual abuse, unpredictable adult behaviors and responses, and dramatic life changes such as moving from place to place, family separations, and placement in foster care. Within a single year, 97% of children who are homeless move up to three times, 40% attend two different schools, and 28% attend three or more different schools (The National Center on Family Homelessness, 1999). Nearly one quarter of children who are homeless have witnessed acts of violence within their family, a significantly higher rate than children in the general population (The National Center on Family Homelessness, 1999). Children who are homeless frequently worry that they will have no place to live and no place to sleep (The National Center on Family Homelessness, 1999). Many worry that something bad will happen to their family members. More than one half are frequently concerned about guns and fire (The National Center on Family Homelessness, 1999).

An unsafe or disrupted relationship with a primary caregiver is one of the most traumatic experiences that a child can face and has a profound impact on health and well-being. More than one third of children who are homeless have been the subject of a child protection investigation (The National Center on Family Homelessness, 1999). Twenty-two percent of children who are homeless are separated from their families (The National Center on Family Homelessness, 1999). About 12% of children who are homeless are placed in foster care, compared to slightly more than 1% of other children (The National Center on Family Homelessness, 1999). Other children are sent to live with relatives.

HOW DO OUR BODIES RESPOND TO TRAUMATIC EXPERIENCES?

Families who are homeless have encountered many threats to their physical and emotional well-being. In order to understand and work with children and adults who have experienced trauma, it is helpful to consider how our bodies are designed to respond to stress and threat.

THE BODY'S RESPONSE TO THREAT

The brain contains a natural alarm system designed to detect and evaluate potential threats and activate physical responses to keep the body safe. When the alarm system detects a threat (e.g., a loud noise, a violent situation, neglect), it readies the body to respond by releasing chemicals that lead to various physical responses such as sweating and increased heart rate and breathing. In these moments, humans respond to stress in one of three ways: fight (actively doing something to the source of the threat), flight (avoiding the stressor), or freeze (shutting-down in the face of the threat). People all experience threats to their well-being from time to time (e.g., a car accident, witnessing a frightening event, experiencing a natural disaster). These experiences may be scary, but may not be "traumatic." Oftentimes, a stressor becomes traumatic when attempts to fight, flee or freeze do not help a person to escape the threat in the way he expects, and he is left feeling helpless, fearful, and out of control (see box Understanding Triggers).

UNDERSTANDING "TRIGGERS"

The term "trigger" refers to reminders of past traumatic experiences that people encounter in the present. Triggers may include sights, sounds, smells, feelings, or experiences that are associated with a previous traumatic experience (Kinniburgh & Blaustein, 2005). When exposed to a trigger, the trauma survivor's brain remembers this as a danger signal based on past experiences and immediately prepares the body to respond.

COMPLEX TRAUMA

The term “complex trauma” is used to describe prolonged, persistent traumatic stress that often originates within the caregiving system during critical developmental stages and leads to immediate and long-term difficulties in many areas of functioning (Cook et al, 2005). Most commonly, it is associated with disrupted attachments. Given the prevalence of chronic interpersonal violence, along with the stress associated with daily survival in an often unsupportive system, the experiences of homeless mothers and their children often fit the definition of complex trauma. Homeless adults and children, as well as other chronically traumatized individuals, are constantly on-guard and prepared to respond to danger. Nearly any threat or danger becomes a reminder of past trauma, and these families are constantly engaged in emergency fight, flight, or freeze responses. This level of physiological arousal has a significant impact on thinking, planning, problem-solving, managing physical and emotional states, and sustaining secure and trusting relationships (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola., 2005).

HOW DO TRAUMATIC EXPERIENCES IMPACT MOTHERS AND CHILDREN WHO ARE HOMELESS?

Homeless women struggle with poor physical and emotional health compared to the general population.

IMPACT ON MOTHERS’ PHYSICAL AND EMOTIONAL HEALTH

Some physical issues may come from injuries associated with violence, while other complaints may represent a deeper physiological response to chronic trauma that results in somatic symptoms or “body memories” (Bassuk, Melnick, & Browne, 1998). More than one third of mothers who are homeless have a chronic physical health condition. For example, they have ulcers at 4 times the rate of other women, and higher rates of asthma, anemia, and hypertension than in the general population (Bassuk et al., 1996; Weinreb, Goldberg, & Perloff, 1998).

