

ZERO TO THREE JOURNAL

The Trauma of Family Separation and Parental Loss in Early Childhood

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Child Well-Being and Immigration Policy

Reflections From Pediatricians Caring for Immigrant Children

A Mother's Experiences of War, Separation, and Resettlement

The Physical, Emotional, and Cognitive Effects of Parent Loss in Babies and Young Children



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Use of the Reflective Supervisory Relationship to Navigate Trauma, Separation, Loss, and Inequity



ZERO TO THREE
Early connections last a lifetime

This Issue and Why it Matters

The issue of family separation exploded in the headlines earlier this year when the federal administration revealed its “zero tolerance” policy as a deterrent to illegal immigration. In May, Attorney General Jeff Sessions announced that, under this policy, any person who crosses the southwest border of the United States without proper immigration documentation will be held for criminal prosecution. As a result, the children could not be lawfully held with their parents while they awaited trials. More than 2,000 children under 18 years old were forcibly separated from family members and moved to facilities around the country.

As the details of the plight of separated children and families began to emerge, child development experts and other child advocates raised their voices about the damaging effects and lasting trauma of family separation. Because of increasing public pressure to end this practice, in June President Trump signed an executive order to end family separation and replace it with family detention. However, the lack of planning for the separation and tracking of the whereabouts of separated children and parents has proven that reunification remains a slow and problematic process for hundreds of children.

At the time of this writing, the issue remains urgent. While immigration remains a complex issue, there is no ambiguity about the paramount importance of the bond between parent and child. In the words of Alicia Lieberman, ZERO TO THREE Board Member and renowned clinician and trauma expert, “Losing a loving and protective parent is the biggest single tragedy that can happen to a child.” Much work remains to be done to reunify the families who remain separated, and to ensure that child well-being is put at the forefront of policies and practices that affect families and children.

Of course, family separation and parental loss is an experience that reaches far beyond the context of immigration. In addition to the collection of articles that address these issues due to family migration, we explore what has been learned about separation and reunion in military families, in the child welfare system, due to parental death, and as a result of natural disasters. We also explore how grief and mourning manifest in very young children, and the critical importance of supporting the professionals who are working with traumatized children and families.

Effective intervention for any child who has experienced early adversity requires trauma-informed care. The hopeful news is that with the appropriate support of sensitive, caring, and consistent adults, children can and do build the resilience necessary to heal from trauma. For additional information, visit the ZERO TO THREE website at <http://www.zerotothree.org/trauma-informed-care>. This page offers resources for families and caregivers working with very young children who have experienced trauma as well as connections to specialized mental health professionals who understand the needs of very young children.

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Family Separation and Parental Loss in Early Childhood

SEPTEMBER 2018 • VOL 39 NO 1

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It's All Connected

Using ZERO TO THREE's P-5 Competencies™ to Find the Professional Resources You Need

ZERO TO THREE is committed to supporting you, the professionals who touch the lives of infants, toddlers, and their families, by providing knowledge and tools that help you to foster healthy early development. As part of that commitment, we are continually looking for better ways to help you find the professional resources and learning experiences that will be most helpful in your professional capacity.

To that end, we are introducing a new feature to the *ZERO TO THREE Journal*: icons that connect each article to the *ZERO TO THREE Competencies for Prenatal to Age 5 (P-5) Professionals™* (P-5 Competencies).

The Need for Competency-Based Framing

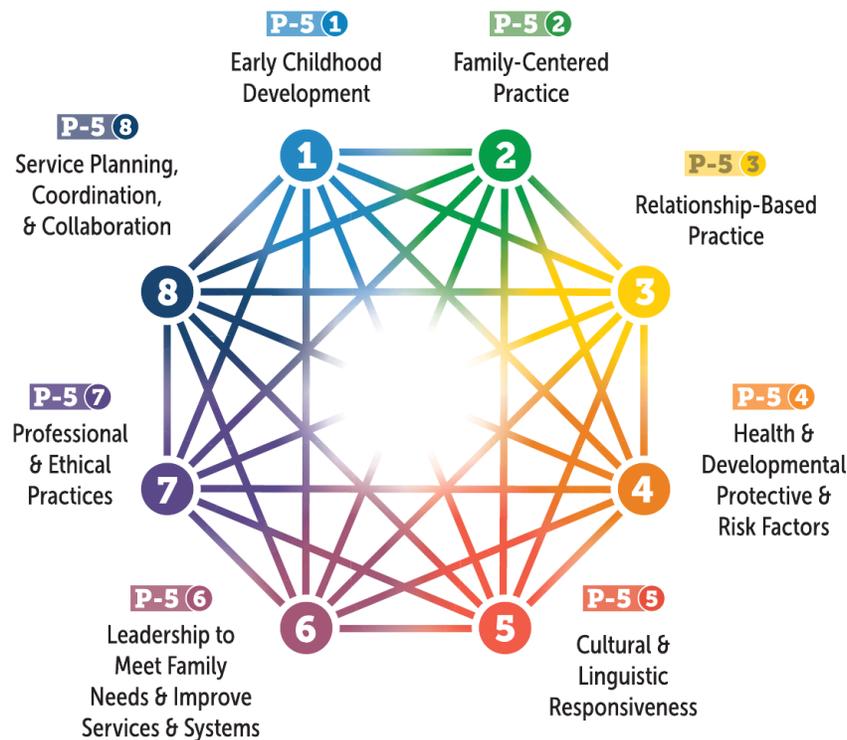
ZERO TO THREE believes that there are core knowledge, skills, and attitudes needed by professionals in all disciplines who work with young children and their families. All children and families deserve the attention of well-qualified professionals

when they seek services across the fields of early childhood education, early identification and intervention, mental health, physical health, and child welfare/social services.

The P-5 Competencies (see Figure 1) were developed to strengthen prenatal to age 5 (P-5) professionals' capacity to collaborate and coordinate services on behalf of young children and their families. The P-5 Competencies provide a consensus of key knowledge, skills, and attitudes necessary for responsive, comprehensive, and collaborative services and work among the professionals working in five identified fields or service sectors (see Figure 2). The P-5 Competencies create a common language grounded in fundamental concepts, including relationship-based practice, family-centered approaches, and self-reflection, and unify practices across the sectors.

Look for the following icons to identify the competency domain or domains most closely represented in each article's content.

Figure 1. P-5 Competency Domains



The ZERO TO THREE Competencies for P-5 Professionals Model

The P-5 Competencies consist of eight competency domains. Each domain provides a base for core knowledge, skills, and attitudes necessary for professionals in five key sectors working with young children and their families. Each of the P-5 Competency domains are equally important, and they enhance and reinforce one another.

What Is Contained in Each of the 8 Domains?

- 1. Early Childhood Development:** how development unfolds from conception to 5 years old across social, emotional, cognitive, language, physical, and motor development and ways to responsively support it
- 2. Family-Centered Practice:** why and how to effectively partner with families to support children's health and development by building positive, supportive relationships
- 3. Relationship-Based Practice:** why relationships are central to supporting the development of children, and how to create responsive and productive relationships with children, families, and other service providers
- 4. Health and Development Risk and Protective Factors:** how and why multiple factors—including community, economic, political, and cultural influences—support or impede healthy development and the quality of relationships; and ways to work with families to identify strengths and use them as resources to reinforce protective factors, help manage challenges, and reduce risks

- 5. Cultural and Linguistic Responsiveness:** how culture and language have profound effects on child and family development, ways to raise awareness of our own assumptions about cultural attitudes and values, and strategies to integrate culturally and linguistically responsive methods
- 6. Leadership to Meet Family Needs and Improve Services and Systems:** why and how to exercise leadership in advocacy, policy, and sharing knowledge and resources with families, colleagues, and the general public to promote optimal outcomes for expectant parents, young children, and their families and caregivers
- 7. Professional and Ethical Practices:** why and how to follow and apply high-quality practices consistent with ethical and legal standards, behaviors, requirements, and obligations; and improving practices based on evidence, emerging knowledge, and promising approaches
- 8. Service Planning, Coordination, and Collaboration:** why effective and responsive service provision requires planning, including a coordinated effort with other sectors and service providers; and how to take a strength- and relationship-based approach in partnerships

Beyond the Journal

It's not only the *ZERO TO THREE Journal* where you can find a connection to the *ZERO TO THREE Competencies for Prenatal to Age 5 Professionals*. The P-5 Competencies Model is now linked to every source of professional development that ZERO TO THREE offers.

The Learning Center

The ZERO TO THREE Learning Center is the hub for our professional development, all of which is now categorized and searchable by the P-5 Competencies to make it easier for you to identify areas for growth, find the professional content you need, and even track your learning successes.

ZERO TO THREE Critical Competencies for Infant-Toddler Educators™

The P-5 Competencies also provide a foundation for the specialized ZERO TO THREE Critical Competencies for Infant-Toddler Educators™ (see Figure 3). The Critical Competencies define the specific evidence-based teaching methods and practices that support and nurture young children's social-emotional, cognitive, and language and literacy development and learning. (Note: Offerings in the Learning Center that are relevant for early childhood educators are also categorized and searchable by the Critical Competencies areas and sub-areas as well as the P-5 Competencies domains.)

Figure 2. Five Early Childhood Sectors



The ZERO TO THREE Annual Conference

When you attend the 2018 conference in Denver, you will find all of the conference sessions organized by the primary P-5 domain addressed in each session. If you are unable to attend in October, you can access the sessions, and those from the most recent previous Annual Conferences, on the Learning Center, all organized and searchable by P-5 Competencies domain.

Learn More

ZERO TO THREE's P-5 Competencies

For more information on ZERO TO THREE's P-5 Competencies and the Critical Competencies, and how you can use them to inform your professional development goals, visit: www.zerotothree.org/p-5competencies and www.zerotothree.org/criticalcompetencies

ZERO TO THREE Learning Center *Connect to Learn*

www.zerotothree.org/learningcenter

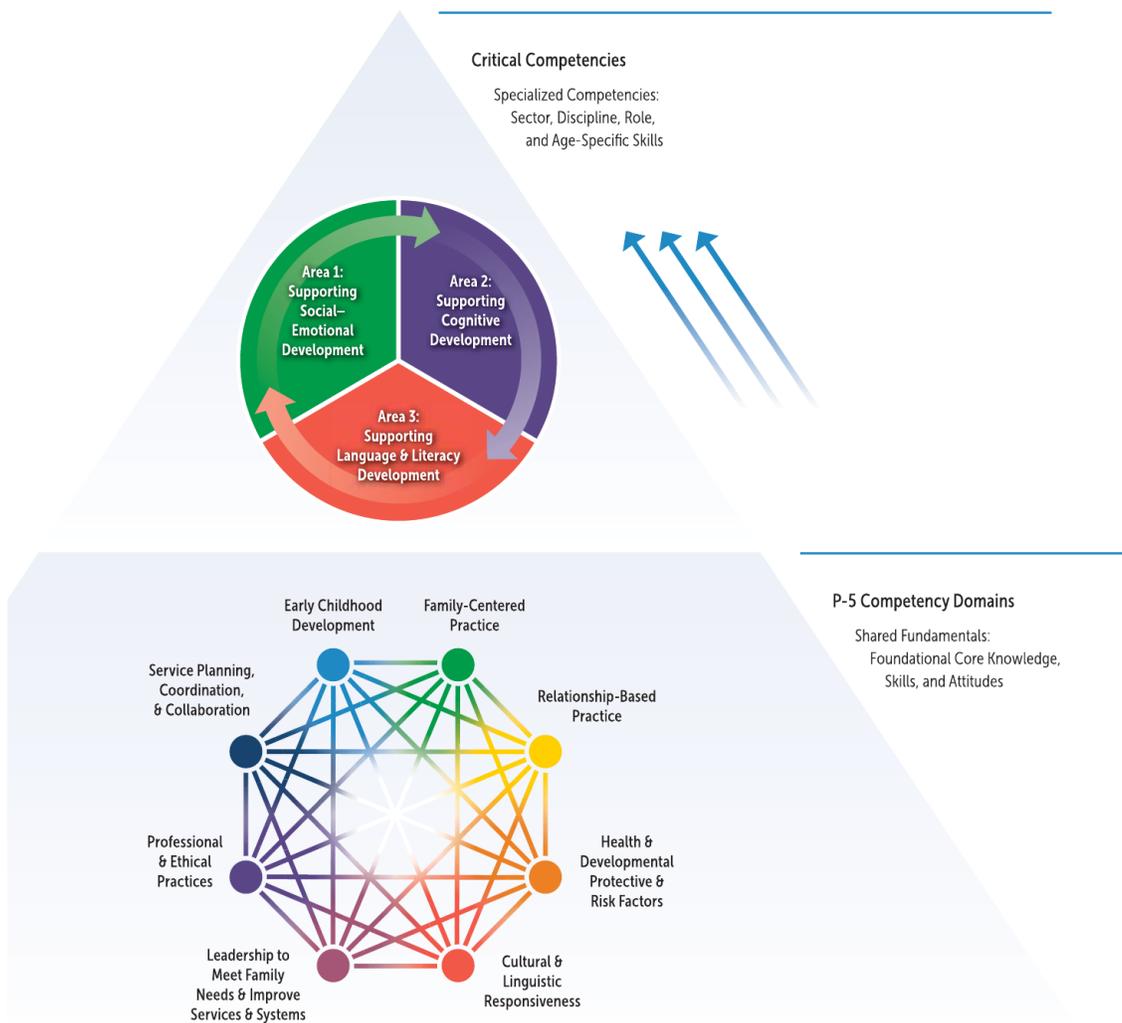
ZERO TO THREE Annual Conference

Join us for ZERO TO THREE's Annual Conference 2018, October 3–5 in Denver, CO. Learn more and register at <http://annualconference.zerotothree.org>

ZERO TO THREE Competencies for P-5 Professionals™ Online Course

Visit the Learning Center to take our 8-hour online course.

Figure 3. Critical Competencies Build on the Foundation of the Competencies for Prenatal to Age 5 (P-5) Professionals



Historical, Sociopolitical, and Mental Health Implications of Forcible Separations in Young Migrant Latin American Children and Their Families

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Abstract

This article will address immigration as a psychosocial event and will describe the different stages of the immigration process, when immigration becomes traumatic, and how each immigration stage can place vulnerable Latin American families at high risk for traumatic stress. It will explore pre-migration experiences and the factors bringing young families to cross the United States–Mexico border. The authors discuss (a) the long- and short-term effects of family separations on young children and their caregivers and (b) trauma- and diversity-informed interventions targeted at increasing safety, empowerment, and hope.

Between May and July 2018 (when this article was written), more than 2,300 children were forcibly separated from their parents while attempting to cross the United States–Mexico border (Domonoske & Gonzales, 2018; Lind, 2018) as a result of immigration enforcement activities. The short- and long-term effects of parent–child separation on children's functioning and overall well-being have been well documented; these effects can be particularly multifaceted, complex, and toxic for very young children (González, Kula,

González, & Paik, 2017; Miller, Hess, Bybee, & Goodkind, 2017). Moreover, for young children who have experienced traumatic events, as is the case for many migrant children, the separation of an attachment figure not only represents an additional traumatic event, but robs them of the comfort and protection that the relationship with these figures can provide in times of stress and hardship. The absence of the parent also decreases the possibility of regulating affect, making meaning of experiences, re-establishing of a sense of safety, and ultimately recovering from trauma (MacKenzie, Bosk, & Zeanah, 2017). Thus, these separations can cause extreme emotional distress and have a cumulative impact which can place these children at risk for mental health, developmental, behavioral, and physical difficulties in early childhood and later in life (Cardoso, 2018; Lieberman & Van Horn, 2008; Massachusetts

Competencies for Prenatal to 5 (P-5) Professionals™

P-5 3 P-5 4 P-5 5 P-5 6 P-5 7

For more information see page 5, or visit www.zerotothree.org/p-5

Association of Infant Mental Health: Birth to Six, Inc, 2018; Okello, Nakimuli-Mpungu, Musisi, Broekaert, & Derluyn, 2014; Rubio-Hernández & Ayón, 2016; Zayas & Bradlee, 2014).

The separation of families under the Trump administration stems from their implementation of the Zero Tolerance Policy. On May 7, 2018, Attorney General Jeff Sessions announced that, under this policy, any person who crosses the southwest border of the United States without proper immigration documentation will be held for prosecution (Sessions, 2018). At the same time, the *Flores Settlement* and the *Trafficking Victims Protection Reauthorization Act* prevent the government both from holding children in restrictive environments or from holding them for longer than 20 days. Therefore, the children could not be lawfully held while their parents awaited trials and, as a result, were separated upon arrival at the border. Following separation, children from birth to 17 years old are being held in facilities run by the Office of Refugee Resettlement. The youngest children are held in “Tender Age” shelters which are specially equipped to house children under 5 years old. Eventually, some children are sent to foster families, but many have remained disconnected from their parents (Domonoske & Gonzales, 2018).

These fear-invoking policies and family separation tactics were intended to deter families from crossing the border but have not proven successful in doing so as migrants continue to try to reach the United States (Domonoske & Gonzales, 2018). This, some commentators have noted, speaks especially to the dire circumstances that force people to migrate: Few migrants perceived these policies as being worse than the conditions in their home countries (Vásquez, 2018).

On Wednesday June 20, President Trump signed an executive order to end family separation and replace it with family detention. He has requested from the federal courts an addendum to the existing laws so that children can be held in detention with their parents indefinitely. However, for the children who have already been separated, the process of reunification is relatively hazy (Shear, Goodnough, & Haberman, 2018). While there are formal procedures in place to reunite families following the parents’ deportation trials, some lawyers and advocates have noted a lack of formal tracking systems to ensure that the children are both accounted for and connected to their parents’ cases, and, in fact, some parents have been deported with their children remaining in foster care or in detention facilities in the United States (Domonoske & Gonzales, 2018; Shear et al., 2018).

“Until very recently, the plight of young migrant children affected or threatened by the loss of their attachment figures to immigration enforcement activities has been often omitted or ignored in debates and enforcement policies on immigration” (Hainmueller et al., 2017; Zayas, Aguilar-Gaxiola, Yoon, & Rey 2015; Zayas & Heffron, 2016, as cited in Osofsky, Wieder, Noroña, Lowell, & Worthy, 2018, p. 35). These policies run against developmental science and social justice principles in which early childhood and mental health work is grounded



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On Wednesday June 20, 2018, President Trump signed an executive order to end family separation and replace it with family detention.

(MacKenzie et al., 2017). Therefore, in order to avoid becoming silent bystanders of normalized violence and to better advocate and serve these children, infant and early mental health practitioners must: (a) increase their understanding about the impact that separation from primary caregivers under sudden, frightening, and chaotic circumstances can have on young children who might have been exposed to prior significant traumas and losses; (b) raise their awareness about the ripple effects that these unnecessary separations have on the immigrant community, on the providers, on institutions charged with the protection of children (e.g., child welfare agencies), and on society in general; (c) learn about the dynamics of immigration and about the historical, socio-economic, and political factors and contextual forces influencing families’ decisions to leave their countries and that further endanger them once they cross the border to the United States; and, most important, (d) engage in intentional self-exploration about how their own personal histories, socio-cultural contexts, and professional cultures have shaped their views, values, and preconceptions about working with undocumented migrant families (Osofsky et al., 2018; St. John, Thomas, & Noroña, 2012).

