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The Impact of Trauma on Infants

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*The **Children's Mental Health eReview** summarizes children's mental health research and implications for practice and policy. This is the fourth issue in a series focusing on trauma and child welfare. This issue captures the presentation of Dr. Alicia Lieberman on May 12, 2010 titled "Child-Parent Psychotherapy in a Cultural Context: Repairing the Effects of Trauma on Early Attachment". This presentation was sponsored by the Irving B. Harris Foundation and presented as the 2010 Harris Forum (http://www.cehd.umn.edu/CEED/events/harrisforum/2010forum.html) and part of the 2009-2010 Lessons from the Field seminar series (http://z.umn.edu/osb).*

RESEARCH SUMMARY

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Introduction

Infants and young children in the United States are exposed to a wide range of traumatic stressors, including child abuse and neglect, natural disasters such as hurricanes and floods, community and school violence, domestic violence, and terroristic acts. Very young children are at disproportionate risk of experiencing traumatic events; they represent the majority of children who die from child abuse and neglect [1], are more likely to live in a home with domestic violence [2], and for the first year of life experience the single most dangerous period of their childhood [3]. In addition to the increased risk of exposure, infants and young children are also at increased risk of negative outcomes related to trauma because of their limited ability to cope with challenging experiences[4]. We long believed that children too young to talk about traumatic events were not affected by them, but research and observation has shown that this is far from the truth. It has been described by some that children can have a "visual memory" about a traumatic event that precedes their ability to speak [5]. Infants as young as three months old have demonstrated traumatic stress responses following direct exposure to trauma [6]. Infants and young children show many of the same symptoms of posttraumatic stress as adults [7], and research has shown that children exposed to traumatic events have higher rates of depression, anxiety disorder and other impairments [8]. These findings demonstrate the critical need to understand and respond to the needs of infants and very young children experiencing trauma, not only to reduce possible negative effects but also to prevent later mental health challenges.

Infant Mental Health and an Ecological Lens

According to the national organization Zero to Three, the term "infant mental health" refers to (1) how an infant experiences, expresses and regulates emotions, as well as recovers from dysregulation of these emotions, (2) how an infant learns to establish trusting relationships and repair conflict within them, and (3) how an infant explores and learns from her environment, managing and mastering fear and trepidation when they arise [9].

Infant mental health cannot be separated from

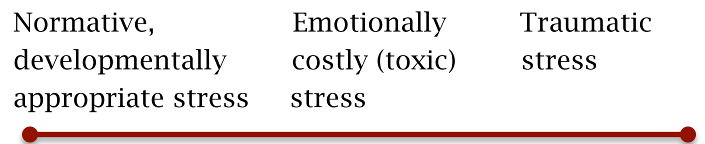
physical health or healthy development, and parents, family members and community members all contribute to the infant's state of mental health [10]. Because infants' activities happen within the context of family and community, it is important to view the infant's state of mental health within an ecological context. This perspective considers the infant's well-being within multiple ecological environments that influence one another and the child's development [11]. For ideal infant mental health, supports must be in place at each level of the model. For example, the *infant* receives support from family and community to achieve optimal growth and development (security, self confidence, character strength and social relationships). The *family* receives support, resources and guidance to prepare for the birth and provide a responsive environment after birth. The *community* embraces and supports all families, celebrates the birth of the child and creates a comprehensive and integrated array of accessible services that promote well-being [12]. Donald Winnicott [13], a psychologist and pediatrician, states "there is no such thing as a baby", meaning that an infant cannot exist independent of someone else who cares for him. The "holding environment" of each level of the ecological model is necessary not only for the infant's mental well-being, but for his very survival.

Children's environments vary. Children in Minnesota experience a range of characteristics of families, neighborhoods and communities. Because this historically homogeneous state has experienced an influx of immigrants from disparate places in the world, Minnesota children now experience a greater variety of child-rearing practices, a range of images about what constitutes a productive adult, and differing perspectives about the best ways to get there. Generally, there are now more types of ecological contexts and, therefore, greater variability in children's experiences, responses to those experiences, and appropriate types of interventions. This diversity points to the usefulness of the ecological perspective as a tool to help identify and understand an infant's web of influences from family, community, policy, and culture, as well as possible ways to strengthen parts of that web to benefit the child.