Along with physical health issues, mothers experiencing homelessness struggle with high rates of mental health and substance use issues (Bassuk, Buckner, et al., 1997; Bassuk & Rosenberg, 1988; Bassuk et al., 1996; D’Ercole & Struening, 1990; Ingram, Corning, & Schmidt, 1996). High rates of posttraumatic stress disorder (PTSD) among homeless and extremely poor women are well-documented (Bassuk, Buckner, Perloff, & Bassuk, 1998; Bassuk, Dawson, et al., 2001; Bassuk, Melnick, & Browne, 1998; Bassuk et al., 1996; Browne, 1993; North & Smith, 1992). More than one third to one half of homeless mothers have experienced PTSD—a rate 3 or more times greater than among women in the general population (Bassuk, Buckner, et al. 1998; Weinreb, Buckner, Williams, & Nicholson, 2006). In addition, 85% of homeless mothers report a history of major depression (Weinreb et al., 2006). Given high rates of violence and mental health issues, it is not surprising that women who are homeless also have twice the rate of drug and alcohol dependence as in the general population (Bassuk et al., 1996). As a result of these challenges, women who are homeless and have experienced chronic trauma have considerable difficulties trusting others and accessing help and support for themselves and their children.

IMPACT ON CHILDREN

Tyrone is a 3-year-old child living in a homeless shelter on the south side of Chicago. His family includes his 4-year-old sister, a 1-year-old brother, and their mother. Tyrone exhibits significant developmental delays in the areas of cognition, language, and motor skills. His emotional functioning is marked by erratic responses toward his mother and other adults and excessive crying spells. In therapy, the child’s mother disclosed that Tyrone had witnessed repeated incidents of domestic violence.

ATTACHMENT

The health and well-being of a parent is inextricably linked to the health and well-being of her child. The quality of the parent–child relationship has a profound impact on a child’s awareness of self and others, social and emotional

development, and school adjustment (National Scientific Council on the Developing Child, 2004). Parents who have been traumatized often have greater difficulty being responsive and sensitive to their children’s needs (Osofsky, 1999). Disrupted parent–child relationships can impact all aspects of a child’s functioning, beginning at the most fundamental, neurobiological level. Research suggests that “relationships children have with their caregivers play critical roles in regulating stress hormone production during the early years of life” (National Scientific Council on the Developing Child, 2005, p. 3). Experiences such as abuse, neglect and maternal depression can lead to elevated levels of stress hormones that may impact brain development and future coping skills. In addition to the neurobiological impact of stress associated with disrupted attachments, research shows that children who have a parent with a mental health issue are at greater risk of presenting with developmental delays, struggling with psychosocial and academic problems, and developing psychiatric diagnoses (Nicholson, Biebel, Hinden, Henry, & Stier, 2001).

The level of fear and unpredictability in the lives of children who are homeless can be extremely damaging to their growth and development, especially to the formation of secure attachment relationships. Family violence and separation threatens physical and emotional connections. Mental health issues, such as the high rates of depression seen in homeless mothers, significantly impede a parent’s ability to bond with her child. As a consequence, children who are homeless often present with developmental delays and physical and emotional health challenges.

DEVELOPMENT

The experiences of children who are homeless, both prior to and after becoming homeless, have a significant impact on growth and development (Bassuk & Rosenberg, 1990; Bassuk & Rubin, 1987; Bassuk, Rubin, & Lauriat, 1986; Rafferty & Shinn, 1991). Studies of children who are homeless cited by Rafferty and Shinn have documented developmental delays, including difficulties with attention, speech delays, immature peer interactions, language disabilities,

and cognitive delays. Bassuk and her colleagues noted that children who are homeless demonstrated significant delays in language development, gross motor skills, fine motor skills, and social/personal growth. More than half of homeless preschoolers showed at least one major developmental lag.