This article will address immigration as a psychosocial event and will describe the different stages of the immigration process, when immigration becomes traumatic, and how each immigration stage can place vulnerable Latin American families at high risk for traumatic stress. It will explore pre-migration experiences and the pull and push factors (Goldberg, 2014) causing young families from the Northern Triangle, Mexico, and neighboring countries to cross the United States–Mexico border. We will analyze two powerful push factors: the current drug wars in Mexico and the social violence reverberating in Central American countries as the aftermath of historical traumas that affected the region between 1960–2000, in the form of foreign-sponsored political violence and massacres.



A great majority of undocumented families detained and separated at the United States Mexico border are nationals from Mexico and from the Northern Triangle.

We will present forceful separation of migrant children from their caregivers as a continuation of systemic forms of oppression and violence with this population and a replication of practices historically used in the US with the most vulnerable. The article will emphasize how protecting migrant children's rights to be with their families is not only a historical debt and a human rights responsibility, but a way of breaking historical patterns of abuse and oppression

We will briefly address the long- and short-term effects of family separations on young Latin American children and their caregivers, and we will discuss trauma- and diversity-informed interventions targeted at increasing safety, empowerment, and hope (Osofsky et al., 2018).

Overview of Immigration as a Psychosocial Event

Migrating across borders is a complex psychosocial process that includes the initial decision to leave, the process of migration, and of adjustment to the new country (Pérez-Foster, 2001). Whether permanent or temporary, forced or chosen, immigration entails losses, family fragmentation, and psycho-structural change, all of which has a lasting impact on a person's identity (Akhtar, 1995; Pérez-Foster, 2001). Immigration then, has deep effects on the overall health and well-being of youth and adults, including their mental health functioning.

From a mental health perspective, immigration is undoubtedly linked to major adjustment stressors; it has been associated with depression, anxiety, substance abuse, increase of violence, and posttraumatic stress disorder (Pérez-Foster, 2001). The impact of immigration to a family's and individual's functioning depends on a number of factors such as: reasons to leave

the country of origin, degree of choice to immigrate, age of immigration, mode of migration, temporary versus permanent migration, possibility of revisiting the home country, migrating alone or with family, the possibility of keeping original professional and socio-economic status (e.g., a medical doctor cannot practice any longer as a result of his degree not being recognized in the receiving country), and how the host country receives the immigrants (Pérez-Foster, 2001).

Certain risk factors associated with what has been described as immigrant trauma (Pérez-Foster, 2001) place individuals who have fled their native countries as a result of war, genocide, violence, or oppression at very high risk for further psychological trauma (Aisenberg & Herrenkohl, 2008; Bernal & Sáez-Santiago, 2006; Fortuna, Porche, & Alegria, 2008; Murphey, 2016; Zayas & Cook, 2016). These potentially toxic factors include not only pre-migration stressors but also negative experiences occurring during the transit into the US and during temporary settlement such as, parental separation, sexual assault and rape, intimidation, exploitation by human smugglers, witnessing acts of violence, deprivation of basic needs, discrimination, and uncertainty. Once in the US, immigrants face additional stressors such as language barriers, discrimination, substandard housing and overcrowding, extreme poverty and isolation, acculturative stress, and vulnerability to exploitation and violence (Pérez-Foster, 2001). One of the most deleterious post-migration conditions for adults and their children is the lack of legal immigration status. There is evidence that the anguish and stress generated by a person's undocumented status compounds pre- and during migration stressors as well as intra- and extrafamilial acculturative stress increasing the risk for psychopathology (Cavazos-Rehg, Zayas, & Spitznagel, 2007; Fong & Earner, 2007; Kanaiaupuni, 2000; Potochnick & Perreira, 2010; Suárez-Orozco, Yoshikawa, Teranishi, & Suárez-Orozco, 2011; Yoshikawa & Kholoptseva, 2013; Zayas & Cook, 2016).

Fears of immigration authorities may discourage undocumented immigrants from seeking help for employment and health services (including mental health services), from maintaining family and social connections, and from participating in public and educational programs which their children may be eligible for and could benefit from (e.g., child care subsidies, public preschool, food stamps; Kanaiaupuni, 2000; Yoshikawa & Kalil, 2011) thus, increasing their isolation and vulnerability.

The literature highlights that it is not uncommon for undocumented immigrants to feel that they are being hunted (Cavazos-Rehg et al., 2007) and that they are trapped and to consequently experience loneliness, disorientation, isolation, depression, sadness, and confusion (Pérez-Foster, 2001). Immigration enforcement practices, like the ones currently implemented in the U.S., are just a confirmation of some of the worst fears and fantasies in undocumented families and consequently can trigger previous traumas in children and their parents (Potochnick & Perreira, 2010); impact parents' ability to be available emotionally and physically for their children; and lead to severe mental health symptoms for the

entire family, especially children (Garrison, Roy, & Azar, 1999; Kanaiaupuni, 2000).

A great majority of undocumented families detained and separated at the United States–Mexico border are nationals from Mexico and from the Northern Triangle (El Salvador, Guatemala, and Honduras), which is a reflection of the prevalent danger and instability in these countries (Kaltman, Hurtado de Mendoza, Gonzales, Serrano, & Guarnaccia, 2011; MacKenzie et al., 2017). In the case of Mexico, the escalation of violence by the drug cartels has forced families to flee within Mexico and then to the US. Regarding Central America, there are a number of studies (Goldberg, 2014) that have analyzed the factors that motivate families from the Northern Triangle to emigrate, and one of the most significant reasons is to escape the high levels of violence in the region. Violence in Latin America has its roots in a history of colonization; foreign interventionism; repeated ethnic massacres; and oppression and violence against minority communities, the elderly, women, and children. The next section provides a closer look at the socio–political and historical context of violence in the region and evidences its significance in parents’ decisions to bring their children to the United States–Mexico border despite dire circumstances.

Why Do Families Leave Mexico and the Northern Triangle? Push Factors

Human migration is a fundamental human activity (Daniels, 2002). Waves of anti-immigrant sentiment are surprising because the United States was built by immigrants. America was not discovered but invented by the minds of Europeans who were looking for another land and stumbled upon America (O’Gorman, 2000). The continent was not “discovered” because people lived here already, but America was conceived from a Eurocentric view of the world with its inherent beliefs toward the land, its resources, and indigenous people. These beliefs led to destruction of indigenous groups, including their cultures and languages, and their dehumanization that led to the brutality and injustice inflicted upon them and recorded in history. The perceived inferiority of the “naturals,” as Cortez called the Indians, was imbedded in the minds and the institutions of the cultures of the new nations, continues until present day, and now is expressed in covert ways as segments of the public become skilled in using coded language to hide racist views. It is a form of “racism without racists” that is particularly practical since it places the “blame on the victim” to justify their treatment and at the same time save face (Bonilla-Silva, 2013; Hartman, Newman, & Bell, 2014; Mueller, 2017). The strong anti-immigrant sentiment, based on false notions about how migration affects the US, has contributed to the current restrictive and controversial immigration policies that authorities have perceived as having public support (Hartman et al., 2014). The rhetoric coming from these segments of our population defines the immigration of “certain people” as a threat to national security by describing them as dangerous rapists and criminals who come to the US



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Urban violence has increased in Central America and affected the living conditions of people in El Salvador, Guatemala, and Honduras.

to deplete its resources and threaten American culture. This is how families escaping from Latin America, especially those fleeing the violent Northern triangle, are currently perceived.

The brutal act of separating caregivers from their children at the United States–Mexico border has been justified as an effort to enforce the law. However, it is important to remember the plight of these families. The US has been intimately involved in Central and South American countries, defending U.S. interests and asserting military and cultural dominance (van den Berk, 2017). Between the years 1960 and 2000, the US provided aid that supported political violence in these countries (Buergenthal, 1994). In addition, the US continues to be connected to Latin America through drug trafficking dynamics as the US is the primary customer of a multibillion industry driven by its suppliers: Mexican drug cartels and Central American transnational gangs which engage in bloody wars fight fiercely for control of supply routes. During President Calderon’s administration, drug violence took more than 120,000 lives in Mexico (Heinle, Rodriguez Ferreira, & Shirk, 2017). But this is not just a Mexico problem; violence associated with drugs and the gangs that profit from and traffic drugs has spread throughout Central America and has been particularly brutal in El Salvador, Guatemala, and Honduras. These countries have some of the highest homicide rates in the world, higher than Mexico (Ribando Seelke, 2011). Central America is more vulnerable to violence due to the proliferation of illicit firearms as a result of prolonged armed conflicts, historical trauma, high unemployment rates, and growing youth populations. Central America is also located between the largest drug producing countries in the world and the trafficking routes to Mexico and eventually the U.S. (Ribando Seelke, 2011).

Urban violence has increased in Central America and affected the living conditions of people in El Salvador, Guatemala, and Honduras. The fight between gangs over territorial control

is ongoing and has eroded the economies and the social fabric of those communities (Medina, 2014). Families leave not only to search for better economic opportunities but also to survive (U.S. Conference of Catholic Bishops, 2014). Many parents migrate to prevent their young girls from being raped (UNHCR, 2015) or their young men from being killed or recruited by the gangs. For many, migration is the only option. Some families seem to prefer the dangers inherent in the long journey from Central America to the US over the insecurity they face at home (Medina, 2014). These dangers are too many to describe in this article, but they include financial exploitation by traffickers and bribes, physical and sexual assault, physical deprivation, harassment and discrimination, and sometimes death. Families who cross the border face severe trauma pre-migration and are willing to experience numerous additional risks to seek safety for their children; however, these children are now enduring further trauma by being unnecessarily separated indefinitely from their parents.

Based on what was expounded above, it seems that there needs to be increased awareness at the institutional and societal levels of the United States' historical debt with the countries mentioned above. "Rather than emphasizing that the risk families navigate on their journey reflect a parents' dangerous choice, the Department of Homeland Security (DHS) could more helpfully focus on the violence and instability that so many of these families are fleeing" (MacKenzie et al., 2017, p. 2314) and implement policies in a more humane way.

Separating families as a mechanism of control of diverse racial and ethnic groups is not new in the history of the US, or in the history of immigrants in the US, and we propose that recent enforcement activities, directed at frightening and fragmenting immigrant families, embody echoes of unresolved historical wounds.

Echoes From the Past and Forced Family Separations

While the separation of families migrating from south of the border has received extensive media attention, the Trump administration are not the first actors in U.S. history to implement practices of removing the most vulnerable children from their families. Prior to the current situation, 19th and 20th century U.S. policies violently separated people from their families to be sold into slavery and then separated Native American school-age children from their parents. The oppressive mechanisms of fear and family fractures have been used since the early 19th century to control populations and perpetuate fear, all in the context of a prolonged and multigenerational history of struggle and pain.

In the antebellum period (1800–1860), people who were enslaved lived under the consistent threat of family separation. Young slaves were often exchanged as gifts or given as a part of an estate when an estate needed to be divided. Other times, slaves could be sold in long-distance sales that would physically divide the families across the country. Further, if families were spared from separation they, nonetheless, felt the daily stress of the possibility of separation (West, 1999). This prolonged anxiety and fear most likely caused physiological changes to the body that place slaves and descendants of slaves at higher risk of stress-related diseases. In the 1880s and 1930s, the

U.S. government implemented a new family separation policy, but this time the policies impacted Native Americans. Children were removed from their homes to attend boarding schools where they were not permitted to participate in traditional practices or speak the languages they had grown up speaking (Evans-Campbell, 2008; Evans-Campbell, Walters, Pearson, & Campbell, 2012;

Hummingbird, 2011). More recent studies have found that the impacts of this forcible separation to boarding schools include higher incidence of substance use disorders, depressive and anxiety related issues, suicidality, and severe post-traumatic stress disorder when compared to Native American children who remained with their families and did not attend boarding schools (Evans-Campbell et al., 2012; Hummingbird, 2011). These symptomatic responses have been attributed to a loss of relationships and connection to culture, the internalization of negative self-identity, and historical traumatic experiences.

Forcible separations of young children in migrant families represent the purposeful and systematic utilization of fear and pain by those in power, to control and subjugate a target population; thus, they constitute a re-enactment, a modern expression, a perpetuation of historical trauma experiences that were previously inflicted to other vulnerable groups in the US.

Historical trauma refers to a "cumulative and psychological wounding, as a result of group traumatic experiences, transmitted across generations within a community (Substance Abuse and Mental Health Services Administration, 2016; Yehuda et al., 2016)" (National Child Traumatic Stress Network, [NCTSN] 2017, p. 2). These experiences include traumatic events executed by dominant groups that were usually directed to a particular population as a result of a specific diversity characteristic of that group (e.g., race, ethnicity, religion, nationality, immigration status, gender, or sexuality; Hooker & Czajkowski, 2007; Lewis, Noroña, McConnico, & Thomas, 2013; National Child Traumatic Stress Network, 2012; Sotero 2006). The long-term and prolonged impact of historical trauma influences both physical health and mental health of entire populations (Mohatt, Thompson, Thai, & Tebes, 2014; Sotero, 2006). Examples of historical trauma experiences include political violence, genocide, systematic family fragmentation, rape, generations of structural inequities, and discrimination based on group membership (Duran, Duran, & Brave Heart, 1998; Eyerman, 2004;

Immigration has deep effects on the overall health and well-being of youth and adults, including their mental health functioning.

Healey, 2013; Hooker & Czajkowski, 2007; Lewis et al., 2013; Sotero, 2006). The reverberations of these experiences, if not processed, can be transmitted across generations in the form of traumatic stress and other symptoms and have continued effects at the individual, family, institutional, and community levels involving not only the oppressed groups but those who are oppressors and those who are bystanders (Hooker & Czajkowski, 2007). "The impact is not only about what happened in the past, but also about what is still happening in the present to target a group of people or actions by others that serve as reminders of historical targeting (NCTSN et al., 2017, p. 2)"; (Evans-Campbell, 2008).

As was mentioned previously, the lasting legacies of historical trauma of an identified group have implications for the physical, social, and psychological health of individuals, families, and communities. At the individual level, these may be expressed through inherited biological changes in the stress response (Evans-Campbell, 2008). At the family level, these may manifest through parent-child relationships in a variety of ways that can impact young children's outcomes (e.g., specific developmental expectations and socializations patterns that may be no longer adaptive; the intergenerational transmission of trauma through heightened levels of stress and neglectful and abusive patterns in the attachment relationships or through secrecy; Lewis & Ghosh Ippen, 2014; Lewis et al., 2013; Sotero, 2006).

At the community level, the impact of historical trauma may manifest through ongoing community exposure to oppression and inequities including racial trauma, discrimination, and fear (Ghosh Ippen, in press), systems of care where surreptitious patterns of injustice get reproduced with families.

From this perspective, "the legacies from enslavement of African Americans and the displacement and murder of American Indians" (NCTSN, 2017, p. 2) have not only been transferred to current descendants of these targeted groups, but they have affected society and institutions. These legacies are currently reproducing historical patterns of control and oppression with young immigrant children and their families who already carry the legacies of historical trauma from their own countries.

The impact of historically traumatic events which unconsciously transcend many generations of Latino immigrants attempting to cross the border, in tandem with the experience of family separation, is likely creating a detrimental physical and mental health impact.

In the US, the decision to separate children from their families usually constitutes a last resort used by the state to protect them from maltreatment by family members (MacKenzie et al., 2017). Hence, it is extremely concerning that presently thousands of the most vulnerable children and families are systematically endangered by the U.S. government in order to discourage other families from crossing the border (MacKenzie et al., 2017).

The situation of these children constitutes a humanitarian crisis that cannot be minimized or ignored, and developmentally appropriate and equitable solutions cannot be postponed.



Photo: Joseph Sorrentino/shutterstock

Families who cross the border face severe trauma pre-migration and are willing to experience numerous additional risks to seek safety for their children.

By respecting and honoring the rights of these families, we believe that the US and its people can have the opportunity to begin breaking the legacies of abuse, racism, and oppression toward underprivileged groups. This journey toward reparation and healing may start by: (a) Immediately interrupting the separation of families and expediting the reunification of the ones already fragmented; (b) incorporating an understanding of how historical trauma has shaped present days' interactions toward disenfranchised groups; (c) creating a narrative that acknowledges past harms to these groups, and offers hope and restitution; (d) and developing care arrangements for children and families that offer alternatives to detention in the asylum and migration context (United Nations High Commission for Refugees, 2017).

There is also evidence that the immigration policies not only impact undocumented immigrants, but also documented ones and even citizens and communities (Brabeck, Lykes, & Hunter, 2014). Countries with more inclusive and supporting immigration policies have better outcomes on general indicators of health and mental health in young populations (Marks, McKenna, & García Coll, 2018).

Furthermore, the *United Nations Convention on the Rights of the Child* (United Nations Office of the High Commissioner for Human Rights, 1990), requested that countries make decisions based on the best interests of the child (Article 3) and declare the right of the child to be cared for by her/his parents (Article 7). Tenet number 2 of the Diversity Informed Infant Mental Health Tenets also reminds practitioners in the field of infant and childhood mental health that "Infants are citizens of the world. It is the responsibility of the global community to support parents, families, and local communities in welcoming, protecting and nurturing them" (St. John, Thomas, & Noroña, 2012, p. 15).

Impact of Family Separation on Children

Since late 1930s, there have been many scholars studying the effects of separation and deprivation in infants, first in animals and afterward in humans (van der Horst & van der Veer, 2008). Spitz and Wolf (1946) showed that children suffered deep depression after separations from their mothers, and that this experience was associated with serious deterioration during child development. Young children process their emotional states thanks to their caretaker's attunement to their emotions and concordant response (Stern, 1985), which help children regulate. When children experience traumatic events, "infants and young children engage in unpredictable responses that present a challenge...leading to fears that the child has been permanently damaged and altering the parent's emotional attunement to the child" (Lieberman & Van Horn, 2008, p. 19). Children need the comfort of sensitive and responsive parents or caretakers to process stressful events (Hostinar, Sullivan, & Gunnar, 2014), especially the ones who have been already impacted by the aftermath of the process of immigration while their world is changing as they accompany their parents to presumably safer places. As discussed previously, many of these families fled from civil conflicts or oppressive dictatorship in their countries of origin, which implies that they may also carry pre-immigration traumas (Pérez Foster, 2001). Not having access to their primary caretakers can worsen the physiological and psychological effects of stressful events on children, especially in younger ones (Masten & Narayan, 2012). On the other hand, while one parent is absent, the opportunity to receive the warmth and support from other parental figures or caregivers can serve as a protective factor (Rodríguez & Margolin, 2015).