Traumatic Stress in Young Children

Children experience many different types of stressors throughout their lives. Some stress may be normative and developmentally appropriate. For example, a two-year-old who experiences the birth of a new baby in the family may feel *normative stress* (see Figure I).

Figure I. Risk as a continuum



Used with permission, Dr. Alicia Lieberman, May 12, 2010 presentation 'Child-Parent Psychotherapy in a Cultural Context: Repairing the Effects of Trauma on Early Attachment'

The child finds it difficult to learn to share the mother's attention, but will also likely learn coping strategies that benefit him later in life. Further down the continuum of risk to the child, *toxic stress* is a "strong, frequent, and/or prolonged activation of the body's stress-response systems in the absence of the buffering protection of stable adult support" [14]. The baby or toddler who constantly worries that his parents will fight with one another bears an emotionally costly burden with potential long-term consequences. Children exposed to family violence, physical or emotional abuse, extreme poverty, or parental substance use may experience toxic stress. Toxic stress can lead to physiological changes (such as brain architecture) that in turn can lead to poorer management of stress over time, so the presence of toxic stress in childhood can have long-term effects. At the end of the spectrum of risk, *traumatic stress* can result when the young child is exposed to an unpredictable event or series of events that overwhelm the ability to cope. It can result in feelings of horror and helplessness. A traumatic event can be a one-time shock such as a serious automobile crash, or a long-term situation such as domestic violence or sexual abuse, but by definition it is one for which the young child cannot prepare. The event or circumstance is perceived as horrifying because it involves "actual or threatened death or serious injury to the child or others, or a threat to the psychological or physical integrity of the child or

others” [15]. Finally, the event immobilizes the child’s coping mechanisms and renders him helpless. These feelings in young children often result in disorganized or agitated behavior. The five criteria for posttraumatic stress disorder in very young children are:

1. *Exposure* to a traumatic event (actual or threatened death or serious injury or threat to physical or psychological integrity of child or another person);
2. *Reexperiencing* the traumatic event through posttraumatic play, recurrent or intrusive recollections of the traumatic event outside play, repeated nightmares, physiological distress, recurrent flashbacks or dissociation;
3. *Numbing or interference* with developmental momentum revealed by social withdrawal, restricted affect, decreased interest in activities, or avoidance of trauma reminders;
4. *Increased arousal* characterized by at least two of the following – difficulty sleeping, difficulty concentrating, hypervigilance, exaggerated startle response, increased irritability or outbursts of anger/extreme fussiness or temper tantrums
5. *Persistence of symptoms* for at least one month[15]

Memories that are emotionally charged are more likely to be remembered than everyday happenings [16]. Implicit memory precedes verbalization, so children can report retroactively traumatic events that happened to them before they acquired language [5,17]. Though an event may not always be remembered accurately in detail, some part of it is often “remembered” in the body. For example, maltreated children have been shown to have higher levels of stress hormones [18,19]and anatomical differences in brain structure related to memory and planning (smaller brain volume, larger fluid-filled cavities, less connective matter) [20-23].

Cicchetti & Lynch [24] use the ecological model to better understand traumatic stress in young children. Their “ecological/transactional” model is based on prior theories of human development and ecology [11,25] and created to understand child maltreatment. The ecological/transactional model reflects how variables within the culture, community, and family as well as the child’s history come together to influence subsequent development. Traumatic events at one level can be exacerbated or overcome by potentiating or compensatory factors at another level [24,26]. For example, a situation of domestic violence (family level) can lead to family disruption (family level), which could result in a decline in financial safety if the wage earner leaves the family (family level), a move to a new neighborhood (community level), and a new preschool for the child (community level). In contrast, a child who adjusts well to the ongoing challenges of poverty or community violence (community level) may develop internal coping characteristics (individual level) that later help her overcome a situation of domestic violence (family level).

The presence of traumatic events, and therefore potential traumatic responses, can vary among infants in different communities. Generally, childhood adversities are more prevalent for minority families [27], which tend to be underserved and disempowered. Children who live in poverty have been shown to experience a greater number of potentially traumatic events than other children [28].