PHYSICAL AND EMOTIONAL HEALTH

Children who are homeless are often in poor physical health (American Academy of Pediatrics, 1996; Rafferty & Shinn, 1991; The National Center on Family Homelessness, 1999). They are more likely than children in the general population to suffer from acute illnesses such as fever, ear infection, cough, stomach problems, and asthma, as well as chronic diseases such as sinusitis, anemia, asthma, bowel dysfunction, eczema, visual problems, and neurological deficits (American Academy of Pediatrics, 1996; The National Center on Family Homelessness, 1999). Nearly 70% of infants, toddlers, and preschoolers who are homeless have chronic illnesses (The National Center on Family Homelessness, 1999). Children who are homeless and families living in poverty lack routine and timely medical care. They often have poor nutrition associated with a lack of money to provide adequate meals (The National Center on Family Homelessness, 1999). In addition, some health issues are related to experiences of trauma (American Academy of Pediatrics, 1996). A lack of consistent health care prior to and while homeless combined with the stress of homelessness itself contributes to poor health outcomes for children (The National Center on Family Homelessness, 1999).

As discussed above, experiences of loss or events that impact the parent-child relationship can have a significant impact on a child's sense of safety and well-being and result in intense emotional responses. In addition to physical health complications, children who are homeless have 3 times the rate of emotional and behavioral problems compared to non-children who are homeless (National Child Traumatic Stress Network, 2005). Children who are homeless have high rates of anxiety, depression, sleep problems, shyness, withdrawal, and

aggression (Bassuk & Rosenberg, 1988; Bassuk & Rubin, 1987). In a study of preschool-age homeless and poor housed children, Bassuk and colleagues (Bassuk, Weinreb, Dawson, & Perloff, 1997) found that children who are homeless had significantly higher externalizing scores on the Child Behavior Checklist (Achenbach & Edelbrock, 1983) and slightly higher internalizing scores. They also found that 12% of children who are homeless had clinical problems such as anxiety, depression, and withdrawal, and 16% had behavior problems evidenced by severe aggression and hostility. High scores on the Child Behavior Checklist were most closely predicted by length of time in foster care, experiences of physical abuse, death of a childhood friend, and mother's emotional status (Bassuk, Weinreb, et al., 1997).

HOW CAN SERVICE PROVIDERS RESPOND TO FAMILIES EXPERIENCING HOMELESSNESS?

Case managers, clinicians, child care workers, educators, school liaisons, and shelter staff all work with children and families who are homeless. Given the high rates of trauma among the homeless population, how can providers work with these family members most effectively? To meet the needs of this population, providers must move toward a new way of providing care. Becoming "trauma-informed" means learning about trauma and its impact and using this knowledge to tailor services and avoid additional harm. In the following section, we outline concrete strategies for providing trauma-informed care to children and families who are homeless and can be applied in various service settings.

1. EDUCATING STAFF

Educating all providers in an organization about traumatic stress and its impact is essential to providing trauma-informed care. Trauma survivors, particularly those who have experienced multiple traumas, have developed survival skills that have helped them manage past traumas. These survival strategies (e.g., substance abuse, withdrawal, aggression, self-harm) were adaptive

when the original trauma occurred, but can be confusing and difficult to understand and manage since they often interfere with achieving current goals. Without understanding trauma, providers may view a parent as "manipulative," "oppositional," or "lazy." Instead, these behaviors may be better understood as trauma-based responses used to manage prior overwhelming feelings and situations. Professionals may label a child as "hyperactive," "oppositional," "shy," or "spacey," when these behaviors may be fight, flight, or freeze responses to on-going stress. Adequate training ensures that all providers understand these responses as adaptive and offer consistent, trauma-sensitive responses.

Basic education for all service providers working with homeless families must include:

- Information about the homeless service system, resources, families' experiences living in shelters, and the medical and mental health needs of this population;
- Education about the impact of traumatic stress on children at different stages of development, and how traumatic stress affects early attachments;
- Training on the developmental stages and tasks accomplished during each stage—particularly birth to 6 years, as this is the age range of many children who are homeless; and
- An understanding of attachment, including types of attachment (e.g., secure vs. insecure) and the relationship between attachment and the development of coping skills, identity, and future relationships.

2. CREATING SAFE ENVIRONMENTS

"My son never had problems sleeping until just before we came to the shelter. We moved a lot in the past year. Before coming to this shelter, we stayed with a friend. My son was sitting on a bed and nearby gunfire frightened him. One bullet passed through the apartment and just missed him. Since then, he can't sleep, unless he's next to me. It's worse in the shelter because we have less privacy. The staff is great and try to help, but he's just scared all the time."