In circumstances when there is a sudden separation from the caregivers, as in the case of parental detention (Brabeck et al., 2014), all family members experience the event as a crisis; there is usually no time to make preparations for the aftermath of the separation, including arrangement in terms of child care, and there is a state of heightened confusion and anxiety as there might not be easy access to information regarding the detained adults (Androff et al., 2011; Capps, Castañeda, Chaudry, & Santos, 2007). Sometimes, not knowing where their parents are and what happened to them can also trigger in children memories of disappearances experienced in their country of origin (Brabeck, Lykes, & Hershberg, 2011) or cognitive distortions by which the children blame themselves for the parents' arrest and/or absence. Many families can be separated and moved to different states (McLeigh, 2010); children may be placed in foster care in cities far away from the adult's detention facilities. Young children may experience the separation as annihilation, losing the parent's love and protection, which leads to emotional distress and can affect

relationships and behaviors later in their lives (Gindling & Poggio, 2012; Lieberman & Van Horn, 2005).

On June 20, 2018, the Society for Research in Child Development declared in a statement of the evidence that young children separated from their family can present short- and long-term consequences in their overall functioning due to the impact of dealing with stressful or traumatic events without their primary source of comfort and security, and that being separated from their family is one of the principal sources of toxic stress and possibly posttraumatic stress disorder in these population (Bouza et al., 2018).

Based on what has been studied regarding the impact of parental separation due to detention or deportation in mixed-status families, there is evidence that young children can exhibit behavioral, developmental, and emotional difficulties including separation anxiety, ambivalent feelings toward the absent parent, aggression toward caregivers, withdrawal, depression, loss of appetite, feelings of shame, and confusion because the parent was arrested (Yoshikawa & Kalil, 2011). For many children, the most traumatic characteristic of the separation is witnessing the parent being handcuffed, threatened, or beaten during the detentions and facing unresolved questions and concerns regarding the parent's well-being and whereabouts (Allen, Cisneros, & Tellez, 2015; Osofsky et al., 2018). Some authors have compared the experience associated with parental separation to the constructs of

traumatic grief (NCTSN, 2016) and more specifically of ambiguous loss (Luster, Qin, Bates, Johnson, & Rana, 2008). *Traumatic grief* is a condition that takes place when the circumstances of the death interfere with the grieving process. In children it is characterized by posttraumatic responses including intrusive thoughts; nightmares; disturbing images of the event represented in play or art; avoiding reminders of what happened (e.g., places, people, things associated with the event); distorted beliefs about oneself, others, or the event; and negative changes in mood (anger, sadness, fear, shame; NCTSN, 2015). Although children who have been separated from their parents might develop clinically similar responses to children whose parent has died, the challenge for the children who experience a traumatic separation is that their caregivers are still alive and the children have justifiable reasons to hope to be reunited with them. However, this reunion may not happen in many years or may not happen at all (NCTSN, 2015), giving place to unsolved distress, confusion, and emotional pain. Ambiguous loss is defined as when a family member is psychologically or physically absent (Tubbs & Boss, 2000), and it creates stress and pain because situations associated with it produce ambiguity about the status of the loved one and because, in general, closure is not possible. Even if reunification with the family member happens, the separation can lead to psychological difficulties: depression, detachment, feelings of powerlessness,

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or feeling immobilized. Several studies evidence that children whose parents migrated and reunited with them afterward are susceptible to attachment difficulties, depression, decreased academic performance, and behavioral problems (Abrego, 2014, and Artico, 2003, cited in González et al., 2017; Dreby, 2015; Lovato-Hermann, 2017). Furthermore, there is evidence in Latino children that the impact of family separation can persist after family reunification and that problems may become more intense and frequent after longer periods of separation (Gindling & Poggio, 2012).

Supporting Young Children and Families Affected by Separation

On March 1, 2018, Colleen Kraft, president of the American Academy of Pediatrics, wrote a letter to Kirstjen M. Nielsen, Secretary of Homeland Security, about the profound trauma caused by abrupt family separation on young children. She declared that children's brains change due to environments and experiences and that being exposed to prolonged fear and stress can harm the developing brain and impact short- and long-term health, especially when children don't have access to the buffering protection provided by stable, responsive relationships. Kraft encouraged keeping families together to buffer the effects of times of strife that children are experiencing.

Our stance on the topic of family separations is that all children, regardless of their immigration status, are entitled to basic human rights such as: physical safety, meeting other basic needs, and appropriate immigration processes including legal representation. The parent-child relationship is fundamental, and children should not be separated from their parents while legal actions are taken. If separation is explicitly necessary it should avoid re-traumatization, and agencies should be trained in assessing and supporting children through the time that they are in government custody (Murphey, 2016).

Recommendations and Resources That Can Help During the Time of Separation

It is important to remember that how young children experience the separation from a parent, the reunification process, and the multiple stressors linked to all of this, is going to depend on a number of factors including (Yoshikawa & Kholoptseva, 2013):

1. **Caregivers' functioning:** The quality of the caregiving environment (attuned to child's needs, available to help the child make meaning of experiences, increase opportunities for self-regulation, provide consistency, predictability and protection) and the relationships in it, either with the biological family or the adults in charge of the child (foster parents, guardians chosen by the family)
2. **Child's strengths and vulnerabilities:** Child's temperament, developmental, medical, socio-emotional, self-regulatory abilities, history of mental health issues and prior traumas

3. **Neighborhood and network social resources:** Connections to ethnic enclave communities or other community supports (e.g., church) that can provide important information on services for the child as well as continued exposure to socio-cultural aspects of the child's country of origin, that could guide the caretaker and support him in supporting the child.

4. **Access to developmentally appropriate, diversity- and trauma-informed mental health resources and services:** As mentioned in this article, a great majority of families coming through the border with Mexico are nationals from Mexico and from the Northern Triangle. When thinking about appropriate interventions for these children and their caregivers, it is critical to address the complexities and possible compounding effects of immigration trauma, historical trauma, and traumatic separation on child development, child developmental expectations, child-parent relationships, and family functioning. In addition, a multipronged, multilayered approach to intervention is recommended for addressing the multiple urgent needs (e.g., legal advice, assistance with concrete needs, safety planning) presented by these children and families (Osofsky et al., 2018). This approach involves a comprehensive assessment (including obtaining information, as much as possible, on immigration and experiences of oppression), developmental guidance, dyadic relational treatment, parental support, and advocacy. The intervention pays attention to the child-parent relationships threatened or broken by immigration enforcement and helps to make meaning of the impact of this trauma on the child's and the parent's behaviors and their relationship. As part of the process, the clinician helps the caregiver(s) and the child to "speak the unspeakable" that in the case of children who were separated and placed in foster care (and/or with families, who were reunited) might include making meaning out of the separation, of what being undocumented means, and the creation of a safety plan addressing new threats.

The following are more immediate strategies and resources to support children and the caregivers supporting them:

The Psychological First Aid (Brymer et al., 2006) provides a framework that allows providers to organize their actions while working with children and adults immediately after intense traumatic events. Even though this resource was created for implementation after disasters or terrorism, we believe that separated families would benefit from the usage of its guidelines. The eight core actions include: (a) contact and engagement in a non-intrusive and compassionate manner; (b) physical and emotional safety and comfort; (c) stabilization, when needed to calm survivors' overwhelmed feelings; (d) identify immediate needs and concerns; (e) offer practical help to address current needs and concerns; (f) connect survivors with persons or other helping social supports; (g) provide information and resources on coping,

to promote adaptive functioning; and (h) link survivors with services for short- and long-term needs and concerns (Brymer et al., 2006). In the case of family separations at the border, they might need immediate legal assistance, and in the case of reunifications, referrals to mental health services and other family-centered supportive services should be a priority. (See Box 1.)

Reunification

Even when excitement may arise after knowing that families will be reunited, reunifications brings challenges that might be more demanding than the ones experienced during separation (González et al, 2017). Understand the unique effects of family separation on each child and family member, and develop personalized strategies to help each family member manage the process of reunification (Lovato-Hermann, 2017).

According to Falicov, (2007) “interventions for reunited families need to target making meaning out of the separation, restoring narrative coherence, and making family identity more clear, because all of these are likely to have become blurred over the time of separation” (p. 160).

The Workgroup on Adapting Latino Services (2008) provided guidelines for serving Latino children and their families when affected by trauma. These guidelines were developed to provide culturally sensitive and responsive mental health services to the diversity represented among Latinos in the US and highlight that trauma assessments and intervention for this population must be founded in evidence while paying attention to the unique needs of each family.

One of the interventions aligned with this approach is Child-Parent Psychotherapy; Lieberman, & Van Horn, 2005; Lieberman et al., 2015; Reyes, Stone, Dimmler, & Lieberman, 2017). This is a trauma-focused, relationship-based intervention for young children birth to 6 years old and their caregivers who have experienced a wide variety of traumas. Its main goal is the restoration of the child-parent relationship, which in turn is seen as the agent of change. Here the therapist's working relationship with the child-parent dyad is used as the vehicle for treatment under the premise that the quality of the relationship with the therapist will affect the child-caregiver relationship (Reyes et al., 2017).

Box 1. Helpful Strategies to Address Traumatic Separation

While young children are separated from their parents and living with other caregivers, there are strategies that might help to address the needs of children who have experiences traumatic separation, which are summarized in the document *Traumatic Separation and Refugee and Immigrant Children: Tips for Current Caregivers*” (National Child Traumatic Stress Network, 2018). Summary and adaptation of these strategies:

- (a) Provide security and comfort, by speaking with a calm voice, in the child's own language, following their lead.
- (b) Take care of immediate needs.
- (c) Help children understand what happened, find out what is happening to the child's parents, ask the child about what they know of the separation (if the child has verbal language and if developmentally appropriate) and provide reassurance that what happened is not their fault and tell them you understand that what is happening is very hurtful.
- (d) If possible, try to contact the child's parents and provide ongoing contact between them.
- (e) Understand that children may have unpredictable reactions, regressive behaviors, or other difficult behaviors due to traumatic events; try to encourage calm situations and activities that help with body and affect regulation and allowing the children to decide which activities are adequate for them.
- (f) Reassure them that they are safe now and ask them (if the child has verbal language and if developmentally appropriate) what would make them feel safer.
- (g) Comfort the children when needed and assess the level of physical proximity that feels safe for them; you can try singing or talking, and then see whether the children allow you to hug or rock them; also look

and offer other objects that can be comforting, such as stuffed animals or blankets.

- (h) Try to allow the children to express what they are feeling, reassure them that these big feelings are okay when scary things happen, and that it's normal to feel physically uncomfortable. It might be useful to use books for young children such as *Once I Was Very Very Scared* (Ghosh Ippen, 2016; PDF versions available online in different languages). In addition, coloring or playing may allow children to express what they are feeling, particularly very young children.
- (i) Help the children to stay connected with their family and culture, obtain information or ask them (if the children have verbal language and if developmentally appropriate) about traditional foods, activities, routines, and ways in which they can feel closer to their traditions.
- (j) Limit the access to media but keep children genuinely informed, according to age and development (National Child Traumatic Stress Network, 2018).
- (k) Engage in intentional self-exploration regarding your views, perceptions, and biases about working with undocumented immigrant parents or children and how these biases are affecting your work (Osofsky et al., 2018; St. John et al., 2012).
- (l) Pay attention to the possible affects of the work on you (vicarious traumatization, secondary traumatic stress) and seek support via reflective supervision from a mentor, a supervisor, or a peer group (Osofsky et al., 2018).
- (m) Convey a sense of hope to children and caregivers by identifying their strengths and providing them with information that is accurate, as much as possible.

This empirically supported intervention can be implemented with immigrant families, considering their unique experience, cultural beliefs, parenting practices and the intergenerational transmission of trauma (Noroña, 2011).

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In Danger at the Border

Parents Are Children's Best Tool Against Toxic Stress

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International Rescue Committee
San Salvador, El Salvador

Abstract

Since the 1980s, El Salvador has survived a 12-year civil war, two major earthquakes, devastating hurricanes, a massive drought, a famine, and now the current levels of violence related to gang presence across the country. Nearly everyone has had personal experience with at least one but more likely multiple traumatic experiences during their lifetime. Children are at high risk for experiencing toxic stress and being locked into a stress response that limits their possibility for healthy development. Parents, also victims of high levels of adverse childhood experiences (ACEs) and current trauma, choose migration as their best chance for a better future. The best possibility for a better future for children is promoting their resilience by ensuring a constant caring caregiver and preventing any disruption of that bond. Ensuring children and parents can be together is the hope for children in what is an impossible situation.

I have three children who, as I write this article, are digging in the garden and discussing fairies and magicians; earlier today they were riding bikes and drawing with chalk in the garage, their gleeful shouts echoing around the house. By happy fortune of birth, they are both U.S. and Salvadoran citizens. They are fortunate to speak two languages, feel at home in two cultures, go to good schools, live in a safe neighborhood, and have the protected luxury to wake up and think about what they would like to play and be confident that they will have enough to eat. They are further, and most importantly, fortunate to have two parents who love and care for them and provide them with that most important building block of development: constant stable caregivers who give them love and attention.

We live in El Salvador, a country that is an intense study in contrasts—our neighborhood is protected and safe; I can walk to a branch of a major international coffee chain (though I would rather drink the local coffee, which is much better!); there are world-class beaches, breathtaking lakes carved out of volcanic craters, mountains that scrape the sky as the clouds dance up and over their peaks ... and yet El Salvador is also home to one

of the highest rates of violence outside of an active war zone, and for many people in my adopted country life here is a war zone. El Salvador as a country is resilient. Since the 1980s, the people have lived through a 12-year civil war, two major earthquakes, devastating hurricanes, a massive drought, a famine, and now the current levels of violence related to gang presence across the country. Approximately 6 million people live in El Salvador, of which an estimated 300,000 have been internally displaced in the last 5 years, and an estimated 60,000 are active gang members on the streets with another 10,000 in prison (ElSalvador.com, 2016). Also, there are an estimated additional 2 million citizens living outside the borders. The impact of violence is pervasive in El Salvador (Garsd, 2015), with nearly every person having personal experience with at least one but more likely multiple traumatic experiences during their lifetime.

The current situation of violence is a constant undercurrent in how people make decisions about what they will do, where they will go, and what time of day they can do these things. People talk about "the situation", "the way things are", "how it is" and any number of other allusions to refer to the gangs, gang violence, and the level of stress that the population endures. If people have resources, calculations to keep themselves and their family safe are easily done and become background noise. For those who are poor, this constant calculus combined with the real and visceral threats and consequences, creates a level of toxic stress in families that will continue to have

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repercussions for much time to come. For children, their experience of toxic stress and that of their family is especially concerning, and parents know this. There is no parent living in a gang-controlled neighborhood who thinks their current situation is a good one—even the gang members.

The Children Are the Future

Children’s development is the cornerstone of the future of any country, not just developing countries and not just countries living in violence. The country’s human capacity needed for the future begins with early child development. For many developing countries, child development has historically been focused simply on survival: how many children will live past 5 years old (Ki-Moon, 2007). However, as programs that support survival to 5 (e.g., prenatal care, vaccinations, tropical disease prevention, dysentery treatment) have been successful in decreasing child mortality, other aspects of child development such as social–emotional and cognitive development have become a greater concern (Jensen et al., 2015). Social–emotional development is becoming more understood to be as essential as survival and physical development, perhaps even as the key to both.

Child development experts (Shonkoff, Garner, and The Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics, 2012) posit stable responsive relationships as one of three essential components for healthy development including also a healthy environment and sound and appropriate nutrition. A stable and responsive relationship is essential for healthy development as it “provides young children with consistent, nurturing, and protective interactions with adults to enhance their learning and help them develop adaptive capacities that promote well-regulated stress-response systems” (Shonkoff et al., 2012, e240). Love, attention, and the stability for the children of knowing that they will receive this affection and have their basic needs met is the foundation of a stable child–caregiver relationship. It is a defining characteristic of stable relationships that they endure even in adverse situations in which they are even more essential for children’s well-being.

Adverse Childhood Experiences

Child development can be significantly impacted by genetics, environment, and opportunities for development as well as experiences. Adverse childhood experiences, or ACEs, are stressful experiences occurring during childhood that directly hurt children or affect them through the environment in which they live (Felitti et al., 1998). ACEs include 10–13 items (depending on whether the scale is the US-based or international version) such as abuse, violence, poverty, and lack of stability in the home and with caregivers. Exposure to ACEs can alter how children’s brains develop as well as the development of their immunological and hormonal systems (Reuben et al., 2016).



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El Salvador is a study in contrasts, including world-class beaches and breathtaking lakes carved out of volcanic craters.

ACEs or stressful experiences cause a biological response that triggers the body’s survival instincts. The body responds to stress by increasing heart rate and blood pressure and releasing high quantities of hormones such as cortisol (Sheridan & McLaughlin, 2014). This reaction is the body’s “fight-or-flight” self-preservation instinct. A one-time or short-lived stress response can be a positive and protective response by the body. While a healthy adult is able to regulate her response to stressors by distinguishing threats from non-threats, children do not have adequately developed neural structures or sufficient prior experiences to successfully navigate stressful experiences (Montroy, Bowles, Skibbe, McClelland, & Morrison, 2016). As the neural connections governing stress response are reinforced through frequent usage for children who experience ongoing stress and violence, fight-or-flight responses become the predominant pathways the brain uses to assess situations. A fight-or-flight response as the predominant response mechanism by children to stimulants and stressors, regardless of whether they are big or small, is an indicator of prolonged exposure to “toxic stress” (McEwen & McEwen, 2017).

Within the brain’s physical structure, toxic stress causes the brain’s more primitive areas to become overdeveloped, while areas responsible for emotional control and rational decision-making, such as the cerebral cortex, are underdeveloped (Middlebrooks, & Audage, 2008). Children who live in high-stress/violence situations or are constantly subject to negative situations, become “locked” into a higher state of alertness, have well-developed abilities to recognize anger, and they become defensive with less provocation than children nurtured in a safe environment (Gunnar, & Quevedo, 2007).

Research consistently demonstrates that the more stress children are exposed to, especially in critical development periods like zero to 3 years old, the less energy they have available for their physical, mental, or emotional development. The impact of a high ACEs score begins with the stressful experience itself and continues through adolescence into adulthood as stress



Children's development is the cornerstone of the future of any country, not just developing countries and not just countries living in violence.

changes the actual brain architecture. Increased exposure to ACEs predisposes children to health concerns that last across the lifespan such as mental health illnesses and diseases such as cancer, heart disease, and diabetes. Experiencing higher levels of ACEs also correlates with poor social-emotional well-being as demonstrated by increased likelihood (a) of poor performance in school, (b) of involvement in criminal activity, and (c) to be both perpetrator and victim of violence; all of which decrease the likelihood of being a productive member of society (Brown et al., 2009).

Happily, there is one factor that is consistently shown to counteract the effects of ACEs and promote resilience and even more happily this factor is not an expensive intervention—a constant stable relationship in the form of a caring caregiver (ideally mom or dad, but it can be any adult).