Research has shown that exposure to one stressor in childhood tends to predispose the child to experience other stressors [29]. For some children, the impact of these adversities is cumulative. Some children become more vulnerable to traumatic stress because of repeated exposure to a greater number of adversities combined with less access to resources that might help mitigate negative effects. “Understanding the context of childhood trauma makes clear that addressing the needs of traumatized children must entail attention to the child, the family, and the environment in which they live. This ecological-transactional approach, although long recommended [11,24,30] is seldom implemented” [31].

Intervention with traumatized families

The physiological and emotional stress of challenging conditions in early childhood is not necessarily permanent. In the Bucharest Early Intervention Project (BEIP), Nelson and his colleagues studied young children being reared in orphanages, a situation considered to be an adverse environment and associated with neurobiological and behavioral challenges [32], with children who moved from the

orphanage into caring foster homes [33]. Research related to the BEIP found that the effects of early deprivation on attachment, cognitive ability, internalizing disorders such as depression and anxiety, attention, and affect were overcome by placement into stable foster care environments [10,34-36]. These results show the critical importance of early and long-term intervention and demonstrate the use of the ecological model; the intervention of placement changes the child's environment, which in turn improves the child's mental health functioning.

In 2001, the organization Zero to Three convened a task force that emphasized the importance of a public health approach to understanding infant mental health [9]. This approach incorporates strategies of *promotion* (ensuring that those factors supporting mental health for all – such as prenatal care – are present within a community), *prevention* (identifying and reducing conditions that lead to mental health problems – such as maternal depression), and *intervention* (creating positive change for children experiencing mental health needs – such traumatic stress). Attending to all three will help all infants, not just those with mental heath challenges, attain the goal of "overall health, competence, and successful function in life tasks"[10].

Environmental stressors within each level of the ecological model, perhaps particularly the family level, have potential to threaten the well-being of the infant. Clearly, trauma can affect parents as well as children and "clinicians working with traumatized young children seldom have the luxury of focusing only on the child" [4]. As a result of trauma, a parent can develop similar symptoms of hypervigilance, fear and emotional dysregulation, and these symptoms can affect parenting behaviors and the parent-child relationship. For example, consider a mother who has been a victim of domestic violence. She approaches relationships with heightened concern and sensitivity about getting hurt. When her toddler has a tantrum and lashes out at her, she experiences this as a trauma reminder and responds with words or actions that serve to protect her but may increase fear and contradictory feelings in the child. The child may learn that he is bad, and that his mother will not protect him. Intervention with this family should address the trauma effects on both mother and child. All children and adults have *normative anxieties*, such as fear of separation, loss of love, or damage to the body [37]. These can be exacerbated by traumatic experiences. *Normative parental functions* of caregiving, protecting the child from danger, and promoting socialization can help counterbalance these anxieties. Interventions can support the parent in carrying out these normative parental functions in the midst of heightened anxiety. Instead of sending a message of fear and confusion, the parent can send the message "I don't like what you did, but I'm going to stay with you and teach you what I expect".

One specific researched and manualized treatment approach for traumatized families is Child-Parent Psychotherapy [38]. Based on Fraiberg's Infant Parent Psychotherapy [39] and supported by several randomized control trials [40-45] Child-Parent Psychotherapy focuses on emotional communication between parent and child, including issues related to current sources of stress and restoring trust and intimacy. This approach teaches the parent and child how to calm when faced with trauma reminders or upsetting feelings [38]. Child-Parent Psychotherapy uses an integrated theoretical approach that is *developmentally informed,* uses an *attachment focus*, is *trauma-based*, considers *psychoanalytic theory* (how is the past affecting what is happening now?), considers *social learning processes* (how is the child imitating what he/she observed?), utilizes *cognitive-behavioral strategies* and is *culturally attuned.* Child-Parent Psychotherapy also emphasizes open communication about the child's trauma as well as support for the parent in responding to it.