Traumatic experiences challenge people's idea that the world is a safe and predictable place, and often leave people feeling insecure and distrustful of others. The loss of home leads to an additional loss of safety, security, and control. To begin to heal, families must feel safe. Physical safety is critical—especially in the immediate aftermath of a traumatic event, but it is also important for clients to feel emotionally safe. Emotional safety involves the need to feel protected, comforted, in control, heard, and reassured. For children this need is often met by their primary caregivers. However, when the whole family has been affected by traumatic stress, children and their caregivers need service providers to help them feel physically and emotionally safe. Service providers must examine their physical space and overall culture or environment to develop strategies for promoting safety and modeling this for parents and other family members.

CREATING A SENSE OF SAFETY IN YOUR PHYSICAL SPACE

Creating a welcoming and relaxing physical environment provides a sense of safety and security that is essential to the trauma survivor who is always on the look-out for danger. This begins from the moment a family walks through the door. The way a family is greeted and oriented to the space can set the tone for developing relationships. Examples include:

- Familiarizing families with the space (e.g., location of exits, choices for where they sit, locations of restrooms).
- Maintaining the overall environment (e.g., fixing things when they are broken, keeping things clean). A well-maintained physical space conveys respect for clients.
- Creating a sense of physical safety by doing the following: keeping the space well-lit, implementing security measures, and informing clients of these measures.
- Providing a space for children to play, particularly if you work in a space that is less child-focused. Child-friendly spaces include developmentally appropriate toys, chairs, and books; colorful pictures and paintings; learning materials and posters with “feelings faces” and “feelings thermometers” to foster skill-building.

- Identifying “safe spaces” for children to go when they are feeling overwhelmed or triggered. These safe places may include: (a) a reading corner in a classroom; (b) the guidance counselor's office or an area of the playroom separate from the main activities; (c) a particular chair in an office; (d) a “calming room” where children can draw, listen to music, rock in a chair, or take a nap; or (e) a multisensory room where children can utilize balls, weighted blankets, mats, etc., to help them calm down. Adults should talk with children directly to help them determine a safe place to go when feeling scared, overwhelmed, or sad. At home, parents can work with their child to identify safe places where they can calm down and relax their bodies. When a child shows signs of distress (e.g., crying, acting out, withdrawing), take the child aside and ask her if she would like to go to her safe place until she feels calmer.

See box “Examining Your Physical Environment” for an example exercise to do with your staff.

MAINTAINING A SENSE OF EMOTIONAL SAFETY

There are strategies for creating a sense of emotional safety within your service setting. These include establishing routines and rituals; recognizing triggers and fight, flight, or freeze responses; and creating safety plans.

Establishing routines and rituals provides the structure and predictability help all people, especially young children, feel safe and secure. For children who have experienced trauma, restoring a consistent and predictable environment helps them recognize that safe places do exist. For providers, this means having a clear, consistent schedule with well-planned transitions. For children who are living in shelters, it is important to provide a clear sense of what they and their family can expect (e.g., what is a shelter, why do families come here, what happens when they leave, what can kids expect, what are their parents' goals). Providers can encourage individual families to establish their own rituals around

“EXAMINING YOUR PHYSICAL ENVIRONMENT” EXERCISE

Ask your staff to do the following:

- Picture your organization's physical space. Focus on a place where you frequently meet with children and families: the community room, an office, a playroom, a classroom, or a waiting/reception area. What do you see? Notice the physical layout of the room. What about the room's security? What about privacy? What does the overall atmosphere convey?
- Take 10 minutes to draw the space that you just envisioned, with any additions or changes you would make to the space to make it more welcoming or safe for families. Be realistic and honest, but also keep in mind what we have been talking about today.

mealtimes, bedtimes, and after school.

It is important to recognize triggers and fight, flight, freeze responses.

Shortly after entering a homeless shelter, 3-year-old John became markedly distressed. He resisted change, constantly tested limits, and responded to directions by physically throwing himself on the floor, kicking, and hitting. He was verbally threatening and physically aggressive toward adults and other children.