The Importance of Stable, Responsive Relationships

For infants and young children, caregiving mitigates the stress response, with the caregiver-child relationship serving as a buffer against stressful experiences (Gunnar & Quevedo, 2007). Caregivers can help a child recover from stressful events by showing consistent responses to his emotions, modifying the

environment as needed to provide buffers from stressful situations, and soothing the child (Witten, 2010). Consistent and responsive attention to children from infancy helps build the neurobiological capacity to tolerate future stress by instilling a sense of security and supporting a greater capacity to tolerate stress (Perry, 2001). Nurturing relationships with caregivers and exposure to other positive experiences promote a strong foundation for healthy brain development. The confidence of a stable emotional space through a protected caring relationship is essential for children, because when the brain is not engaged in mere survival of real or perceived threats, it is able to dedicate energy to development.

Out of the Fire and Into the Frying Pan

People who have experienced high ACEs scores as children often raise their own children in situations that cause those children to similarly have high ACEs, creating a transgenerational experience in which the cycle of childhood adversity is difficult to break (Merrick et al., 2017). It is not that parents don't know that the situation their child is living in is not ideal, it is that they don't have another option or they themselves have low levels of resilience from surviving a lifetime of toxic stress and have difficulty planning a different future. However, this is an important question: Why would a parent take a child from her home and from her country of origin; go through multiple gang territories; pay more than their annual income while risking rape, extortion, human trafficking, and abuse; cross multiple international borders; and risk having the child taken from her? Simple: it seems like a better option.

How could that be a better option? For families that choose to take this journey fraught with danger, the possible risks of the journey and the new unknown give a possibility of future safety, while remaining where they are gives certain danger. A decrease in the legal options for seeking asylum (and even when it is possible to request asylum, the approval rates are quite low) makes the actual situation worse. Decreasing opportunities to seek asylum does not keep a 6-year-old boy from being a target for recruitment by gangs, it does not protect a 13-year-old girl from being told that she must become a gang member's girlfriend or have her family killed, it does not protect a family from extortion, and it doesn't take away the terror of "VER, OIR y CALLAR"—See it, Hear it, Be quiet—which is painted on walls after gang retribution to make sure people understand the limited scope of their power.

One Light Where There Is No Power

The best-known way to combat toxic stress is through providing a stable and caring caregiver, and yet the "zero tolerance" policy of the Trump administration led to more than 2,000 children being separated from their family members at the U.S. border without knowing when or if they will ever see their family members again. While the administration amended this policy with an executive order in June 2018 to "maintain family unity," there was no clear plan, and at the time of this writing there still is no clear plan, for the reunification of the separated

children and parents. The compounded trauma of leaving a terrifying situation, going on a terrifying journey, and then the separation from parents at the border is what makes the situation so very concerning. The younger the child, and the longer the separation, the more concerning.

For the children in “tender age facilities” the impact on the child’s sense of attachment with their caregiver (parent) is heart-wrenching, but more importantly it has devastating developmental impact. A child normally learns between 9 months and 18 months old to trust that a parent or caregiver will return when they are not visible, and the child’s sense of attachment continues to strengthen through the critical period up to 3 years. But researchers know that if the parent or caregiver disappears and doesn’t return and the child is cared for by multiple people without care and affection, this loss can affect the child’s ability to form healthy attachment throughout life, even as an adult.

Evidence demonstrates that children under 3 years old are particularly vulnerable to developmental delays when not provided with appropriate care and attention (Johnson, Brown, Hamilton-Giachritsis, 2006; Smyke, Zeanah, Fox, & Nelson, 2009). More important, there is a strong body of international evidence that shows the positive effects of quality care and attention (Baker-Henningham & Lopez Boo, 2010; Center on the Developing Child at Harvard University, 2007; David & Appell, 2001). The need for children to have their parent or other stable and caring caregiver is not new knowledge. The most recent literature showing how important healthy attachments are is based in institutional care settings such as the orphanages in Romania that caused irreparable impact on children’s development (Sheridan, Fox, Zeanah, McLaughlin, & Nelson, 2012).

The children separated from their parents at the border have left traumatic situations, are cared for by adults who have also lived through traumatic situations, and now are facing new trauma will be scared by the experience. The scarring could be dramatic enough to create the next generation of gang members. The tool that is the most consistently successful in alleviating the impact of trauma for children and promoting resilience is the support, love, and care from trusted stable



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Child development can be significantly impacted by genetics, environment, and opportunities for development as well as experiences.

adults (ideally, their parents). For El Salvador’s children, how ACEs are addressed and whether children are given a chance to be protected from these experiences could be what allows the country to move forward or continues the regional unrest for future generations.

The international community cannot be complicit in the abuse of the children separated at borders—it has seen the photos of children, it has heard their voices on recordings; it cannot be quiet.

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Heightened Immigration Enforcement and the Well-Being of Young Children in Immigrant Families

Early Childhood Program Responses

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Abstract

Since 2017, immigration enforcement in the US has increased, and as a consequence, many more young children are vulnerable to being separated from their parents and are living with daily fear and stress of parental deportation. This article documents stories from interviews with early care service providers and immigrant parents in six states conducted by the Center for Law and Social Policy in 2017. It outlines concerns for children in the current immigration context and offers recommendations for classroom practice, family supports, and actions that early childhood educators can take when working with young children of immigrants and their families.

In 17 years, I've never seen this before. The stress is so high, they're biting their fingers.

In this quotation, a preschool director described a young boy's anxiety in her preschool in Georgia. She is not alone. Early childhood educators across the country have similar stories about young children who live in immigrant families in the current political environment. The stress is like none they have ever seen before.

Nearly 6 million young children in the US live with one or more parents born outside of the country, comprising 25% of the population of children under age 6 years old (Migration Policy Institute, 2018). The majority (94%) are U.S.-born citizens. While most of these children live with parents who have some form of legal immigration status, such as lawful permanent residents or "green card" holders, an estimated 5 million children under 18 years old live with one or more parents who are undocumented, including nearly 1.6 million children under 5 years old (Capps, Fix, & Zong, 2016).

Immigration enforcement is any action taken by U.S. Immigration and Customs Enforcement (ICE) or U.S. Customs and Border Protection to apprehend, arrest, interview, search,

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Although children may not be the targets of immigration policy changes, they still suffer the traumatic consequences.

surveil, or deport an individual for enforcement purposes. Since 2017, immigration enforcement in communities throughout the country has increased (Breisblatt, 2017). Rather than prioritizing individuals with criminal records, current policies direct immigration agents to deport any undocumented immigrant, including parents of U.S. citizen children (Albence, 2017; Executive Order 13768). Consequently, many more children are now vulnerable to being separated from their parents due to deportation, and they are living with daily fear and stress.

Research shows that harsh immigration enforcement policies undermine the health, economic security, and overall well-being of children in immigrant families (Cervantes & Walker, 2017). Children experience heightened anxiety and exhibit many trauma-related symptoms when their families have been separated due to immigration enforcement (Society for Research in Child Development, 2018). The threat of family separation alone has been associated with deteriorating mental and physical health for children (Satinsky, Hu, Heller, & Farhang, 2013). Although children may not be the targets of immigration policy changes, they still suffer the traumatic consequences.

In this article, we share stories from interviews and focus groups with teachers, home visitors, family services staff, social service providers, and immigrant parents in six states conducted by the Center for Law and Social Policy between May and

November of 2017 (Cervantes, Ullrich, & Matthews, 2018; Matthews, Ullrich, & Cervantes, 2018). In the interviews, early care professionals spoke about children in immigrant families, as young as 3 years old, expressing fears about separation from parents. They described seeing behavioral changes in children, including increased self-harm and social withdrawal, and reported that children expressed more feelings of aggression. Providers also described families' increasing fears leading them to keep children home from child care and preschool and to refuse nutrition assistance and public health insurance.

In the emotionally intense interviews with early childhood professionals, many of them wanted to know more about how they could support children and families. This article discusses concerns for children in the current context. We offer ideas for classroom practice, family supports, and actions that early care and education professionals can take when working with young children of immigrants and their families.

Immigration, Trauma, and Cultural Considerations

It is during the early years when children acquire an understanding of how they fit within their family, culture, and community. The formation of trusting relationships is rooted in the child's ability to develop an emotional connection with a caregiver or parent. Neuroscience has shown that early positive emotional experiences encourage the growth of neural pathways that allow for the development of stable relationships during life (Tierney & Nelson, 2009). This bond formed during the infant years is the basis for cognitive, social, and emotional development.

Confidence in one's family, including an ethnic and cultural identity, is important to health and well-being and provides protection from the effects of discrimination (Brown, 2015). In the current political climate around immigration, educators must recognize the increase in public hostility and bigotry that some immigrant families endure and the effects that these will have on children in their classrooms. Immigrant children in early childhood classrooms may experience both personal and structural discrimination, which can have a lasting impact on their sense of self and social identity (Adair, 2015). Presently, this may be compounded by experiences such as this one, described to an educator by a family's home visitor:

ICE agents apprehended a father as he and his wife were walking their 4-year-old daughter into child care. "ICE came and served him papers, and in front of his children, put him in the vehicle," the family's home visitor told us. "They didn't allow for him to say goodbye or to even give any attention to the child to let her know he would be okay."

As this story illustrates, children have witnessed family members being detained and taken into custody by ICE agents. Although young children in early childhood classrooms are typically U.S. citizens and protected from deportation, many of their parents and family members are not. Interviews with educators revealed harmful implications for these children as they express fear for

their parents' safety. Children who have seen a parent arrested or have been separated from a parent during an interrogation by immigration agents may be particularly susceptible to increased anxiety, aggression, and withdrawal, all signs of trauma (Chaudry et al., 2010).

Numerous studies have documented that separation of parents and children is traumatic and has lasting impacts. The seminal adverse childhood experiences study (Felitti et al., 1998) recorded that any lengthy parent and child separation is related to long-term consequences such as alcoholism; drug abuse; suicide; and diseases of the heart, lungs, and liver. More recently, with the forced separation of families on the U.S./ Mexico border, experts in child well-being across the country have condemned the separation of children from their parents, with the knowledge such separations are highly stressful for children and increase lifelong risk of mental illnesses such as depression, anxiety, and posttraumatic stress disorder. But the same risks hold true for children living in the US with the daily fear of being separated from their parents. Here is an example from an interview:

An elementary school counselor in North Carolina reported overhearing children planning for "when their parents go back to Mexico—not if, but when." One little boy was writing down what he knew how to cook—peanut butter sandwiches and cheese sandwiches—in order to reassure his frightened 5-year-old sister that they would be okay if their parents were deported.

The child in this vignette is fearful enough to start planning what to do when he loses his parents. Just the persistent threat of losing a parent can constitute a traumatic experience even if the arrest or deportation of a family member has not occurred (Satinsky et al., 2013). Experiencing trauma can undermine a young child's ability to form healthy and supportive relationships and can affect learning (National Child Traumatic Stress Network Schools Committee, 2008). The following expressions of trauma may be seen in the classroom with children whose families have been disrupted due to immigration enforcement, or who live in fear of family separation:

- Difficulty with managing impulses. This may include becoming aggressive or harmful toward others and self, such as a child unable to stop biting her or his fingers.
- Distancing or withdrawal from peers and teachers. This may look like fading interest or concentration. A preschool director in New Mexico said that some of her students "are just kind of sad, anxious, not wanting to participate as much as they used to." A pre-K teacher in Georgia said, "The children are reluctant to talk."
- Change in play, such as increases in conflicts or not wanting to play. One preschool director in California described a 3-year-old child who began fighting with his classmates after his father was deported. She noticed he directed his aggression toward three children whose fathers bring and pick up the children from school.



Photo: Mema/shutterstock

The formation of trusting relationships is rooted in the child's ability to develop an emotional connection with a caregiver or parent.

Educator and Provider Responses

An early childhood educator in California said that following the 2016 election, "The kids were crying. It was tough for the kids to say goodbye to the parents when they came to school [for the morning drop off]. It was awful." Another teacher in North Carolina told of reading a story about houses to her pre-kindergarten class. When she got to a page with a picture of the White House, children burst into tears.

Early childhood educators may not be able to anticipate the reactions of children during story time, but they can provide a trusting environment, build resiliency, and promote well-being. Safe environments and warm, caring responses from adults can support children as they cope with traumatic experiences. Educators can create such classrooms by providing soft restful spaces, lower or diffuse lighting and sound, choices for activity, and a place for a child to work independently (Schwarz-Henderson, 2016).

Trauma-informed teaching involves enacting problem-solving strategies and clear communication with children and their families. To identify specific concerns and support, the adults seek to understand any change in well-being through careful engagement with the child and dialogue with a peer or specialist. Educators and specialists can assist children who experience trauma to express their emotions by providing multiple opportunities for them to share feelings. However, children under stress (similar to adults) may not have the words to discuss feelings, and instead these feelings can manifest in different ways. It is important to make time for compassionate connections with the children.

Early childhood education and family-support programs can develop a system of care in which everyone plays a critical role in meeting the needs of immigrant families and their children. For example, McConnico, Boynton-Jarrett, Bailey, and Nandi (2016) developed a recommended framework



Safe environments and warm, caring responses from adults can support children as they cope with traumatic experiences.

for trauma-sensitive schools called STRIVE. This approach is applicable for immigrant families and their children as it takes an ecological perspective, taking into consideration culture and community, the overall structure of the school or agency, and the educator, as well as the children and their family.

Teachers and staff directly serving children and families may experience intense emotions themselves. In the interviews with early care professionals, CLASP found educators voicing great emotion as they discussed their desires to meet immigrant families' needs and to learn more ways to provide resources and information to help families prepare for potential separation. As one home visiting program director stated:

We provide trauma-informed services, but even so... we're not [child protective services]. Our expertise is not to work with families who are going to be separated from their kids. So this was new territory for my staff... Safety planning was not something we normally do. Helping families figure out what to do if they're separated from their children—that's a different kind of trauma.

Program directors might consider the impact of the current immigration landscape on their staff and take steps to provide needed supports. Adopting trauma-informed programs can intentionally address parent trauma, emphasize staff wellness, and make resources available to children, families, and providers (National Child Traumatic Stress Network, n.d.).

Parents also often look to early childhood professionals as trusted sources of information. Teachers, home visitors, and family support staff can connect immigrant families with accurate information about immigration policy, family eligibility for public benefits, and other needed resources. One grandmother said,

Right now we're the guardians of our grandsons, and one never knows how that might affect things. What if I apply for that benefit and they say I'm living off that? Or maybe even they come looking for me? Or maybe they will say

that's why they don't want us living here? Really that's why I haven't applied for anything.

This grandparent expressed a common concern that participating in public health and nutrition programs could jeopardize their immigration status or long-term residency or make them identifiable to immigration enforcement agents. While many immigrant families have long been apprehensive about enrolling in public benefits, concerns are more acute in the current climate. Early childhood professionals must be prepared to talk through these concerns and provide parents with accurate, up-to-date information about policy regarding participation in public benefits programs.

Educators interviewed reported that families are also coming to them with requests for new and different information than previously, including stress management, free or low-cost legal services, information on immigration and immigrant rights, and information on family safety planning. These areas are generally outside the knowledge base of many early education providers. Developing partnerships with trusted community-based organizations, including immigrant-serving organizations, is one effective strategy to better connect parents to information and resources about immigration policy.

Establishing Safe, Welcoming Early Education Programs for Immigrant Families

The following recommendations come from the Southern Law Poverty Center and can assist schools, administrators, and organizational leaders in responding sensitively to the circumstances of immigrant families.

- Issue a statement—in Spanish, English, and in other languages spoken at the school—articulating that the school supports immigrant students and parents and that affirms publicly that it is a welcoming site.
- Identify a bilingual person at your school who can serve as the immigration resource advocate at your center.
- Post and have copies of materials delineating individuals' rights should they be stopped by law enforcement.
- Create a list of resources, such as the names of mental health providers, social workers, pro bono attorneys, and local immigration advocates and organizations, that can be shared with your students and their families. Ideally, this is available in Spanish, English, and other languages spoken at the center.
- Find out whether there is a local immigration raid rapid response team. These teams usually consist of attorneys, media personnel, and community leaders who may be able to provide support.
- Continue to support all children with welcoming environments. For curricular ideas, see the toolkit *Immigrant and Refugee Children: A Guide for Educators and School Support Staff* (Teaching Tolerance, 2017).

Department of Homeland Security policy establishes places that are considered “sensitive locations,” where enforcement from immigration agents is limited. Parents and children should be able to use the services without fear or hesitation. These sensitive locations include:

- known and licensed early care and education programs, including child care programs, preschools, and Head Start;
- K-12 schools, colleges and universities, after-care programs, and other education-related activities and events;
- school bus stops that are marked or known to the officer, during periods when school children are present at the stop;
- medical treatment and health care facilities, such as hospitals, doctors’ offices, accredited health clinics, and emergent or urgent care facilities;
- places of worship, such as churches, synagogues, mosques, and temples;
- religious or civil ceremonies or observances, such as funerals and weddings; and
- during public demonstration, such as a march, rally, or parade.

CLASP also recommends that early education programs adopt policies to safeguard their locations and to protect families’ confidentiality. Programs can do the following:

- Ensure that all personnel and parents are familiar with the ICE sensitive locations policy and other internal safety procedures. English and Spanish factsheets on sensitive locations are available on CLASP’s website.
- Review existing policies to ensure compliance with federal policies and consider additional policies that will prevent the inappropriate recording and release of immigration status.
- Share policies with families so they feel safe accessing programs.

As sensitive locations, early childhood programs can host workshops and trainings for immigrant families in partnership with legal service providers, enrollment specialists, and immigrant-serving organizations. Potential topics may include:

- creating family deportation safety plans;
- how to talk to children about deportation;
- know your rights; and
- immigrant eligibility for public benefits programs.

Conclusion

Heightened immigration enforcement in the Trump era has caused a wave of fear and instability for children in immigrant families, resulting in disengagement from many forms of public support and educational services. Children who are separated from their parents and family members are experiencing

trauma, which affects their health, well-being, and engagement in education. Early childhood professionals can respond and serve as a resource for children and families experiencing mistrust of services. When teachers, family support staff, and program leaders are well-informed about the rights and protections that exist for the immigrant families they serve, they can create safe spaces in their programs to help children process their situations and support their long-term well-being.

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A Guidepost in Shifting Sands

Child Well-Being and Immigration Policy

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Abstract

In the swift shifts and complexity of the system of government agencies making decisions about babies at the border, the ZERO TO THREE Policy Center relies on decades of research on brain development, child well-being, and the impact of trauma to serve as crucial guideposts for our work. This article offers a description of this moment in the landscape for babies at the border and tools for *ZERO TO THREE Journal* readers, using your expertise and experience in efforts to speak on behalf of those babies and families.

Infant–toddler professionals may hesitate to wade into the policy issues surrounding immigrant children being separated from their parents. Yet, in this complex, ever-changing, and uncertain landscape, one clear guidepost leaps out: the overriding need to protect the well-being of young children for whom each facet of the migrant experience creates sometimes unbearable stress at a most sensitive time of development. If U.S. immigration policies are shifting sands, nowhere is the upheaval more wrenching than for infants, toddlers, and young children whose developmental course depends on security and stability. Separations are especially unsettling for a young child, but how they occur—without warning or with preparation, placement with strangers, or being received by a familiar adult—can contribute to the degree of the trauma experienced. Likewise, trauma can result from the inverse of separation, the detention of families together in large central facilities. The extent to which the danger of that trauma is recognized and weighed in the balance also can shape the policies that determine families' fate. In our role as the nation's advocate for babies, toddlers, and their families, ZERO TO THREE is steadfast in our position that all young children should have a stable foundation from which to grow and thrive.