Lieberman and Van Horn speak of "angels in the nursery" [46]. The idea stems from the image of "ghosts in the nursery" described by Fraiberg and colleagues [39] in reference to the parent who repeats negative behaviors because of her own

unremembered experiences in childhood. The concept of "angels in the nursery" suggests that the parent can choose positive, or benevolent, behaviors in order to create shared moments of emotional connection in which the child feels loved and understood. These benevolent experiences between parent and child can create early nurturing experiences for the traumatized child and help to create love, protection, and repair within the parent-child relationship. Interventions with parents can begin with an assessment of these benevolent experiences the parent experienced as a child, even if these experiences were rare. These memories can instill optimism and "promote hope in the future by holding up a supportive model of the past" [38]. Then the parent can be encouraged to help create the same types of interactions, in which she felt loved and cared for, with her child.

Lieberman and Van Horn have outlined some common features of trauma treatments for families in "Don't Hit My Mommy: A Manual for Child-Parent Psychotherapy with Young Witnesses of Family Violence" [38]:

1. Encouraging a return to normal development, adaptive coping, and engagement with present activities and future goals;
2. Fostering an increased capacity to respond realistically to threat;
3. Maintaining regular levels of affective arousal;
4. Reestablishing trust in bodily sensations;
5. Restoration of reciprocity in intimate relationships;
6. Normalization of the traumatic response;
7. Encouraging a differentiation between reliving and remembering;
8. Placing the traumatic experience in perspective.

Generally, it is clear that therapeutic intervention with traumatized families helps, but this is not enough. Young children do not spend all their time in clinics – they also frequent schools, doctors' offices, playgrounds, juvenile detention centers, courts, etc. Trauma is a social problem with social repercussions. The need for collaborative service systems working jointly to address trauma in families is perhaps best described by Harris and colleagues in their article "In the best interests of society" [31]:

> *The psychiatric and behavioral manifestations of traumatic stress are so compelling that there is an understandable but ultimately misguided tendency to treat child trauma only as a clinical phenomenon that must be addressed with the tools of the mental health field. This narrow focus must be superseded by the ubiquity of trauma as the frequent cause of physical and mental illness, school underachievement and failure, substance abuse, maltreatment, and criminal behavior. This multiplicity of traumatic manifestations outside the mental health setting leads to the inescapable conclusion that we are dealing with a supra-clinical problem that can only be resolved by going beyond the child's individual clinical needs to enlist a range of coordinated services for the child and the family*[31].

The National Child Traumatic Stress Network (NCTSN) provides information about how to create trauma-informed systems, including child welfare, education, juvenile justice, law enforcement, and medical and mental health (http://www.nctsn.org/resources/topics/creating-trauma-informed-systems). NCTSN also offers a list of empirically supported treatments and promising practices with detail about supporting research and contact information (http://www.nctsnet.org/resources/topics/treatments-that-work/promising-practices).

In their article "Creating Trauma-Informed Systems: Child Welfare, Education, First Responders, Health Care, Juvenile Justice", Susan J. Ko and colleagues [47] include these recommendations:

- Promote the integration of trauma-focused practices across formal mental health treatment and other service sectors;
- Identify changes in practice that providers and policymakers in each system view as important to achieving outcomes that matter to them (e.g., school attendance, grades, recidivism, physical health outcomes, service utilization, cost-effectiveness) and then partner with these systems to assess the extent to which

practice changes are effective in improving these outcomes;

- Rigorously evaluate the benefits of implementing trauma-informed care;
- Introduce trauma-informed services into the core education and training for every child- and family-serving system;
- Provide trauma-informed care and traumatic stress interventions early and strategically;
- Replicate specialized evaluation, assessment, and treatment services provided by programs within the NCTSN;
- Emphasize interdisciplinary collaboration and relationship-building.