No matter how young the child, the brain and body responds to traumatic stress and retains memories of these experiences, which may be stored as “felt” or “body” memories of fear, loss, anxiety, and need. Similar situations or experiences in the present may remind children of these traumatic experiences. Potential reminders or “triggers” for children who have experienced trauma may include:

- Loud noises
- Hand or body gestures
- Fighting
- Confusion or chaos
- Transitions
- Change in routine

- Feelings of anger, sadness, or fear that trigger similar feelings connected to past trauma
- Physical touch
- Emergency vehicles and police and fire personnel
- Certain smells
- Separation from caregivers
- Loss (e.g., of things, people, home)

When faced with reminders of traumatic experiences, children’s brains and bodies are programmed to go into automatic fight, flight, or freeze response mode. These behaviors can be very confusing, and there is a tendency to misunderstand or mislabel trauma-related responses (see box Fight, Flight, and Freeze Responses).

FIGHT, FLIGHT, AND FREEZE RESPONSES

Fight responses to triggers may include:

- Yelling, tantrums, or both
- Swearing
- Hitting or fighting
- Throwing things or damaging property
- Hyperactivity
- Being hyperalert to potential danger

Flight responses to triggers may include:

- Withdrawing (e.g., isolating, curling up in a ball, hiding)
- Not responding to others
- Running away from others
- Regression to an earlier developmental stage

Freeze responses to triggers may include:

- “Spacing out” (e.g. appearing disconnected, forgetting or appearing confused about what just happened, becoming nonresponsive)
- Going to sleep

As providers working with traumatized children and families, it is essential to identify potential triggers for children and, when possible, avoid them. It is also important to identify potential triggers for parents (e.g., loss of control, feeling put-down or misunderstood, feeling overwhelmed or frightened), to avoid these situations in daily programming. It can be helpful for providers to review their daily interactions with children and families when they enter the program to identify triggers, and strategize about how to eliminate potentially negative experiences for clients (see box Identifying Triggers).

Children who have experienced the trauma of homelessness and family violence are likely to have many triggers. It is helpful for adults to create individualized safety plans for each child that include the following components: (a) a list of triggers; (b) a list of “warning signs” that the child is escalating or becoming overwhelmed; (c) responses that are helpful when she is in distress (e.g., physical touch, space away from the group, offering them a specific toy or stuffed animal); (d) responses that are not helpful when the child is in distress (e.g., physical touch, multiple adults attempting to help, offering to call a child’s parent); and (e) safe people and places for a child when she needs to calm down.

Staff should create safety plans with children and their parents and share the plans with providers working with the family. For young children, parental involvement in identifying triggers, warning signs, and soothing strategies is essential. This activity offers providers the opportunity to ask parents for assistance in keeping their children safe when the parents are not available. At the same time, providers can use this exercise to educate parents without shaming or blaming them. Providers can encourage parents to use these safety plans at home as well.

IDENTIFYING TRIGGERS

Example:

A parent and his child come in for an intake assessment.

Potential triggers include: where he has to sit in relation to the door; what information is shared; understanding what will be done with this information; trusting another person with this information and his child; feelings of embarrassment and shame re: lack of housing, mental health or substance use issues, violence in the home, difficulties parenting; the stress of reliving past traumatic experiences when telling his story.

Staff response may include: A clear explanation of the purpose of the intake and what is done with the information; time for breaks and awareness of when the parent or child appears overwhelmed; confidential spaces to conduct the assessment, a focus on parent strengths and skills.

3. CONDUCTING CHILD ASSESSMENTS

Children’s needs often go unmet within homeless service settings. The focus tends to be on the parent, who has to find housing, employment, and benefits, etc., and children’s needs go unmet. Children living in shelters with their families face a variety of challenges to their well-being and healthy development. The children sometimes display difficult behaviors and a confusing set of symptoms. Young children may lose previously acquired skills (regression) or may have problems sleeping (insomnia, restless sleep) and eating. They may be highly distractible, unable to play for more than a few minutes, or their play may be constricted and repetitive. To adapt to prolonged traumatic experiences, children and adults may develop symptoms that mimic other disorders. Traumatized children may present with symptoms that are consistent with a diagnosis of attention-deficit hyperactivity disorder, bipolar disorder, oppositional-defiant disorder, or reactive-attachment disorder (Cook et al., 2005). Without a thorough assessment that includes a history of trauma, providers may diagnose or