Often it seems that policy and practice—at the borders, in courts, and in Congress—change by the hour and are characterized by chaos and murkiness. Early childhood professionals who want to advocate may find themselves in unfamiliar, dynamic terrain. But trying to sort out the labyrinth families seeking asylum must face when they come to our country can help lead to logical points of advocacy.

Recent Instability in Immigration Policy

Instability in the policy and implementation is exacerbated by the number of federal departments, managed by the President's appointed secretaries and funded by Congress, that can be involved in immigration activities and by how their different roles reflect the ebb and flow of the tension between tightening enforcement against adults and protecting children caught up in enforcement actions. U.S. immigration law allows immigrants to seek asylum within our borders when they are fleeing countries where certain conditions of violence and unrest jeopardize their safety. They are supposed to come to official "ports of entry" to request asylum, but bottlenecks led an increasing number of immigrant families to look elsewhere. Crossing the border between such ports is an illegal act that carries only a misdemeanor charge for the first offense.

Border crossings are run by the Department of Homeland Security (DHS). Until about a year ago, immigration enforcement policy emphasized not unnecessarily disrupting parental interests unless a child's safety was considered endangered. In

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Separations are especially unsettling for a young child, but how they occur—without warning or with preparation, placement with strangers, or being received by a familiar adult—can determine the degree of the trauma experienced.

practical terms, this policy meant families crossing the border were allowed to stay together, sometimes for a limited time in DHS family detention centers—which are not an ideal environment for young children—and other times in community release programs while awaiting asylum decisions. Then, a little-noticed change in August 2017 dropped policy provisions that previously emphasized the use of prosecutorial discretion to protect parental interests and keep more parents with their children. It is believed that family separations began to tick up around that time.

In the beginning of April 2018, the Department of Justice (DOJ) announced a new “zero tolerance” policy, under which all adults crossing the border illegally would be prosecuted. In concert, DHS began turning all such adults over to DOJ for prosecution, but children cannot accompany their parents to DOJ prison facilities. So, they were separated, declared unaccompanied alien children, and entered the custody of yet another federal agency, the Department of Health and Human Services.

Given the numbers of separated children quickly entering the system, however, and the fast track of this change in practice, there was little planning given to how to house and care for these children. When the family separation policy was reversed by an Executive Order in June, and a court ordered swift reunification of parents with their children, it became clear that separations had likewise occurred with little thought about how families would be reunified.

Now, the path forward requires a coordinated effort among government agencies to reunite families and make decisions for children and families seeking asylum and otherwise entering the US. Plans seem to be taking shape to keep families together in detention centers, though those plans faltered when another court rejected attempts to eliminate restrictions on the length of time children could be detained. Congress could intervene, but divisions over overall immigration policy make that more

difficult. Trying to take action could open the door to others. It can take action to limit funding for certain agencies or practices within those agencies, or it can require those agencies to take actions on behalf of families. It could also remove court-driven barriers to treating families as executive branch agencies would like, such as imposing unlimited detention.

Immigrant children already in the US also can experience separation from parents—or live in fear of it—because of immigration policies. Sometimes a parent without documents is arrested and deported, leaving a citizen child behind. Refugees from countries that have experienced debilitating events such as natural disasters may be granted Temporary Protected Status (TPS) and allowed into the US until the country’s safety is assured. TPS for three countries, El Salvador, Haiti, and Honduras, is being revoked, leaving hundreds of thousands of families whose children have been born in the US vulnerable to deportation. They face a wrenching decision about whether to separate, go underground in the US, or return as a family to an unsafe situation, sometimes in a country which families continue to flee.

One constant for young children in these situations is that their emotional well-being may be threatened by varying levels of stress that can become intolerable and permanently damaging. In communications with policymakers, it is this constant, verified by decades of research, that should be planted in bedrock as a guidepost that early childhood advocates should use in informing the policy debate.

Navigating Immigration Policy With Child Well-Being as a Guidepost

Clear areas have emerged within the immigration policy debate where the well-being of children, and especially young children, rises to the surface. At these points, advocates must work to establish child well-being as a central guidepost, seeking to educate and inform policymakers on the implications for babies’ physical and mental health when placing them in situations that exert intolerable stress on young bodies, hearts, and minds. The guidepost lifts up the secure attachments young children form to their caregivers that are the foundation of healthy development and emotional stability, providing a sense of security and a buffer from the toxic effects of stress and trauma. Furthermore, even after reunification, as families recover from these kinds of trauma at the border, the children will be at incredible risk for profound physical and emotional disturbances, and will likely need specialized, dual-generation infant and early childhood mental health services and support. Policy areas where this guidepost is helpful include:

- **Family separations as families seek to enter the country:** Separation at this point, especially after a long, arduous journey, is a trauma that can have long-term impacts on a young child’s well-being. In the recent episode of family separations, public opinion—together with the courts—weighed the trauma of the children, some of whom were infants and toddlers, against the value of

certain enforcement approaches and found the children's well-being more important. At least temporarily, the primacy of the parent-child bond was reestablished, and the agonizing process of reunifying families in a largely chaotic "system" began. That process highlighted *key points for education of policymakers: the trauma created by these separations, especially for the youngest children, and the lack of efforts to mitigate the trauma to young children through infant and early childhood mental health support.*

- **Family detention:** The harm to young children of living in group shelters has been well documented. Currently, a court agreement, *Flores v. Reno*, based on the need to protect children's well-being, prohibits placement of children in family detention for more than 20 days. This agreement was recently reaffirmed and would need legislation to change it, providing another point at which *early childhood advocates can educate and inform Congress about the impacts of institutional detention on young children and their families and the imperative to keep their needs in focus.*
- **Separation of families living in the US:** Many children, a large portion of whom are U.S. citizens, live with parents who do not possess legal status. They are under the constant stress of fearing apprehension by immigration authorities and possibly deportation. DHS policies protect some "sensitive locations," including places such as early care and learning programs or medical facilities, from having immigration enforcement actions take place in those areas. These restrictions help ensure that children receive needed support services without fear of risking the family unity. However, as enforcement actions increase, some families may fear or not know about these restrictions and forego these services. As noted previously, some immigrants may have their TPS revoked, putting thousands of families at risk. *Advocates can work to ensure early childhood providers understand their rights as a sensitive location and push to ensure trauma-informed policies and services to mitigate the stress of young children and their families.*

Raising Your Voice for Babies at the Border

In the last several months, the powerful outcry of seasoned and emerging advocates for young children has helped focus national attention and urgency on issues for young babies and their families at the border. As the country moves toward its next step, young children without a voice will continue to need the expertise and voices of early childhood advocates. Use the following tips in your advocacy with members of Congress, state legislators, leadership in the administration, and others as you advocate for babies at the border:

Speak for the Babies

Many people are speaking in these discussions, but few are speaking for young children. Many decisionmakers continue to believe that babies will not be affected by these early



Photo: Rena Schild/shutterstock

Immigrant children already in the US also can experience separation from parents—or live in fear of it—because of immigration policies.

Learn More

Set Up a Twitter Account

www.thinkbabies.org/wp-content/uploads/2018/03/ST18-How-To-Create-Twitter-Account.pdf

You Have What It Takes! Advocacy Tool

Consider different strategies for advocacy and how they align with your interests and skills.

www.zerotothree.org/resources/494-you-have-what-it-takes-advocacy-tool

Join ZERO TO THREE's Policy Network

Sign up to receive the latest news, and baby-specific actions and resources.

www.zerotothree.org/policy-network

Watch www.zerotothree.org/stopseparatingfamilies for the latest updates, action, and resources related to babies at the border.

Additional Resources

www.zerotothree.org/policy-and-advocacy/advocacy

Includes information on writing an op ed, meeting with an elected official, and messaging around infants and toddlers.

experiences, but infant–toddler advocates know that the brains of infants and toddlers are developing more rapidly than at any later point in their lives. Traumas like these affect the very architecture of the brain, disrupting the foundation of all future development. Be a Big Voice for Little Kids™ as you consider and speak to the impact of implemented or proposed policies and practices.

Stick to the Science and Your Expertise

When issues become highly politicized and partisan, it is essential to maintain your focus on the guidepost—child well-being. What researchers know about young children experiencing trauma is compelling and powerful. Relay messages steeped in the decades of research on early child development, and your own expertise from working with babies experiencing trauma. Use the talking points identified in the articles in this issue of the *ZERO TO THREE Journal* (see Box 1).

Remember That Relationships Matter

Get to know your elected officials and their staff by continually reaching out to them. By building these relationships, you are positioning yourself as a resource to them. (Don't have a relationship yet? There is no better time to start a relationship than now.)

Work in Partnership

Your voice is louder when it is combined with other voices with similar messages. Just as you recognize the unique value you bring to this work, consider which organizations bring complimentary expertise and familiarity to this issue. Look to local, state, and national organizations with long and respected histories of working in the interest of migrant and refugee children with mission statements and strategies that reflect respect for child and family experiences and commitment to evidence-based advocacy and practices. Then, explore ways to partner and amplify the impact of one another's work.

Box 1. Talking Points for Advocating With Policymakers

Policymakers have limited time to engage in conversation. In order to make sure you use your time most effectively, identify the key messages you want to share before you go. Use information on www.zerotothree.org/StopSeparatingFamilies and the following talking points, drawn from the articles in this issue, to choose from:

Familiar caregivers protect young children from the hardship and trauma present from start to finish of the difficult journey to the US.

From Lopez (this issue, p. 22):

- Families choose to leave their families and communities and make what they know will be an arduous trip to the border only in the face of profound hardship and trauma at home. At one time, immigrants came to the US seeking opportunity, the possibility to escape from poverty. More recently, violence is increasingly driving families, particularly families from Central America, away from their homes.
- When a child is experiencing trauma, including trauma in a home community, the loss of leaving familiar people and places, the hardship of a difficult journey, and difficulty at the border and in transition to a new home, a familiar caregiver offers the child a crucial buffer to stress.

From Al-Qubati and Ostler (this issue, p. 49):

- Like children, families are likewise deeply affected by traumas that they experience in their home countries, in their travel, and upon entry to the US. Many make extraordinary efforts to protect their children from physical and emotional harm in difficult situations. Undoubtedly, these experiences impact their parenting.

Loss of a parent has a profound effect on a very young child—we need to be aware of the loneliness, hopelessness, and helplessness they feel.

From Witten (this issue, p. 62):

- Very young children are profoundly affected by the loss of a parent that can leave them feeling lonely, hopeless, and unable to cope. In addition, their fear can trigger a flood of stress hormones in the brain, creating extreme anxiety, and making them more susceptible to disrupting their developmental progression.

Lessons from experiences of military families separated by deployment demonstrate that the process of separation and reunifying with parents can be hard on children and parents alike.

From Walsh and Rosenblum (this issue, p. 68):

- Even when separations between parents and children are planned, discussed, and prepared for, as in the case of military deployments of parents, young children may respond with worry, fear, and grief.
- After a deployment, military parents often find that young children have changed dramatically over the separation, that the deployed parent may be unfamiliar, and that it may take a great deal of time and patience to regain a child's trust and reassert their parental roles. Deployed parents may feel forgotten or rejected by their child. "Interactive repair" which helps parents better understand and respond to the meaning behind a child's individual behaviors can help.

Reunifying families benefit from support from professionals in infant and early childhood mental health.

From Fitzgibbons, Smith, and McCormick (this issue, p. 74):

- As families reunify, a system of support for the child and family should include staff with reflective supervision and training in infant and early childhood mental health in order to mitigate vicarious trauma and compassion fatigue and to ensure responsive practice and a commitment to cultural humility.

In the current climate, immigrant families may feel stress that is communicated to their children, so early childhood providers need knowledge about trauma and skills to help children cope.

From Finno-Velasquez, Cahill, Ullrich, and Matthews (this issue, p. 27):

- In the current political climate, immigrant families, even legal-settled families, may feel threatened, unwelcomed, or unwanted. Their children are not immune to that stress. It can manifest in early childhood settings as withdrawal, increased aggression and self-harm, or other behaviors.
- Early childhood providers should be prepared with the knowledge and skills they need to provide responsive, trauma-informed care to affected children.

Use Social Media and Online Resources

Consider how you can use social media to identify trusted voices and amplify their messages, as well as to share your own. Social media also provides an important portal for communication with your elected officials. In particular, Twitter serves a key role in advocacy, as messages are short, easy for political offices to track, and quickly reach a wide audience. Use the Policy Center's online tool to identify your own advocacy strengths and check out additional advocacy resources. See the Learn More box for more information on all of these resources.

Patricia Cole, MA, is the senior director of federal policy at the Policy Center at ZERO TO THREE. There, she leads ZERO

TO THREE's work in federal policy formulation and legislative strategies in a range of areas affecting infants and toddlers, including early care and learning, home visiting, child welfare, infant-early childhood mental health, and health care. Patty has more than 30 years of experience in policy at the federal and state levels, including key positions in child and family policy on the Hill.

Amanda Perez, MSW, comes to her work with ZERO TO THREE's Policy Center after almost 25 years in direct service with infants, toddlers, and their families and in training and technical assistance with infant family staff. As a senior advocacy specialist, she encourages a growing Policy Network to Be a Big Voice for Little Kids™.

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Safeguarding Our Children and Our Future

Pediatricians Caring for Immigrant Children

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Abstract

The American Academy of Pediatrics Council on Community Pediatrics Immigrant Health Special Interest Group consists of 300 members and works to advance pediatric practice and advocacy for diverse immigrant children. Members share practice tools and strategies, and they advocate for the health and well-being of all immigrant children in a number of ways, including direct patient care, public speaking, asylum evaluations, writing op eds, and social media campaigns. This article includes reflections from 9 members of the group on their experiences around the country with caring for the health of vulnerable immigrant children and families. (The views expressed in the article are their own and do not necessarily reflect the policy or opinions of the AAP.)

Immigration, however contentious, is an ongoing thread in the narrative of this nation, and immigrants themselves are woven into the fabric of American communities. Unfortunately, current debates regarding the contributions and "deservingness" of immigrants in American society have been conflated with

the treatment of children in this society. The current national discourse around immigration directly and indirectly impacts the lives of children. Recent policy changes have led to increased fear and anxiety within certain populations, and these have real health consequences for children. Whether passing bans or building walls, when the debate involves children, we as a society confront a heightened level of vulnerability. The least able to advocate for themselves, children, have the most to lose as long-term effects of toxic stress will have a lasting impact on their neurocognitive development (Center on the Developing Child, n.d.).

Competencies for Prenatal to 5 (P-5) Professionals™

P-5 **P-5** **P-5** **P-5**

For more information see page 5, or visit www.zerotothree.org/p-5

Close to 6 million United States citizen children under 18 years old live with a parent or family member who is undocumented (Mathema, 2017). Children in immigrant families will represent one in three of children in the US over the next 40 years. The health effects of immigration have particular impact on the long-term development and well-being of children. Much is at stake for a large swath of the community. What happens to these children now will affect them for the rest of their lives.

As pediatricians serving children in immigrant families, we address the needs of populations that are truly diverse—families of mixed immigration status hailing from a variety of countries, living in the U.S. for different reasons and under various circumstances, and with a wide range of socioeconomic and political backgrounds. Immigrants include a range of people, from those crossing the border on foot to those who've been granted H1B visas, from people who have their travel visas to those "officially vetted" refugees from war-torn countries.

And so too, our ability to care for these families is influenced by our resources and geography as well as the political landscape of our work settings and communities—university setting vs. federally qualified health center, red state vs. blue, border city vs. urban metropolis. The pediatricians who have contributed to this piece hail from seven states located from coast to coast. Many are themselves of immigrant backgrounds or speak more than one language, and these factors also inform their work and ability to relate to families. Some work with families newly released from detention; others care for refugees either here or abroad. Our narratives are as diverse as the communities we serve. One thing we all have in common is our advocacy on behalf of these children and their families and our desire to give them a voice and share their stories.

As a pediatrician in an underserved, largely immigrant suburb on the outskirts of Chicago, I am seeing immigration-related fears play out daily in my clinic. The stories are heart breaking:

- A 4-year-old girl who walks around with a backpack full of toys and favorite possessions in case her parents are taken away by Immigration and Customs Enforcement—not realizing she might not get to go with them
- A teenager having chest pain and panic attacks at school because he is afraid that his dad's workplace will be raided.
- A mother scared to call 911 for her baby in respiratory distress for fear of being detained and separated from her child.



Photo: Krista Kennell/shutterstock

Children in immigrant families will represent one in three of children in the US over the next 40 years.

These are terrifying scenarios and terrible choices to have to make. They have the potential to leave indelible marks on the lives of children. As pediatricians, we are acutely aware of the long-term effects of this kind of trauma. Our hope is to educate others with both the science and the soul, so that we may consider alternatives which safeguard the children and our nation's future.

Minal Giri, MD, is a pediatrician and medical director of Melrose Park Pediatrics, which serves a largely immigrant population on the outskirts of Chicago. She is also founder and chair of the Refugee Immigrant Child Health Initiative at the Illinois Chapter of the American Academy of Pediatrics. She has served as a consultant for the Organization for Refugee Resettlement and contributed to the development of trauma-centered regulations for children. She performs medical forensic evaluations on behalf of unaccompanied immigrant children and asylum seekers.

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The Need for Compassionate Care

Brad D. Berman

A small, scared little girl lays her head on her mother's lap and begins to whimper. And why not? Whom else can she trust in her private moment of terror?

Within the last 72 hours since she arrived at a private family residential center contracted by the U.S. Immigration and Customs Enforcement (ICE) agency, Sofia has seen 7 different health care providers and a few different faceless tele-translators, and now she is being evaluated by an unfamiliar male psychologist, one who is Anglo and not Spanish fluent.

After so many months of being harassed, threatened, and having witnessed horrendous acts of violence against her neighbors and family members, Sofia's mother chose to flee their small town in El Salvador. The road ahead seemed just as dangerous, risky, and uncertain, and yet, remaining in her town was no longer an option. She hoped that if she could just reach the US, perhaps she could live with a family member, hopefully in a safer environment for both herself and her young child. In doing this, she did what every caring and reasonable parent would do.

Currently, children immigrating to the US are labeled with catchy externalizing terms. In the media and even in open Department of Homeland Security statements, these young girls and boys are often called "immigrant alien children" or "illegal immigrant minors."

What seems natural to those of us in the world of pediatric care and child development is to treat these children as who they are, not their "labels," and to hear their stories. These are infants, boys and girls, and young teens who are scared, confused, mistrustful, traumatized, and anxious. For too long in their young lives, they have lived in a world of poverty, ever-present danger, and continual stress. Each child has a name and a personality, and each one is vulnerable!