For more information about trauma assessments and interventions, visit the links below:

Trauma interventions with families: http://www.nctsn.org/content/treatments-children-and-families

Tools for assessing traumatic stress in young children: http://nctsn.org/content/identifying-and-providing-services-young-children-who-have-been-exposed-trauma-professionals

Child-Family Psychotherapy: http://nrepp.samhsa.gov/ViewIntervention.aspx?id=194

Trauma-Informed Systems: http://www.nctsn.org/resources/topics/creating-trauma-informed-systems

IMPLICATIONS FOR PRACTICE AND POLICY

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This research is particularly relevant to practitioners working with immigrant families. The Hispanic/Latino migrant population historically has used migration as an economic tool for progressing in life, based on the belief that a loving mother will do anything to let her children have a better life. Commonly, "seasonal migration" refers to parents who migrate for up to 6 months at a time to work in the host/receiving country. The label "serial migration" indicates that parents will migrate either singly or together with the intention of sending for the rest of their family at a later date, and "parental migration" is described as parents who migrate for a defined time or indefinitely but have no intention of having their children live in the overseas country. Unfortunately the majority of immigrant parents are in denial borne out of helplessness or lack insight as to the magnitude of the psychological impact of separation on children. Many of the parents are not aware that they place children at risk and jeopardize their children's safety and wellbeing. The trauma research outlined in this summary is particularly significant for these families.

The needs of children vary according to their experiences in their home country and in the United States, but many have been exposed to multiple traumatic events. Circumstances in the home country often include extreme poverty, where survival becomes the goal. Typically a father as the head of household may migrate first in order to secure financial resources to send for other family members. This can leave the family without a wage earner and result in a significant negative economic impact. It is a loss for the children and the mother. In this country, he may experience judgment about leaving his children behind and challenges securing work. The mother may move next, and children may be left behind with family members or friends. In many families, the man is the head of the household and it is expected for him to be physically strong,

unafraid, and the authority figure in the family, with the obligation to protect and provide for his family (machismo). A woman may be expected to be self-sacrificing, religious, and responsible for running the household and raising the children (marianismo). However, some unskilled positions may be perceived as better suited to women and she may find work first. This can lead to a power shift that can sometimes lead toward conflict or even violence.

The child first loses the father and then the mother. This loss can be significant – very young children will have no concept of the parent's sacrifice, and many feel anger and abandonment. A young child will not understand financial challenges and will feel that he should not be left behind under any circumstances. Often we see families that expect their children to be well cared for with family members or friends, but sometimes the care they receive is minimal – the goal is still survival. Sometimes older siblings are left responsible for younger ones. Often grandparents serve as caregivers but can have different values – about education, for example, because it wasn't valued in the same way in their generation. Sometimes children are moved from family member to family member because of a lack of formal foster care. Caregivers may be willing to care for the child, but are able to offer only basic care, not social/emotional development. The importance of bonding or attachment are not understood. Physical care related to food and shelter may be provided, but interpersonal skills and protection may be lacking. Girls in particular may be at higher risk of sexual abuse. In some communities children can be exposed to a great deal of street violence, and sometimes trafficking. Concepts about ideal infant mental health mentioned in this article are not even on the radar. Caregivers may not be aware of self-soothing techniques we use in this country – typically the mother served as comforter and she is now gone. Money sent home to the children may not reach them because of the great needs of caregivers. Parents can maintain contact with the child through phone conversations, but the child may be influenced by other family members to make a good report, or parents can be in denial about the circumstances back at home. Contact by phone will never build the emotional connection that's needed for young children. The longer the period of separation, the harder it is to maintain the relationship between parent and child. When children are separated at such a young age, you can see the damage in poor self-esteem and depression – they feel different from other kids. They can also develop a "waiting to immigrate" mentality. Even the typical developmental tasks of a five-year-old don't get done because of a preoccupation with immigrating.

When children travel here to join their parents, they carry the anger and trauma with them. Parents typically expect the child to understand the sacrifices they have made and be loving and accepting toward them now that they are reunited. More typically, however, the child still feels anger. Parents sometimes expect the child to behave according to their age at the time the parents left, but time has passed and the child has changed. When both parents' and childrens' expectations about the reunion are not met, the child may react with anger and rebel and parents may label this behavior as ingratitude and resort to harsh methods of discipline.

Generally, the longer the separation the harder it is for children to reestablish sense of belonging with the family. Parents may be aware of this but, because of extreme poverty, are pushed to do whatever it takes to survive. All family members may experience discrimination and the challenges of learning a new language. The child may learn the language faster, which can upset the power structure of the family. If attending school was not valued, the child may struggle to catch up. High levels of toxic stress can take a toll on all family members.