DEVELOPMENTAL TRAUMA DISORDER

Within the trauma field, experts have suggested a new diagnosis for children who have experienced chronic trauma and adults who have experienced trauma since childhood. Developmental trauma disorder better captures the range of responses and the impact of complex trauma than current diagnoses such as PTSD. The goal is to avoid attaching several diagnoses to a set of symptoms that are better understood as trauma responses. Visit www.traumacenter.org for additional information.

label a child on the basis of presenting behaviors and miss the traumatic experiences that may be the source of the symptoms and the necessary focus of treatment (see box Developmental Trauma Disorder).

Including child assessments as a routine part of any intake process allows providers to focus on the needs of children. Specific questions about mental and physical health, traumatic experiences, and development should be routinely asked. For providers who do not work in shelter settings, questions about housing stability and homelessness should be a routine part of any screening or intake interview. Assessments of infant and early child health and mental health are important, as are questions and measures to assess parenting style, satisfaction, and attachment. Thorough child assessments allow providers to make immediate referrals for further evaluation, and mental health and early intervention services. Because a subgroup of children will require more intensive services, all programs must establish referral networks in the community.

4. BUILDING SKILLS AND CONNECTIONS

When providers understand trauma responses, they can help a survivor better understand her experiences, provide opportunities to practice regaining self-control, and use techniques to de-escalate difficult situations. Important components of support for trauma survivors

SKILL BUILDING FOR CHILDREN

Within the trauma field, experts have suggested a new diagnosis for children who have experienced chronic trauma and adults who have experienced trauma since childhood. Developmental trauma disorder better captures the range of responses and the impact of complex trauma than current diagnoses such as PTSD. The goal is to avoid attaching several diagnoses to a set of symptoms that are better understood as trauma responses. Visit www.traumacenter.org for additional information.

Providers can foster skill building by establishing activities and rituals that help children identify how they are feeling and calm themselves down. The following are some strategies for building these skills:

Feelings Faces and Feelings Thermometers:

Providers and parents can ask children to circle a face that corresponds with the emotion that they are feeling or point to where they are on the “angry” or “sad” or “happy” thermometer.

Relaxation Exercises:

1. Breathing activities (“Put your hands on your stomach. Breathe in deeply and pretend you are blowing bubbles.” Or “Breathe in—pretending that you are smelling flowers, blow out, like you are blowing out candles).
2. Muscle relaxation (e.g., progressive muscle relaxation from head to feet)
3. “Grounding” activities help children calm down and stay focused on the present when they are feeling overwhelmed or triggered. Activities may include the use of tools or toys that focus on the senses, such as stress balls, soft toys, or a weighted blanket*. Drawing, music and movement (e.g., yoga or play) are also helpful means of expression and grounding for children. *Cross-specialty learning can be very effective here. For example, many of the strategies used by occupational therapists can help disregulated children manage their level of physiological arousal.

Group Activities: Physical and Emotional Awareness for Children Experiencing Homelessness

Physical and Emotional Awareness for Children Experiencing Homelessness (PEACH) is an innovative curriculum that teaches young children (age 4–7 years) about good nutrition, physical activity, and how to deal with the stress of being homeless. At the heart of the PEACH curriculum are sessions on emotional health that are specifically designed to help children living in shelters understand their bodies’ reactions to traumatic stress and what to do about it. These sessions help children identify and feel comfortable with a range of emotions and learn strategies that help them feel safe. The program is based on the award-winning OrganWise Guys curriculum, which The National Center on Family Homelessness adapted for shelter settings. The OrganWise Guys are fanciful characters representing the organs in the body. Hardy Heart teaches children how their hearts need love, kindness, and plenty of exercise to stay healthy. Calci M. Bone is also enthusiastic about exercise, almost as much as she is about eating bone-healthy foods such as yogurt and milk. Pepto the Stomach understands that kids need to eat fruits and veggies. He also sometimes gets “butterflies” when he’s nervous. These characters and the other OrganWise Guys come to life for children through interactive and engaging materials, including books, videos, and activities. PEACH is being implemented in hundreds of shelters, health centers, and other community-based agencies around the country. Please visit The National Center on Family Homelessness Web site, www.familyhomelessness.org, for additional information about this curriculum.

involve helping them identify specific triggers, understand what is happening in their brains and bodies, ground themselves in the reality of the present situation, and develop self-soothing techniques and coping skills to manage feelings associated with past traumatic experiences. Particularly for younger children, who have fewer words to express how they feel, the use of play and body-based activities become a primary way for children to manage stress and develop coping skills (see box Skill Building for Children).