These girls and boys, like Sofia, are often dirty, undernourished, and iron deficient. Many are likely to be growth stunted and suffer from neurodevelopmental brain changes that can be positively addressed with proper support and intervention. And that is where compassionate care is so vital.

Sofia's immigration journey as described was arduous, terrifying, and draining. By the time she and her mother crossed the U.S. border they had traveled from El Salvador through Guatemala into Mexico. They had to walk across rugged mountainous terrains with limited water and food for up to 2 weeks, all while being pushed through by human smugglers or "coyotes." Sofia and her mother were exhausted, dehydrated, and nearly starving when they were processed at the U.S. border and placed in an ICE border detention center. All of this took place even before their transfer to the new group family shelter.



Photo: A3family/shutterstock

All children deserve places to feel safe, in which they are cared for and can thrive.

During the first few days of Sofia's stay at the family residential center, she was interviewed by the staff psychologist with her mother present. There was no apparent attempt at establishing rapport with either this frightened and exhausted young girl from another culture or her fearful mother. Sofia was described as having a disruptive behavior disorder not otherwise specified along with a diagnosis of "psychogenic enuresis." This latter term is curious, especially because Sofia had not received any pediatric-informed medical or developmental assessments or care of any kind, at this point. She was later diagnosed with chronic renal disease.

All children deserve places to feel safe, in which they are cared for and can thrive. We would expect no less for our own families and communities. The requirements are conceptually simple: protection, predictable housing, clean water and nourishing food, developmentally focused early child programming and early intervention services, schools for older children, appropriate pediatric medical care, and, specifically for children and parents who make these difficult immigration journeys, trauma-informed child and family-focused mental health care (Substance Abuse and Mental Health Services Administration, 2018).

All personnel who engage with children, from the point of first contact at the U.S. border, to all providers of care in family shelters and ICE family detention centers could and should be educated in this ethos and approach. Standard pediatric care should be provided for all children at all sites. Early childhood intervention and supportive emotional care should be available immediately after arrival and beyond. Researchers know that these approaches help mitigate the deleterious effects of these children's early life adverse exposures and traumatic

experiences while improving health and neurodevelopmental and emotional well-being.

More than anything else, it is the humane and compassionate response that should be carried out regardless of a child's country of birth, citizenship, or immigration status. The immigration journeys that children find themselves in are not voluntary. The causes of their exodus are not by choice but are due to desperation. What the political rhetoric tries to hide is that at the core of the issue, these are children in desperate and dire need.

Sofia's story is only one of many such stories, and while I do not know what has happened with Sofia, I can only hope that in the end the right decision has been made to provide her and her mother with thoughtful and child-informed care. After all, to deny a child in need is akin to denying our own humanity.

Brad D Berman, MD, FAAP, is a clinical professor of pediatrics at UCSF Benioff Children's Hospital and a board certified developmental-behavioral pediatrician in the San Francisco Bay Area. In addition to more than 30 years of clinical experience in caring for children and families with complex neurodevelopmental disabilities, he is a consultant with the Immigrant Law Clinic at USF Law School and a San Francisco Bay-area ad-hoc med/legal partnership.

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The Early Childhood Experience of Trauma

Karla Fredricks

The gaggle of kids raced after the soccer ball I threw toward the playground, attempting to clear a safe path for our reversing vehicle. It was a sunny yet brisk January afternoon on the Greek island of Lesbos, and the other physicians and I were heading home after a shift of caring for refugees from Afghanistan, Iraq, and Syria in the camp's modest clinic. One tiny obstacle remained: a haphazardly bundled toddler who just stood there, unimpressed by my tactic to entice her from her spot in the parking lot.

She appeared to be around 20 months old, and although I had not met this child before, she allowed me to pick her up without protest. Silently and solemnly, she gripped her dirt-streaked hands around my neck and squeezed her legs around my waist. I carried her the short distance to the playground and tried to deposit her there, a seemingly simple task that was met with surprising resistance from the little girl. As I worked to disentangle her, she used her legs as a vise to keep herself attached to my body, all without making a sound or altering her expressionless face. Eventually, I prevailed and set her down on the ground near the other children. She immediately turned around and, with both arms lifted toward me, uttered her first and only word of the entire encounter: "Mama."

Mama. A word that connotes visions of comfort, protection, and unconditional love. Why would this toddler—who had spent a maximum of 2 minutes with me and had Syrian parents present in the camp—bestow this title on me?

All of the children in the refugee camp on Lesbos had fled war, persecution, or both in their home countries and were seeking



Photo: Anjo Kan/Shutterstock

All of the children in the refugee camp on Lesbos had fled war, persecution, or both in their home countries and were seeking safety with their families in Europe.

safety with their families in Europe. When children less than 3 years old experience trauma, it manifests differently than in older children and adults because of their early developmental stage. They lack the emotional understanding and expressive language needed to explain their feelings in words. Instead, the effects of the exposure to trauma—such as war, natural disasters, domestic violence, physical or sexual abuse, or the sudden loss of a parent or caregiver—manifest as changes in behavior. The child might have a regression in development, decreased appetite, poor sleep, excessive crying, fear of loud

noises, increased aggression, or any combination of the above. In addition, they may become “clingy”—wanting to be held at all times or rapidly showing affection with strangers.

Undoubtedly, the trauma that this little girl’s family experienced in their home country and on their journey to Greece, combined with the difficulties of living in a refugee camp, disrupted the previously healthy relationship between this child and her parents. In families who have escaped war, it is common for the caregiver’s own experience of the trauma to result in the loss of this important attachment. With proper guidance, a strong, loving bond can be re-created and the effects of trauma ameliorated. On the other hand, abruptly removing a child from the caregiver can both cause the onset of acute symptoms of trauma and, at the same time, remove the only potential source of treatment.

Similar behaviors to what I saw in this war-experienced toddler are being replicated over and over by young children who were separated from their parents as a part of official U.S. government policy from April to June of 2018. Most of these children were brought to the US by parents who sought to rescue them from the omnipresent violence in certain areas of Central America and Mexico. The phrase “triple trauma” is often applied to the experience of people seeking refuge in a country other than their own: trauma of violence in their home country, trauma of migration hazards during the journey, and trauma of adjusting to life in a foreign land. For the children separated as a result of this policy, theirs is a “quadruple trauma,” including the loss of

their parent or caregiver with no knowledge of whether or not they would ever see them again.

Although many have now been reunified with their parents, there remains much healing work to be done. The majority of these children were in large shelters with insufficient staff to provide meaningful one-on-one attention and protocols that prevented physically comforting the children. The longer these children were submerged in this environment of “toxic stress,” the greater their risk of eventually developing chronic conditions such as learning disorders, substance abuse, depression, posttraumatic stress disorder, cancer, obesity, and heart disease, among others. It is incumbent upon all professionals who care for children to provide the evidence-based recommendations, support, and comprehensive health services that these families need, now and in the years to come.

Karla Fredricks, MD, MPH, is a pediatrician with extensive experience working with displaced and traumatized children in both international and domestic settings. She is the director of the Program for Immigrant and Refugee Child Health at Texas Children’s Hospital and an assistant professor of pediatrics at Baylor College of Medicine in Houston, Texas. Dr. Fredricks is involved in the American Academy of Pediatrics as a co-chair of the Immigrant Health Special Interest Group’s Refugee Health Working Group and a member of the Section on International Child Health.

Access to Services for Immigrant Children With Disabilities

Jack Levine

I am a developmental-behavioral pediatrician and the director of the Center for Autism at a safety net hospital on Long Island, New York. The children and their families are very low income, over 50% are Spanish-speaking, and most have immigrated from Central and South America. Others come from Asia and Europe. I see children with developmental disabilities ranging from severe autism and intellectual disabilities to attention deficit hyperactivity disorder and learning issues. These children with special health care needs and their families have great difficulty accessing community and entitlement programs and communicating with schools because of language, cultural issues, and fear.

Immigration status has significant effects on the lives of children and young adults with developmental disabilities and their caregivers. In New York, while children with undocumented

immigration status are covered by NYS Child Health Plus, they are not eligible for Medicaid except in an emergency. Furthermore, they are not eligible for any of the state entitlement programs such as the Medicaid waiver, Home and Community Based Service waiver through the Office of People With Developmental Disabilities, or the post-secondary vocational assistance program, Adult Career and Continuing Education Services-Vocational Rehabilitation. Although children with undocumented status in New York are covered by the New York Children’s Insurance Program until they turn 19 years old, they are often unable to receive appropriate comprehensive medical care and rehabilitative services at home

such as Applied Behavioral Analysis for children with autism. These children are still eligible for special education-based

Immigration status has significant effects on the lives of children and young adults with developmental disabilities and their caregivers.

services until graduation but are often left with less effective programming. As young adults, they will have no coverage or support from the state or federal government.

An insidious effect of immigration status is seen in parents with undocumented status. This has become more obvious recently. They are afraid of being reported to immigration authorities when they advocate for their children. Whether it is in the hospital or when having school meetings, parents are more timid and less outspoken. This fear makes it difficult for children to receive all the services that they are entitled to and deserve. Many families do not want service providers to come into their homes. This concern of revealing immigration status puts tremendous pressure on providers as well. By encouraging parents to advocate for their children and speak up at school or in federal/state offices, are providers inadvertently exposing them to arrest and deportation? In the back of my mind are stories of arrests in hospitals. Is someone reporting them or can their medical record be accessed?

The story of AH demonstrates a more direct and traumatic effect. AH, a boy with severe autism, was 5 years old when his pregnant mother and his father were arrested at a party during an immigration raid. After a while, his mother was released. The family hired a lawyer for thousands of dollars who essentially did nothing, and the father was deported. I wrote an impassioned letter detailing the need for this very devoted father to remain at home to help care for his son. Unfortunately, my effort was not successful. AH reacted with significant behavioral issues and did very poorly in school. His brother was born and was diagnosed with autism at 2 years old. AH's mother, struggling with depression, battles to keep her family together and to obtain services for two children with autism. One lesson that I learned was the importance of writing these letters with input from reputable and competent lawyers! I still feel regret that my letter was not good enough and worry that I could have been more effective. I have written many other letters regarding immigration issues—with each one I feel an awesome responsibility. This has become a new aspect of delivering medical care to children with special health care needs and their families!

JR is a 17-year-old boy with autism and severe intellectual disability. His mother and father, who have undocumented immigration status, applied for 17A guardianship to ensure that someone would be able to take care of him in the future. Family Court denied their petition because of their status, and they have been getting conflicting legal information regarding how to proceed. Crying in my office, JR's mother was distraught over her powerlessness to provide a safe future for her child. We are concerned regarding his family's role in his future.



An insidious effect of immigration status is seen in parents with undocumented status.

On a positive note, my colleagues and I have begun working toward medical-legal partnerships with local nonprofit legal organizations to ensure that our families are treated justly. We have informal relationships which will hopefully become more permanent over time.

Jack Levine, MD, FAAP, is a general pediatrician with subspecialty certification in developmental behavioral pediatrics. He has been a general pediatrician for more than 30 years in Queens, New York. He is the director of the Center for Autism at Nassau University Medical Center. Dr. Levine is a member of the executive committee of the National American Academy of Pediatrics Section on Developmental and Behavioral Pediatrics. He is a clinical assistant professor of pediatrics at Zucker Medical School at Hofstra University.

The Scars of Detention and Family Separation

Julie M. Linton

A young child and his pregnant mother fled the Northern Triangle countries in search of safe haven in the United States. During an initial pediatric visit in North Carolina, upon being asked if they had been separated at the border, a chilling silence set in. The boy's mother shuddered, whispering, "Seven days." For 7 days, this boy and his mother did not know the whereabouts of the other. Inside the processing centers, cage-like fences extend from the floor to the high ceilings, lights are always on, and aluminum blankets rustle, covering children lying on floor mats. This boy, this mother, and this unborn baby will forever carry the scars of detention and family separation.

The American Academy of Pediatrics believes that detention is never in the best interest of the child and that no child should be separated from a parent unless there are concerns for safety of the child at the hands of the parent (Linton et al., 2017). Highly stressful experiences, including family separation and detention, can cause irreparable harm to developing brains. Serious prolonged stress in the absence of buffering support, known as toxic stress, can threaten short- and long-term health. Short-term problems may include changes in bodily functions, such as sleeping, eating, and toileting problems; behavioral changes, such as aggression and anxiety; and problems with development and learning (American Academy of Pediatrics, 2014). Long-term, prolonged stress places children at risk for problems such as diabetes, heart disease, and depression (Garner et al., 2012).

Family separation does not impact only those at the border; the enduring trauma impacts communities across the nation. Health care professionals, teachers, and other community members are left with the responsibility of repairing the bodies and minds of children harmed by policies forcing detention and separation. Upon release into communities, children need health care, access to legal services, and education. As a general pediatrician in Winston-Salem, North Carolina, more than half of the children I see live in families that prefer to speak Spanish. The majority of children for whom I care have public health coverage. However, a subset of children, including unaccompanied immigrant children and children in family units, are ineligible for coverage, as North Carolina is not one of the few states (California, Illinois, New York, Oregon, Washington, and the District of Columbia) that offers Medicaid or Children's Health Insurance Program to children regardless of immigration status (National Immigration Law Center, 2016). I rely on charity care programs, federally qualified health centers, free clinics, and the local department of public health in an effort to offer high quality, accessible, and affordable health care to all children, regardless of where they or their parents were born.

Julie M. Linton, MD, FAAP, an assistant professor of pediatrics at the Wake Forest School of Medicine, the advocacy director for



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Highly stressful experiences, including family separation and detention, can cause irreparable harm to developing brains.

the Wake Forest Pediatric Residency Program, and the associate director of the Integrating Special Populations Program at the Maya Angelou Center for Health Equity. Dr. Linton serves on the American Academy of Pediatrics (AAP) Council on Community Pediatrics Executive Committee and is the co-chair of the AAP Immigrant Health Special Interest Group. Dr. Linton is a leader in the Culture of Health Leaders program, a national leadership program supported by the Robert Wood Johnson Foundation.* It fosters collaboration among people from all fields and professions that have an influence on people's health (www.cultureofhealth-leaders.org).

*The opinions expressed here are the author's own and do not represent the opinions of the Wake Forest School of Medicine, the Culture of Health Leaders program, or the Robert Wood Johnson Foundation.

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Excessive Stress and Trauma in Mothers and the Dangers to Children

Diana Montoya-Williams

Many have rightfully spoken about the trauma and toxic stress inflicted on children separated from their parents and what researchers know about their short- and long-term effects on child development, immune system development, and risk of chronic illness (Shonkoff & Garner, 2012). Providers and advocates should appropriately focus resources on reducing harmful separations, reunifying those who have been separated, and keeping families out of detention centers. But there are more children at stake than those being torn away in the present. One detrimental consequence of the current immigration attitudes and policies that also merits attention right now is the impact of such trauma on the mothers. Mothers who may one day be able to take care of their children again but who may now experience posttraumatic stress leading to real mental health illness. Mothers who may be currently pregnant and are experiencing high levels of acute stress on top of the chronic stress caused by the conditions back home that pushed them to migrate. Mothers whose unborn infants are being flooded with fight or flight hormones in utero to devastating consequences.

Excessive maternal stress has been linked to poor birth outcomes such as low birth weight or preterm birth (Hobel, Goldstein, & Barrett, 2008). Indeed, severe stress experienced during pregnancy may change the very way in which children's bodies express genetic information, which may explain the link between prenatal stress and a poor birth outcome like low birth weight (Mulligan, D'Errico, Stees & Hughes, 2012). As a neonatologist and perinatal health researcher, I am painfully aware of the struggles faced by infants born too early or too small. Such infants face increased risk of abnormal neurocognitive development, adult chronic illness, and mortality overall (Risnes et al., 2011). Furthermore, research is emerging that preterm and low birth weight infants attain lower educational qualifications and experience lower rates of employment (Bilgin, Mendonca, & Wolke, 2018).

Besides the adversity that is being inflicted on innocent children whose only crime is to be born into a family that has chosen to migrate in search of a better, safer life, it must not be forgotten that children's health depends heavily on parents' health. Providers must assess the damage on these equally traumatized parents. And they must pay mind to what science has discovered about the transgenerational impact of toxic stress experienced by periconceptional women. These future children also deserve providers' outrage and attention.

Diana Montoya-Williams, MD, is a neonatologist who recently completed her training at the University of Florida.* While there, she began the Immigrant Families Mobile Health Fair,



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Severe stress experienced during pregnancy may change the very way in which children's bodies express genetic information.

which cared for immigrant and migrant families in the North Florida area. She is also a health services and health equity researcher who focuses on perinatal and neonatal outcomes and disparities.

**Any opinions expressed in the article are those of Dr. Montoya-Williams and not meant to be a representation of her academic institution.*

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A Mixture of Fear and Hope for Newly Arrived Immigrant Families

Padma Swamy

A young boy stared at me with his large, warm, brown eyes. He stared at me with trepidation of what was to happen next. I am a pediatrician who works in the Houston community caring for children who do not have access to care. I see many children like him on a daily basis. His mother requested to speak with me alone. During those minutes which felt like hours, she described to me the horrors and abuse that she and her son had suffered in their home country and along their journey here. She showed me her scars both physical and psychological. We washed those scars with our tears. She told me that she came here for hope and to create a better life for herself and her son. When I asked her if she was interested in any resources to help make her life easier, she looked at me with fear and stated no. She was afraid of what would come from accessing resources.

Unfortunately, this case is like many of the others that I see. Families are now fearful of driving to schools or taking their children to seek medical care. Families have told me about their fear of being separated from their children or being sent back to the horrific trauma that they had experienced. Children are very perceptive. A mother I was speaking with told me about how her 8-year-old was aware of all that was going on in the house. The sheer amount of worry and fear that these children face has health effects. Toxic stress can alter the brain structure and impact a child's health not only in the short-term, but can have long-term effects. This fear also impacts access to health services. Recently, I saw a young mother with a 2-month-old son who was born here, and she was told not to apply for Medicaid given the current legal climate. This mother was able to pay for every visit, but not everyone is so lucky.

Despite fear, there is also strength. I saw a young mother who was caring for her pre-school aged son. She leaves for work at 6am and often returns after 7 or 8pm. She still makes the time for her young son. This child is growing up in a home of love and strength. Community is another source of strength. Houston is one of the most diverse cities in the country and this has resulted in this city being a welcoming place for many families. There are schools dedicated to newly arrived immigrant



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Houston is one of the most diverse cities in the country and this has resulted in this city being a welcoming place for many families.

children and multiple nonprofits dedicated to improving the health and education of this population. The very love and strength that exists within a home can occur in a city, a state, and a country. This is the reality of what I see every day, a mixture of fear with a tincture of hope.

Padma Swamy, MD, MPH,* is a pediatrician in Houston, Texas, who is passionate about immigrant health and particularly interested in how to improve the social factors that impact immigrant populations. She is faculty at Baylor/Texas Children's Hospital. She is a key member in starting the Program for Immigrant/Refugee Child Health at Baylor/Texas Children's Hospital. She is one of the leaders for the Immigrant/Refugee Health Committee of Doctors For Change, a local Houston nonprofit.