When working with families who have experienced periods of separation, practitioners should keep in mind that each family has its own

unique trauma experience, and the needs of immigrant families from different counties will vary. Families in some areas may have more opportunity to migrate, and the journey may not be as long or risky. But for others, life experiences in the home country and the journey itself can be filled with traumatic events. It's important to assess the family's specific needs.

Given what we know from this research about infant mental health and the experiences of families, we must work to reunite families while children are still young. It is best for children to be with their parents as soon as possible. Immigration reform efforts should aim to keep families together throughout the legal proceedings and encourage reunification when there are separations. Ideally we should inform parents of the significant traumatic consequences of separation. Parents are making survival decisions without the opportunity to wish for their child's mental well-being. Practitioners should be aware of the traumatic events and developmental challenges associated with both pre- and post-immigration, and work with parents to help them understand their child's developmental stage and level of understanding about the migration. Practitioners can also teach parents about the infant mental health concepts in this article and the importance of attachment in immigrant children. They can connect families with others who have immigrated earlier to teach them about the experiences they may face. Practitioners can teach parents how to soothe the child, and how to teach the child to self-soothe. The terms that are used among mental health professionals may not make sense to some families. We should increase awareness among providers (who can examine their own cultural attitudes, beliefs, and biases) and identify the need for training or culturally competent supervision. Providers can learn to ask "are you feeling sad or angry all the time?" rather than "are you depressed?". Child development terms such as "identity development" and descriptors such as "functional" or "dysfunctional" may be foreign. Parents may not have an understanding of the trauma they have experienced. Practitioners must take time to develop a relationship parents can trust.

The research in this summary could be adapted into a tool to educate families and influence social work practices in many countries. The Hispanic/Latino population is highly addicted to soap operas or "telenovelas" A telenovela is a limited-run serial dramatic programming popular in Latin American, Portuguese, and Spanish television programming. The medium has been used repeatedly to transmit sociocultural messages by incorporating them into storylines. A possibility is to adapt the concepts of this research to prepare a "telenovela" depicting a young child's distressing experience due to the feeling of abandonment triggered by the parent leaving the child behind to emigrate.

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Trauma in early childhood has become a subject of intense interest, locally and internationally. We see this as professionals who work with traumatized young families and as researchers who are exploring its effects on development. We see it as epidemiologists who are connecting trauma in childhood with physical outcomes in adulthood. The more we understand the impact of early childhood trauma, the more it can inform our understanding of troubled relationships between children and parents.

In our current system of care, I believe the biggest challenge we face is the gap between what researchers and clinicians have discovered and what practitioners encounter in the field. Despite industrious efforts around the state, some of the key ideas highlighted in this article have not penetrated into practice. Two issues will be addressed here: 1) The impact of early trauma on development, and 2) the role of unconscious experience in the lives of the children and parents with whom we work and in our work as practitioners.

The impact of early trauma on development is not keenly understood by professionals, schools, and families. As a community we need to recognize the magnitude of those effects. We know that without safety and relationships that support emotional regulation, infants and toddlers do not develop in typical fashion. It might be more accurate to talk about the effects of trauma not *on* the developing

child but *in* the developing child. The younger the child, the more impact there is on regulatory systems. Ongoing, overwhelming fear in early childhood, especially when there is no safe adult to turn to, affects regulation of emotion, behavior, and attention. As a result, children can become overwhelmed, overactive, and unable to focus. It also leads to the adoption of powerful coping mechanisms that may support the child's survival but interfere with relationships and learning. In her seminal article about childhood trauma, Terr [48] described these effects this way:

> *…[These disorders] follow from long-standing or repeated exposure to extreme external events…Massive attempts to protect the psyche and to preserve the self are put into gear. The defenses and coping operations used in … childhood—massive denial, repression, dissociation, self-anesthesia, self-hypnosis, identification with the aggressor, and aggression turned against the self—often lead to profound character changes in the youngster*[48.]