SKILL-BUILDING FOR PARENTS

Children experience the world within the context of their family system and the broader community. Family and community stressors such as poverty, violence, and homelessness have a significant impact on child well-being and development. Resilience literature points to a range of protective factors for children including positive parenting, healthy attachments to caregivers, and community support for families (Masten & Gewirtz, 2006). There are many models for strengthening attachment and building parental skills. However, few of these have been used in shelter settings with families who are homeless. The following are examples of promising and evidence-based practices that have been used with or adapted for work with families experiencing homelessness and that focus on parent skill-building and enhancing family connections:

- **Nurturing Parenting Programs.** Nurturing Parenting Programs are designed to treat and prevent child abuse and neglect and improve parenting skills. The Nurturing Parenting Programs teach age-specific parenting skills along with addressing the need to nurture oneself. The program curriculum consists of separate curriculum for parents and for children. The content of the parent portion of the program focuses on increasing self-esteem and self-concept while teaching nurturing parenting skills appropriate for the age group of the child. The program is administered in two formats: Home-Based and Center-Based. A variety of Nurturing Programs support parents and infants, toddlers and preschoolers, prenatal families, as well as families

with older children. Nurturing Programs have been implemented in a variety of settings, including shelters. For additional information, please visit the Nurturing Parenting Web site at www.nurturingparenting.com.

- **Child-Parent Psychotherapy.** Designated a promising practice by the National Child Traumatic Stress Network, Child-Parent Psychotherapy is designed for parents and their children birth to 6 years old. The goal is to improve the caregiver-child relationship, focus on safety, provide education about trauma responses, and mitigate the impact of trauma on development. Child-parent psychotherapy has been used with homeless families residing in domestic violence shelters and transitional housing sites. For additional information, please visit www.nctsn.org.

- **Parent-Child Interaction Therapy (PCIT).** PCIT was designated an evidence-based practice by the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices. PCIT is a treatment program for young children that is designed to improve the quality of the parent-child relationship and change interaction patterns. Parents are taught specific skills to establish or strengthen a nurturing and secure relationship with their child. PCIT is generally administered by a licensed mental health professional. PCIT has been used with families experiencing homelessness in shelter settings. For additional information about PCIT, please visit www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=192.

- **Child-Adult Relationship Enhancement (CARE).** CARE is a trauma-informed modification of PCIT skills for use by nonclinical providers who interact with traumatized children and their caregivers within a variety of settings. With support from the National Child Traumatic Stress Network, The National Center on Family Homelessness partnered with the Trauma Center in Boston, MA, to adapt CARE for use by paraprofessionals in homeless service systems. CARE offers concrete techniques for interacting with children and managing the types of behaviors and problems exhibited by many traumatized children. Providers using CARE include day care providers, medical care

providers, educators, foster parents, social workers, case managers, and staff at homeless shelters. For more information, see www.nctsn.org.

Less clinically driven or formal strategies for fostering parent-child attachment and parent skill-building include the following:

- **Providing parent education.** Providers can take the opportunity to educate parents about child development, attachment, and trauma and its impact on children. Information can help foster healthy relationships between parent and child and increase parent skills.
- **Modeling healthy interactions.** How staff work with parents can impact how the parents respond to their children. How staff work with children (e.g., tone of voice, eye contact, asking permission around personal space, asking them about their needs) serves as a model for parents.
- **Having fun.** Strengthening parent-child relationships through activities such as family nights and joint parent-child groups and activities (e.g., cooking, drawing).

See Learn More for education and training resources for providers working with families who are homeless. These resources contain additional information about trauma and trauma-informed care that include the strategies discussed above.