**Any opinions expressed in the article are those of Dr. Swamy and not meant to be a representation of her academic institution.*

The Deafening Silence of Trauma

Omolara Thomas Uwemedimo

As a mother and a pediatrician, I have been tasked with the unique responsibility of taking care of my two children and thousands of other children—caring for them as if they were my own. Embedded in this role is the critical role of supporting children who experience challenging social and emotional situations. Children such as Rosa, my 15-year-old patient,

who emigrated from El Salvador at 2 years old and quickly became English proficient, who is now having declining school performance and truancy after finding out that she might lose her parents when their temporary protected status visa expires next year.

It is estimated that nearly half of all children in the United States experience adverse childhood experiences (ACEs), that is, a situation that elicits significant and chronic stress for a child or adolescent over time. ACEs such as parental deportation can lead to traumatic stress and negative effects on a child's physical, emotional, and behavioral health. Rosa is only one example of the numerous children who experience ACEs and exhibit significant changes in their personality and behavior. Fortunately, she lives with her parents who try to serve as a pillar of support and strength for her.

As a pediatrician in Queens, New York, arguably the most diverse county in the United States, a significant proportion of the parents I interact with are immigrants—selfless individuals who have made the difficult decision to leave everything and everyone they have ever known for refuge. They seek refuge from gang violence, war, and extreme poverty, and their migration stories are heart wrenching. In particular, for those who have migrated through our southern border, I hear stories of rape, physical abuse, starvation, fatigue, and heat exhaustion worsened by the deaths of friends and family members who accompanied them. Despite the trauma that is inextricably connected to each of the stories, all of them have culminated with threads of resilience and hope about the better life they strive to create as a family together in this country.

As I see images of children living in detention centers, I move erratically through denial, anger, and depression. I reflect on the psychological aftermath of young, fragile minds that not only have to comprehend the horrors that occurred during their migration but the unimaginable tragedy of entering a completely unpredictable social environment. Child health professionals are taught the singular importance of attachment, the relationship between children and their caretakers. They are trained on the devastating consequences of how poor caregiving stability can lead to insecure attachments, which can result in children who disassociate from their normal need for connection, repress their emotions, and/or become physically unable to self-regulate their behaviors.

For immigrant children, the traumatic stress is compounded by “acculturative stress,” a stress that develops from immigration through disruption of family/social networks and/or cultural and social isolation. Acculturative stress can also worsen in the presence of ACEs, such as exposure to trauma that occurred during the resettlement to the new country, and substandard living conditions in the new country due to inadequate supports, discrimination, and/or persecution. In addition to posttraumatic stress, a number of studies have demonstrated that exposure to such traumatic and challenging experiences and transitions can produce a range of psychological problems, including poor identity formation, inability to form relationships, school phobia, inattention, conduct problems, depression, anxiety, and difficulties in school performance.



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It is paramount that children, who have experienced trauma during migration, are protected and supported in order to offer them the best opportunity to thrive.

The silent nature of trauma is always deafening and if unstopped, the effects can be lifelong. It is paramount that children, who have experienced trauma during migration, are protected and supported in order to offer them the best opportunity to thrive in America, their new home.

Dr. Omolara Thomas Uwemedimo is assistant professor of pediatrics and occupational medicine, epidemiology, and prevention at Zucker School of Medicine at Hofstra/Northwell and co-director of the Community Health and Social Medicine (CHASM) Initiative at Northwell Health. Over the past 13 years, Dr. Uwemedimo has worked as a clinician in sub-Saharan Africa, Asia, and Latin America and continues to work in Queens, NY, as an outpatient pediatrician, with a focus on supporting ethnic minority children from immigrant families.

Dr. Uwemedimo is a member of the New York State American Academy of Pediatrics (AAP) Immigration Committee and has worked with local advocacy groups such as the New York Immigration Coalition. She is a member of the AAP's Section of International Child Health and the Immigrant Health Special Interest Group. She has been the recipient of the National Institute of Minority Health Disparities Scholars Institute and is currently a fellow of the Robert Wood Johnson Foundation Clinical Scholars Leadership Institute.

My Zawadi: Working With Refugee Families

Janine Young

I direct a refugee clinic in Denver, Colorado, and have been working with immigrants and refugees for my entire 20-year career. This is what I love to do. Every day, I provide medical care for children and families from around the world. In this work, I have learned to say simple words such as *hello*, *beautiful child*, *thank you*, *have a good day*, and other essential phrases in more than 10 beautiful and varied languages. I learn as much from my patients and families as I hope that they learn from me. It is an equal playing field. No hierarchies needed.

I am regularly in awe of a family's will to do what is best for their children. For reasons that vary from escaping war to a search for a better life, they have fled their country and left behind their home, extended family, culture, language, food, environment—the fiber that provides meaning, and individual and collective identity—to a foreign land where nothing makes sense. I do not know if I possess the strength if I had to do the same, though I hope never to have to make such a choice for my family, as so many others have done and continue to do.

Walking into an exam room to evaluate newly arriving refugees is a momentous occasion for all involved. One recent family— young girls and their a mother originally from the Democratic Republic of Congo—had arrived a few weeks earlier after multiple flights that carried them from their refugee camp in Uganda to their new home in Denver. Though it was winter in Denver, the mother wore flip flops. They were cold and terrified. “*Jambo, habari?*” (*Hello, how are you?*), I asked in Swahili, in the language of their refugee camp, the only language they knew. They now looked surprised.

By the end of our 2-hour screening examination visit, the girls had relaxed. They had new toothbrushes, books from Reach Out and Read—in Swahili(!)—and the mother was learning how to open child-proof bottles of multivitamins for her girls. The mother had also become less guarded, and they were all laughing with me as they tried to teach me the word for *gift* in Swahili—*zawadi*.

These actions are a gift for me, a *zawadi*, as much as I hope they are humanizing, restorative, and demonstrate the respect and kindness that all human beings deserve.



Photo: Daxiao Productions/shutterstock

I am regularly in awe of a family's will to do what is best for their children.

Janine Young, MD, FAAP, is an associate professor of pediatrics at the University of Colorado School of Medicine and the medical director of the Denver Health Refugee Clinic. For 20 years, she has provided care for immigrant and refugee families, and she speaks Spanish and French. She is the co-author of the American Academy of Pediatrics Immigrant ToolKit Clinical Guidelines section and is funded through the University of Minnesota and Centers for Disease Control and Prevention to develop refugee medical screening guidelines. She has consulted for the Office of Refugee Resettlement to establish medical screening guidelines for unaccompanied immigrant children from Central America.

PERSPECTIVES

Between Worlds

A Yemeni Mother's Experiences of War, Separation, and Resettlement

Dalia Al-Qubati

Kuala Lumpur, Malaysia

Teresa Ostler

University of Illinois at Urbana-Champaign

Abstract

The authors wrote this article in the context of the ongoing wars, losses, battles, violence, conflicts, hunger, and unprecedented humanitarian crises in the Arab world and in the context of the discrimination, hatred, and separations faced by many refugee families who are seeking to find a safer life for themselves and their children. Drawing on correspondence and shared conversations between the two authors, they describe what it is like to be a woman and mother of a young child in Yemen, the poorest of all the Arab countries, during its protracted and brutal civil war. Dalia's writings give voice to the complex range of deep feelings, hopes, and fears she experienced as a pregnant mother as war broke out in Yemen and as she decided to flee so that her young son can have a safer future. Dalia's correspondence also underscores the close interconnectedness between attachment, loss, and separation throughout life and the role of memories and early attachment bonds in giving a young child hope in a changing world.

When I (Teresa Ostler) was 30, I began hearing about Dalia. Dalia, the little girl who spoke fluent Arabic and English, who stood tall and proud and rapped on doors asking for milk for a stray cat with my mother. Dalia who was not afraid to speak up and talk. Dalia who read the *Tin Tin* books my mother brought her, who sat in the 4-wheel drive car with my parents as they traveled to Aden, Sana'a, Ta'izz, the Hadramout, and Shibam, for me faraway, almost unheard-of places. Dalia taught my mother about the Arab world, its customs, culture, and music, about the dangers of going out of a compound alone as a woman in Yemen.

My parents often travelled to Yemen to work with Dr. Yasin, Dalia's father, in the City of Light, a leprosarium, which lies at the outskirts of Ta'izz, an ancient and beautiful city in the southeastern highlands of Yemen. Leprosy, one of the oldest mutilating diseases, affects the skin, peripheral nerves, and upper airways. Caused by a bacterial infection, it can lead to loss of pain sensation and protection of bodily organs. The person may lose fingers or whole limbs. When leprosy affects the eyelids, an individual cannot shut their eyes, so they dry out and they lose sight. Through a surgical procedure, my father, an ophthalmologist, would pin the eyelid to the brow, causing it to fall naturally. This procedure helped to preserve sight as the eyes retain their moisture. Because of physical deformities, patients with leprosy are subjected to extreme social suffering, stigma, and isolation.

Dalia, her father, Yasin, and her Yemeni family became part of my world from the first time I heard about them. This article includes correspondence and shared conversations with Dalia

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Photo: Dr. David Heiden

War and violence compel humans to flee, to find safety, and to keep their children out of harm's way.

over the past years. It also draws on correspondence with my mother (Auntie Marian), to whom Dalia has remained close.

Dalia's decision to leave Yemen occurred in the context of the ongoing civil war in Yemen, a war which has led to "the world's worst humanitarian crisis. More than 22 million people—three quarters of the population—are in desperate need of aid and protection" (Guterres, 2018).

The article tells the story of the experience of war and violence from Dalia's perspective as a pregnant mother and of the complex feelings and strengths of Dalia's experiences as a mother during the war. Dalia was pregnant during the Arab Spring in Yemen in 2010 and Boodi's first 3 years saw civil war. In the wake of the violence, Dalia and her husband, Hani, decided to give their son a safer future, so she fled with him to Malaysia. Her husband stayed behind in Yemen to maintain the family business to support them. Her writings tell about what it was like to live between worlds, past and present, childhood and adulthood, the beloved Yemen she grew up in and Malaysia, the country she now lives in. Through Dalia's eyes and words, we explore her experiences fears, hopes, courage, and dreams and what sustains her as a parent. Below is our weaving of her story. Dalia's words are in italics. My comments on her remarkable reflections and experiences as a mother are in plain font.

This Is Not Fair, This Is So Cruel!

The Arab Spring started in Tunisia in December 2010

as peaceful youth demonstrations demanding the change of corrupted regimes that ruled the Arab countries. In Yemen, the demonstrations led to the revolution of the 11th of February 2011. People refused to go back to their homes until their demands were fulfilled. They camped in the squares and slept on the streets. All the people came together, men and women, southerners and northerners, the elite and the commoners, the rich and poor, all gathered for the sake of a better future.

A short time later,

on the 18th of March 2011, tens of thousands of people demonstrated in the capital city of Sana'a after Friday prayer. Snipers took their places on the buildings of the Square of Change, as people gathered after prayer. A massacre took place at once.

I was in my last month of pregnancy with Boodi and watched the horrific pictures of Gumat Alkaram ("Dignity Friday") streaming live on Aljazeera News. People were in panic watching their friends fall down beside them. Most dressed in white for the Friday prayer were soaked in red, either by their friends' or their own blood. More than 45 people died on the spot, and more than 200 were injured. I was shaking and crying hysterically and shouting "This is not fair, this is so cruel!"

On the 29th of May 2011, just before sunset, the Yemeni Army invaded Freedom Square in Tai'zz. Tanks and soldiers poured kerosene on the tents, setting them on fire. In few minutes, the blaze reached to the sky. Handicapped demonstrators lost their lives in their tents in the fire. Bullets were shot and several people were killed. It was hell. From that moment on, the army took over the city, forbidding people from demonstrating or gathering anywhere. The country sank in a spiral of violence and chaos.

This Could Have Been My Son

War disturbs and breaks up family life (Freud & Burlingham, 1943). It disrupts parents' ability to protect their children and keep them safe and shatters people's sense of safety. War takes away all they have come to count on, leaving them vulnerable, traumatized, in disbelief and fear. It robs of hope, safety, and security.

Many people have died in Ta'izz. Continuous shelling on the neighborhoods doesn't stop—day and night! Bombs fall on the streets and houses. The first floor of our building was bombed. And neighbors say another bomb hit the roof. It happened after we left our house. We didn't take much with us. We thought it would not last more than one month or two, but it has been 21 months now. No one can even go and check if everything is all right. Two teenagers were shot dead right in front of our front door. I can't bear thinking that this could have been my son.

War and violence compel humans to flee, to find safety and to keep their children out of harm's way. Fleeing brings with it pain and anguish and change. It means leaving what they love behind and facing uncertainty and hardship ahead.

I felt it was my responsibility to take Boodi off this ship of crazy people. How? I didn't know! But I would find a way. I had my husband's total support, and that's what is important. So, we took the decision to move our young son to a safe place and protect him as much as we could from the ugliness of the war. I was lucky we could leave.

"The Anchors That Secure Our Souls"

Attachment, separation, and culture are closely entwined from early on. Children form bonds of attachment for survival, so that they have a caregiver who protects them, watches over them, and makes sure they are safe. Children's deepest feelings, memories, and experiences are closely tied to their attachments to the caregivers who give birth to them, hold them, sing to them, and help them thrive.

Humans' sense of safety stems from early experiences with caregivers, as does their ability to self-soothe. Parents try to provide their children with a secure base from which they can explore and go out into the world. Parents encourage young children and reassure them that they are present and available to help them as they venture out to explore the world. They also remain a haven of safety to which children can return when they are ill, hurt, tired, afraid, or wander away too far.

Even before young children crawl, walk, run, and venture out, they are part of and yet separate from their parents. They dwell in their own bodies and have their own experiences, hopes, desires, and dreams. Young children also develop their own minds, feelings, and unique ways of coping. While parents and extended family can provide love, comfort, and protection, they also must let children go so they can soar on their own as they grow older.

Biologically based, attachment bonds are complemented by and linked intricately with bonds of caregiving. Parents are biologically prone to hear their child's cries, to observe and read their facial expressions and communications, and to monitor their safety and well-being (Bowlby, 1969/1982). They watch over their children with mindful eyes, help to scoop them up and hold them, and give words to their unique feelings and experiences.

Young children's attachment behaviors are activated by situations that suggest danger or a need for help. Being in the dark, being alone, or feeling ill are all powerful triggers of attachment behavior. Holding and comfort make a child again feel safe (Bowlby, 1988).

Young children have intense responses to separations from parents, especially if they are prolonged, if the separation is unplanned, if children are cared for by someone they do not know, and if they do not yet have the capacity to understand when their parents will return. Common responses include



Photo: Dr. David Heiden

Attachment, separation, and culture are closely entwined from early on.

crying, yearning, protesting, withdrawing, anger, anxiety, and despair. When young children cannot see the end to a separation, they can develop extreme defenses. They may withdraw, cease crying, and fail to recognize the person they long for (Bowlby, 1980). Boodi did not experience a separation from his mother, but his father remained in Yemen to support the family. Although he visits, each separation from his father is deeply felt.

Every time his departure is painful, but each time it comes more painful. This time Boodi laid his head on his father's shoulders, and Hani wrapped his arms tight around him. He cried a lot for his father. Watching this, my heart sank in pain and anxiety.

Longings for parents—and for the experience of safety, love, and shelter—are just as present in parents who have fled a country in war and are resettling in new place. Parents' ability to raise, protect, and care for their children is sustained by their own attachment experiences. Early bonds give rise to great longings but also provide comfort.

I have been spending long times with my young son alone. This has given me the opportunity to contemplate and realize what I long for despite everything I had. I finally realized it was my mother. Being together with my young

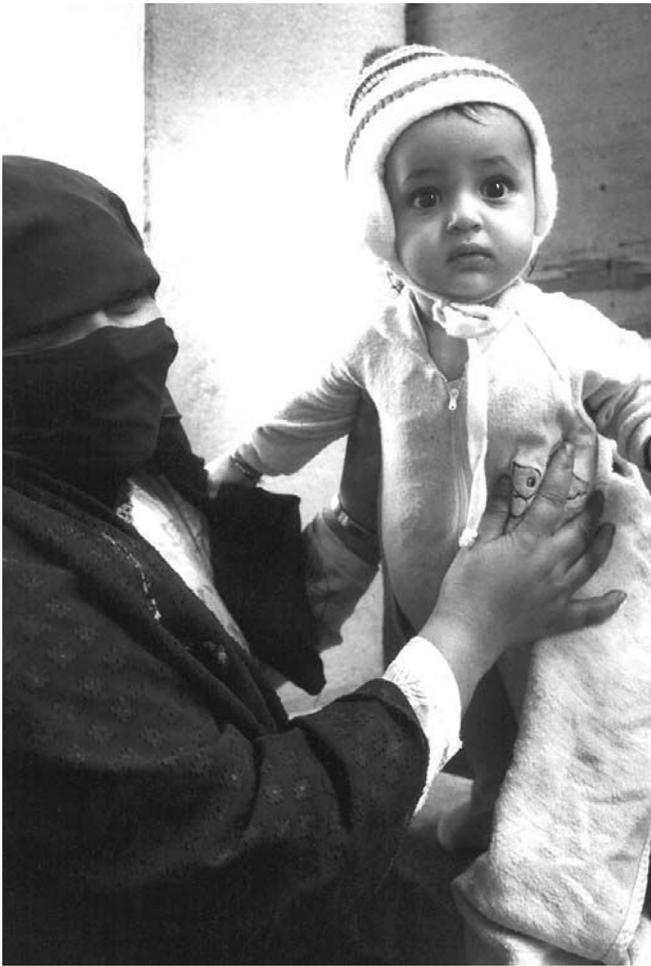


Photo: Dr. David Heiden

"Mothers are very important. They are the anchors that secure our souls when everything around us seems to be drifting away and destabilizes us. A mother's arms are the most peaceful place on earth."

son, I realize more and more every day the depth of this longing. Mothers are very important. They are the anchors that secure our souls when everything around us seems to be drifting away and destabilizes us. A mother's arms are the most peaceful place on earth. One can never be complete without a mother.

Endless Nights

Many Arab women with young children are caught up in the current conflict and crises in the Arab world, and they have experienced the brutality and trauma of war, a perilous departure, and uncertainty in their new countries. Resettlement in a new country is not easy. One loses one's status, employment, and family support and experiences discrimination. Refugees enter their new countries with hopes of safety, but also with great anxiety and uncertainty about their futures.

Sadness and fear overwhelm coping.

Troubling news from Tai'zz distracts me. Watching things only deteriorate and not knowing what will happen next paralyzes my thinking. Boodi keeps asking me to focus with him when he speaks to me. He says I don't listen to him because my eyes are looking somewhere else. I think I will find a peaceful moment later in the day when I can "focus," but it seems like I am so overwhelmed with my own distractions.

Living in a new country can ease

anxiety and tension, but I also have had endless nights where it seemed like I cried forever. I wondered where all those tears came from.

War is haunting. Questions about humanity and the cruelty of this world loom large.