The coping mechanisms themselves can bring children to clinical attention. However, these mechanisms are often not understood as reactions to trauma by parents and clinicians. They are thought to be separate mental illnesses, explained by genetic inheritance because their parents exhibit similar difficulties. In many cases, though, we find that the parents themselves have gone through horrific experiences and have the same regulatory or attentional difficulties. This does not mean there is no genetic contribution to children's behavioral or attentional issues, but one cannot know the relative contribution of genetics when children are developing in the shadow of trauma.

Recognizing the role of trauma in a child's difficulties changes the way we understand the problem and design the interventions. If maladaptive behaviors are seen as adaptations to traumatic experience, they can make sense to the professionals in the child's life. They can be understood as coping strategies that arose out of necessity rather than conscious choice or evidence of inherited mental disorders. Professionals can help the parent, school, and child understand how they came to be and the role they serve for the child. From this perspective, interventions can focus on safety, helping the child and parent make sense of their experience, and creating a regulatory partnership between parent and child. Trauma-evoked coping strategies can slowly be replaced by relational strategies that can help a child over time turn toward rather than away from the community.

In order to help professionals and parents understand the effects of trauma on development, we need to:

- Embed a developmental perspective into academic and professional training programs, including social work, psychology, psychiatry, medicine, nursing, education, and criminal justice. Training across disciplines would create a common language and shared understanding of behavior. In addition, students who are provided with a foundational understanding of typical development will be more equipped to understand the impact of trauma on development.
- Integrate the effects of trauma into curricula on human development, assessment, treatment, and policy/administration.
- Provide cross-disciplinary trainings in trauma and its effects on development and behavior for professionals already in the field
- Provide community education for parents about the effects of trauma on development and behavior. An educated consumer of services will be better able to judge the appropriateness of treatment for his or her child.

The role of unconscious experience in our work manifests in two ways. One relates to disturbed relationships between parents and children, similar to those described in Selma Fraiberg's "Ghosts in the Nursery"[39] described in this article. Central to that article is the idea that parenting evokes experiences from childhood, experiences that may or may not be in parents' awareness but play out in the way they interact with their children. When those experiences are filled with trauma and grief, they are sometimes replayed with devastating accuracy despite the parents' own intentions to not repeat the past.

As a community of mental health professionals, home visitors, teachers, medical practitioners, and childcare providers, we need to recognize how much current parenting is related to past childhood experience. In our work with parents and children we see much that is painfully inexplicable until we remember that parents are acting out of unconscious experience and showing us how it was for them. That parents are not aware of this does not make them uninformed or ignorant; we all parent from the same place of unconscious familiarity. Remembering that parents are acting from unconscious experience, as we do when parenting, can help us stay more allied with them and less judgmental of their behavior.

The second manifestation of unconscious experience is in our role as professionals. Each of us comes from a family and a culture. Our histories decorate our past and present like familiar wallpaper; we do not notice it until we encounter someone else's unfamiliar wallpaper. The role of culture is inextricably linked with our thinking, feeling, acting, and reacting. In work with parents and children, we encounter behavior that does not *feel* right, that makes us uncomfortable and critical. At that juncture it is helpful to remember that we may be acting out of *our* unconscious experience and that our discomfort with parenting behavior does not mean that it is harmful or wrong. One way to address the impact of unconscious experience is through reflective consultation, a practice that is growing slowly throughout the state. It is precisely the idea of stepping back to think about all aspects of work with parents and children that can help to create awareness of these unconscious experiences that may be affecting our work with children and parents.

To examine and understand the complexities in our work, we can:

- Encourage a culture of careful consideration about the work we do, despite internal and external pressure to do more and move quickly.
- Create opportunities for professionals to participate in reflective consultation, both individually and in groups. This would require shifts in agency policies to allow staff the time and funding to participate in consultation.

As a community that works with children and parents, we must be careful not to oversimplify what we see or do. Trauma creates a complex web of emotions and behaviors that affects children, parents, and practitioners. Research continues to complicate our understanding of what is occurring in traumatized children and parents, but it also can simplify what we do in response. Our challenge is to find effective ways to integrate new discoveries into direct service so that both families and practitioners feel that the field is moving forward.

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