CONCLUSION

Families who are homeless face multiple challenges as they attempt to stay together, obtain permanent housing, and access necessary supports and resources. Violence and family disruption have a significant impact on the health and well-being of children and adults. Given the high prevalence of trauma in the lives of families who are homeless, it is imperative that service providers understand the impact of traumatic stress on adults and children and adopt a trauma-informed approach. Trauma-informed practices include creating safe environments, conducting thorough assessments, and helping parents and children build on strengths and learn new skills. Families who are homeless come into contact with service providers in a variety of settings (e.g., shelters, mental health agencies, child welfare

departments, schools, and child care centers). Becoming trauma-informed involves creating an integrated web of service systems that are united in the goal of open communication, cross-system education, and joint service planning to best assist families in their transition from homelessness.

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LEARN MORE

National Child Traumatic Stress Network (NCTSN)

www.nctsn.net

NCTSN offers facts and strategies for working with traumatized children for a range of service providers including educators, general public, mental health and medical professionals, child welfare workers, parents and caregivers, and religious professionals.

The National Center on Family Homelessness

www.familyhomelessness.org

The following resources are available to download:

- *Developing Trauma-Informed Services for Families Experiencing Homelessness An Interactive Training Video and Guide.* This training video and manual includes information about traumatic stress and trauma-informed care and includes concrete suggestions for incorporating trauma-informed practices and activities for skill-building.
- *A Long Journey Home: A Guide for Creating Trauma-Informed Services.* This document offers concrete suggestions for shifting organizational culture, attitudes, and response to those they serve to create trauma-informed environments.
- *What About You? A Workbook for Those Who Work With Others.* This workbook includes education about burn-out and secondary trauma, along with activities to address the self-care needs of individuals and organizations.
- *Trauma-Informed Organizational Toolkit for Homeless Services.* The Toolkit includes an *Organizational Self-Assessment, User's Guide, and How-To Manual* for becoming trauma-informed. This Toolkit is designed for use in homeless service settings, however, many of the ideas and suggestions are applicable to other professionals working with families who are homeless, traumatized or both.

Homeless Resource Center

www.homeless.samhsa.gov

- *Homelessness and Traumatic Stress Training Package.* This training package includes a trainer's guide, power-point slides, a trainer's script, hand-outs, and evaluation materials. This package includes activities and ideas for ways to provide trauma-informed care in shelter settings. Many of these ideas can be applied more broadly to other service settings working with children and families who are homeless.
- *Shelter From the Storm: Creating Trauma-Informed Homeless Services.* This report outlines current trends and promising models for developing trauma-informed homeless service systems and organizations.

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Information and news from the Central Office

Dear WAIMH members,

Last year WAIMH got a new appearance through the new website design. It is not only a design of the web-page, but a thoroughly new way of handling different areas and tasks of the Association. The website is now connected to WAIMH membership register. This means that members can renew their membership and new members can register online. Members can also update their own information themselves, so now you can change your own contact information immediately yourself when needed. For doing this, members only need their username and password.

By being members you get automatically our membership journal, the Signal, which is distributed to all members electronically 3-4 times yearly. In addition you can order the Infant Mental Health Journal (IMHJ) at a special price at the same time you join or renew your membership. The Journal is published by Wiley, and comes out six times every year. If you have experienced difficulties in ordering the IMHJ in connection to membership renewal, you can order it separately with the membership price by contacting the Office.

The new website is still under construction. Many of the features of the new software are not ready, for example for the affiliate web-page we have all the data in the system, but the data is not yet available for members for search purposes. On the positive side it means that the website can be developed according to your suggestions and wishes. It could have more features, for example contain discussion forums, or educational parts. We are sorry for any possible inconvenience that the ongoing construction of the new website may have caused.

All three of us working part-time for the Office are currently busy with the WAIMH Leipzig Congress. We have over 900 accepted abstracts, and hope the event will attract as wide an audience as possible. The programme of the Leipzig congress is very rich and the congress itself will be a great event for the development of infant mental health research and clinical practice. It will also provide us all the opportunity to meet friends and colleagues from all over the world and have fun together. No doubt there will be lots of music!

Hope to see as many of you as possible in Leipzig.

Minna, Kaija & Pälvi