It's the crack of dawn. My heart is heavy. Mind can't rest. Can't find sleep. Sometimes I wonder whether it is the right thing to bring children into this world. Mohammad [a boy Dalia taught in school] will not wake up. He was killed today in Tai'zz by random shelling. He loved to play. He was always smiling. Now he will sleep forever, and his eyes will be haunting me. This is a cruel world.

Young children seek to make sense of their worlds. They ask questions that cannot easily be answered,

especially questions about God and heavens and people who died. My answers don't seem to satisfy his curiosity. "Why did you bring me here?" Because Yemen is not safe. "What about Baba?" Your father is trying to stay in a safe place. "I can stay with him." I promise the war will end soon and we shall be back. This is not true, but I don't have answers.

An Avalanche of Memories

Although the way adults care for children is deeply rooted in biology, individual experiences with caregivers and culture both influence how they care for children. Winnicott (1971) wrote that the experience of culture is located in what he called a "potential space"—a space where a young child is both merged with the parent but is also separate from her. In the safe haven of play, "language, customs, and their enduring symbolic and emotional meanings come into being" (p. 120).

Memories of attachment, of potential spaces, and of people whom she has been close to can be a well-spring of solace and connection for a mother with a young child who has fled war and lives between worlds. The longing for what is not there and for loved ones who are not present is immense.

Flashbacks from my childhood come. Tiny things that mean something sweet for me. I remember my grandfather's village, located on the tip of a high and steep mountain. On a clear night, you can almost touch the stars or jump on the back of a shooting star. The number of shooting stars that pass in one night is incredible! They could be red, green, yellow, or even pink.

My father took me everywhere with him, even to Friday prayer to pray with him. After that he would take me to the market. There he bought me poppy seed pods. I would crush the pods and eat the seeds all the way home. My father managed to give me the feeling that he was always around me, watching me. His presence kept me safe.

Memories of being encouraged, loved, and known are also sustaining.

(From a letter to Auntie Marian:) An avalanche of memories hits me when I think back to earlier times. Those were the best times in my life, the times of innocent and carefree childhood. Time has changed a lot, and life has become more serious and hard. I remember every letter you sent me and all the pictures of your family, your grandchildren, and your big dog. All the books of Tin Tin. I remember how you encouraged conversations with me, letting me express myself with my broken English. You made me feel like I could speak fluently and that I am important. A big part of my inner self is still that little child you knew.

What sustains Dalia and Boodi the most are hope and love from her husband.

He tries his best to help our little family. He is a great husband, and I love him dearly. We are trying our best, and we will keep trying. We survive on hope.

How Hard Is It to Be a Rock?

Yemen, the poorest country in the Arab world, is situated at the tip of the Arabian peninsula.

Poverty, social injustice, and lack of freedom have always been part of Yemeni people, especially women and mothers. There are widows who live in houses on top of rocky mountains, where you literally climb on stones to reach them. Their houses are made of stones arranged on top of each other without concrete. They look so weak and tired. Their skin is so dry and burned from the sun, because they spend the whole day herding their few sheep on the mountains. Their only source of water is rain. They collect rain water in rainy season in tanks. It rains for 2 months in summer, sometimes for 1 month, and they have to save the water for the rest of the year.

It is usually a mother who provides ongoing support for a young child. All mothers uphold family values, cultures, and beliefs, even while helping the child to navigate and adapt to a new culture. Being a mother and a refugee in a new country means giving up much of yourself to be present for your young child.

I stopped thinking about myself a long time ago. I am thinking now how to help my young son get a better chance in life than I had. I want him to be someone important and to be able to make a change to make this world a better place. And I am afraid I can't help him with all the circumstances around us.



Photo: Dr. David Heiden

Parents seek to give their children understanding and hope and to inoculate them against discrimination, hatred, and fear.

In hard times, strengths are sometimes found deep within oneself. Are they always there, or do people find them out of necessity? When a parent is on her own with a child, she becomes strong.

(From a letter to Auntie Marian:) I remember the high plateau we travelled to together. It was as if there was a mountain that had been sliced with a big sword from the middle! A perfect cut! There were pieces of rocks—not big ones, about the size of two big hand palms widely open—scattered everywhere as if they had been showered down from the sky all together in one night. The strangest thing about these rocks was that they were so black and if you flipped them over to the bottom side, they had a different color. Their original color was light!

My first thought was how long had these rocks been roasting under the harsh sun of the desert! How hard is it for a rock to be a rock? Not being able to change who you are, not being able to save yourself from cruel circumstances, to help yourself! To be a rock, to stand in one place for eternity, you watch life passes by you, every day the sun rises

and sets, the stars come and go, travelers and vehicles roar and create that big cloud of dust as they pass by and maybe step on you and never recognize you were there? How hard is it to be a rock? The sun sears your face every day, and you can't hide from it? How hard is it to be a rock in Yemen? How hard is it to be a woman and mother in Yemen? It is so hard but also so strong!

There Is so Much to Learn About Our Differences

Dalia's correspondence evoked powerful feelings in me: love, hopelessness, despair, outrage at our world, joy, and a deep desire to make her world whole—to give her, Boodi, and her family what is not possible to give: a return to a safe place where life is secure.

Separation, loss, and attachment are closely intertwined throughout life. Because of this, humans dwell between worlds. They seek to find those they love and have lost, they cry, they protest. They yearn to be comforted by those who are not there and find strength from bonds of love. They seek to give their children understanding and hope and to inoculate them against discrimination, hatred, and fear.

Yemenis with leprosy still live in the City of Light, even though leprosy is treatable. You cannot get leprosy by touching a person with leprosy, but stigma, fear, isolation, and discrimination persist.

About 650 ago, villagers in Kaidon, a desert village in the Wadi Dawan Hadramout in Yemen started a festival once a year on Friday in the Rajab Hihri month, the seventh month of the Islamic calendar. On that day each year, people in the village intermingle, as they are immune from the stigma of disease. Lepers and non-lepers break bread; they talk and share.

Yes, it is important learn about our differences. And if we learn that much, we realize that basically we are not different at all. We share the same needs, the same rejections, and the same fears. Love is what we all look for.

Warmth and affection help our souls to rest and relax in this crazy world.

Dalia Al-Qubati learned English at the Mohammad Ali Otham School and obtained her degree in English Literature at the University of Tai'zz in 2004. She taught school for 10 years before leaving Yemen. She is married, lives in Malaysia, and is mother to Boodi, now 8 years old.

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When Migration Separates Children and Parents

Searching for Repair

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Abstract

This article describes the impact on young children of sudden and extended separation from a primary attachment figure. It recommends clinical intervention when the child's development and family functioning are negatively affected by the severity of the child's symptoms, and it highlights key treatment modalities derived from Child-Parent Psychotherapy, including the importance of "speaking the unspeakable," defined as affirming reality by giving words to the separation and its sequelae and the importance of offering a safe space for the child's expression of sadness, anger, and fear in the supportive presence of the caregiver. Two clinical examples illustrate treatment while the separation is ongoing and after reunion takes place.

Sudden and extended separation from a loving parent is among the most emotionally harmful events that can happen to a young child. Scientific understanding of this experience began with the seminal studies of maternal separation during the first half of the 20th century, which documented young children's responses to separation as the result of war (Burlingham & Freud, 1944; Freud & Burlingham, 1943), maternal imprisonment (Spitz & Wolf, 1946) and other circumstances (Ainsworth & Boston, 1952; Bowlby, 1951, 1973) and which laid the foundations of the field of infant mental health. Prolonged separation from a primary attachment figure creates fear, triggering the release of stress hormones that can become toxic at chronically high levels and may lead to dysregulations of physiological arousal, increased susceptibility to physical illness, and damage to the child's capacities for affect regulation, trusting relationships, and age-appropriate exploration and learning that define early childhood mental health.

When separation also involves unpredictable and dangerous circumstances, the negative impact on the child is exacerbated by the traumatic events or secondary adversities preceding and co-occurring with the separation, which may include violent exchanges and overwhelming sensory experiences. There may be no opportunity to engage in protective measures such as helping the child anticipate what will happen, provide a trusted substitute caregiver, and maintain predictable caregiving routines that offer a sense of continuity. In the case of migration-related separation, there are also disruptions of the physical and cultural environment, with surroundings that may change abruptly and differences in the language, appearance, and caregiving practices of the people interacting with the child. Even if the child remains in the care of other attachment figures, those adults may become so distraught by their circumstances, or focused on practical necessities, or both, that they may not be available to respond supportively to the child's sadness, anger, and distress.

Clinical intervention is indicated when separation reactions interfere with the child's developmental progress and family functioning. Migration-related separation presents a complex clinical challenge because ethical, sociological, cultural, and psychological factors converge in creating a pathogenic impact

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Migration-related separation presents a complex clinical challenge because ethical, sociological, cultural, and psychological factors converge in creating a pathogenic impact on the child and the family.

on the child and the family. In this sense, separation as the result of migration is a case example of the notion that social justice concerns are linked inextricably with the field of infant mental health (St. John, Thomas, & Noroña, 2012). This article focuses on clinical intervention with the child and the parent(s) and describes some therapeutic interventions used in Child-Parent Psychotherapy (CPP; Lieberman, Ghosh Ippen, & Van Horn, 2015) to help young children affected by parental separation.

Manifestations of Separation Distress in the First 3 Years of Life

Bowlby (1968/82) reviewed dozens of studies of child separation from the primary caregiver and concluded that there was a remarkable uniformity among the findings in spite of differences in child age, background, health status, length of separation, and type of care received, as well as differences in the professional backgrounds and expectations of the observers. Three phases of separation response emerge among children between 6 months and 3 years old: Protest, Despair, and Detachment. These phases may alternate or merge into each other, with no clear temporal demarcation between the phases.

The initial response involves protest, which may begin immediately or emerge after hours or days and involves acute distress, crying, throwing oneself about, searching, calling out, looking eagerly toward any sound or sight that might indicate the return of the attachment figure, and sometimes refusing care from an alternate caregiver. Active protest is often followed by the phase of despair, which indicates increased hopelessness about the loved one's return and is shown through little interest in the environment, low energy level, and monotonous, low-key, intermittent crying. The subsequent phase of detachment emerges most clearly during reunion. During this phase the child's renewed engagement with the environment and acceptance of substitute care may be mistaken for a complete recovery, but upon reunion the child does not engage in the normative

reunion behaviors of seeking proximity and maintaining contact with the parent figure. Instead of coming close and holding on, the child may remain distant and aloof, turn away, and show no interest in re-establishing a connection. The defensive nature of this response is evident from the fact that the child readily recognizes other people or objects that had also been absent but with whom the child did not have a primary attachment relationship. This differential response indicates that detachment is not an ordinary form of forgetting, but rather a defensive exclusion from consciousness of the pain that has become associated with the attachment figure through the separation experience.

Prolonged separation from a primary attachment figure may be considered a traumatic event for young children because their perceived safety is organized around the attachment relationship, and its absence may be experienced as a significant loss. As a result, traumatic stress responses may emerge following separation and take different manifestations, as described in the next three sections (ZERO TO THREE, 2016).

Re-Experiencing

Re-experiencing may occur, for example, in the form of re-enacting the separation in play or behavior, preoccupation with the separation as shown in repeated questions and statements, repeated nightmares, significant distress at separation reminders, marked physiological reactions, dissociative episodes such as marked detachment or unresponsiveness in response to separation reminders, or a combination of these.

Dampening of Positive Emotional Responsiveness

This reaction may include social withdrawal, reduced positive emotions, diminished interest or participation in play and social interactions, and increased fearfulness or sadness.

Increased Arousal

This reaction may include difficulty going to sleep or staying asleep; difficulty concentrating; hypervigilance; exaggerated startle response; and increased irritability, outbursts of anger, or temper tantrums.

These symptoms serve as useful guides to understand the meanings that the child gives to the separation. A case formulation based on possible links between the separation experience and the child's symptoms can help both the caregiver(s) and the child in creating a separation narrative that increases safety, corrects age-appropriate but pathogenic explanations ("My dad doesn't love me"; "It is my fault because I cried"), and builds trust-promoting communications between caregiver and child.

Helping the Child Grieve While Continuing to Grow After a Separation

It is advisable to start treatment with a foundational assessment and case formulation phase that includes initial meetings alone with the caregiver(s) to collaborate in developing a treatment

plan. These sessions allow for a candid exploration with the caregiver of the circumstances surrounding the separation; presenting symptoms; family background and current circumstances; exposure to adverse/traumatic events, including historical/cultural trauma; and protective factors in the child, the caregiver(s), and the environment (Lieberman et al., 2015; ZERO TO THREE, 2016). When a young child is referred for treatment following separation from an attachment figure, one of the first questions a clinician should ask is whether the caregivers have spoken with the child about the event. Often the caregivers respond that the child is too young to understand or that talking about what happened will make the child remember the separation and become more distressed. Clinicians need to address this adult defense tactfully but straightforwardly. One of the most important initial interventions may be to empathize with the caregiver(s) about the separation's effect on everybody involved and to provide developmental guidance about young children's capacity to remember, their need to have their knowledge of painful events confirmed by the adults they trust, and their relief when adults respond supportively to their intense negative emotions.

Gilda's Story: Affirming a Painful Reality and Giving Permission for Feelings

Even very young children can be keenly aware of their caregivers' unspoken expectation that they suppress upsetting memories and negative feelings. A 3-year-old girl named Gilda, separated from her mother after an immigration raid, said to her child care provider: "I want to go to your house to cry for my mommy." She understood implicitly that her grandmother, who was raising her, was so distraught that the mother's absence had become a forbidden topic, and that, after the initial shock, the family was expected to go about their daily routine as if nothing had happened. Gilda knew she was not supposed to cry for her mother. Instead, she had nightmares; uncontrollable angry screaming and non-compliance at home; and reckless, self-endangering behavior in the child care setting.

In individual meetings with the therapist during the initial assessment, the grandmother cried openly while describing the raid and its aftermath. Only after she could express and feel supported in her own feelings did she open herself to the possible links between the separation and the child's symptoms. She could then join with the therapist in creating a "formulation triangle," causally linking the separation and its sequelae to the child's symptoms and to the reason for treatment. Based on this understanding, the grandmother and the therapist explained to the child that everybody in the family was very sad that Gilda's mother was not with them. They told her that the mother's absence made the child so sad and mad that she could not sleep, yelled and said "no" a lot, and did things that could hurt her. They added that the grandmother wanted to help Gilda with her sad and mad feelings so that she could sleep well and have more fun at home and at school, and that the therapist would help find ways to remember Gilda's mother that made them feel better while waiting for her return.



Photo: Mason Vranish/shutterstock

Prolonged separation from a primary attachment figure may be considered a traumatic event for young children because their perceived safety is organized around the attachment relationship.

The child's response to this explanation was eloquent: she took the police car, pushed the mother doll inside it, and made it careen at full speed around the room. Although Gilda had not witnessed the raid, she enacted in this scene of intrusive traumatic images that she had developed from overhearing numerous highly emotional family conversations immediately following the raid. Subsequent sessions gave graphic expression through play, behavioral re-enactment, and verbalization to the existential questions in this little girl's mind: Did the "police" take away the mother because she was bad? Were the "police" bad for taking her mother away? Did the mother leave Gilda because the child was bad? Other questions had to do with the mother's well-being: Did she have food? Was she in jail? Last but not least, the most heart-rending plea: "When will my mommy come back?"

The effort to offer Gilda developmentally supportive explanations that were also truthful haunted the therapist and the grandmother, who wanted to reassure the child without lying to her. The therapist kept remembering Albert Camus' statement in his Nobel Prize acceptance speech that we have the dual duty of refusing to lie about what we know and resisting against oppression (Camus, 1957). How to help translate these goals for a little girl suddenly and arbitrarily bereft of her mother and for a grandmother arbitrarily bereft of her daughter and struggling with uncertainty, grief, poverty, and the challenges of providing a good enough life for a very young child while coping with her own waning energies as an older woman?

The treatment involved a patient co-creation of narratives that, rather than giving answers, gave permission for feelings. An extended initial phase of about 8 weekly sessions was characterized by Gilda's expressions of anger: at the "police" for taking her mother, at her fantasized omnipotent mother for leaving, at the grandmother for not being the mother, and at herself for her fantasized bad self that made the mother go away. This angry phase was followed by a "repair" phase, during which Gilda became excessively solicitous of her grandmother,



There is no guarantee of a "happy ending" when family life is derailed by social conditions and public policies that endanger safety and continuity.

cooking for her, saying "I am good," insisting on sitting on the grandmother's lap, and telling her "I love you" repeatedly and most particularly after the grandmother corrected her. At the same time, there was a very bad doll that Gilda constantly punished by shaking her and putting her in a corner of the room.

With the therapist's guidance, the grandmother reassured Gilda that she was good even when she did things that the grandmother did not like and that the grandmother would not leave her even when she became angry at Gilda's behavior. On one such occasion, Gilda responded, "But you left my mommy." The grandmother was initially speechless, and when she denied it Gilda replied, with great conviction "Yes, you did." Seeing the grandmother's distress, the therapist asked, "What do you think happened, Gilda?" The child then recounted a fight between mother and grandmother, which the grandmother confirmed saying they had reconciled and life proceeded as usual afterwards. She was shaken by the idea that Gilda now blamed her for the mother's detention. The therapist said,

Gilda, grownups get very mad sometimes. They can even throw dishes when they forget their words. Your mommy and grandma were very angry a long time ago, but your grandma loves your mom and she did not make her go away. It is very sad and bad that the police took your mommy and will not let her come back because they think she should live in Mexico. It is not your fault, and it is not your grandma's fault that the police think that way.

The grandmother burst into tears, and Gilda started crying as well. The therapist commented, "The two of you miss her so much." The grandmother opened her arms to Gilda, who went straight to her and sobbed loudly, hiding her face in her grandmother's chest. They held each other for several minutes, each crying for the absent mother and daughter. This session showed the competing explanations Gilda had of her mother's absence and her continuing efforts to give meaning to the separation. At

the same time, it enabled Gilda to cry openly for her mother for the first time, while held and mirrored by her grandmother as they both grieved together. Treatment ended soon afterwards, after 5 months of weekly sessions that culminated in a joint capacity by child and grandmother to tolerate their own and each other's pain through their love for each other.

Joaquin's Story: The Pain of Separation, The Stresses of Reunion

Children are biologically programmed to grow best in the care of a parent figure, and losing a loving and protective parent is possibly the biggest single tragedy that can happen to a child. The relief of reuniting is so profound that there is a common misconception that the child's separation-related emotional problems are resolved once reunion occurs. This is far from the case. The detachment responses identified by Bowlby (1973) demonstrate that the emotional damage caused by separation remains, but detachment is only one of the multiple emotional sequelae of separation. The experience of Joaquin, who was 2 years old when his father was separated from him and his mother at the border, illustrates some of the challenges involved in restoring a modicum of security to the child's attachment. Joaquin and his mother were referred by their pediatrician because of the symptoms the child developed following a terrifying journey from their country of origin in Central America into the United States that culminated in the father's detention on entering the country 2 months prior to the assessment session. The father did not resist detention and was allowed to say goodbye to his family, with Joaquin clinging to him and saying "No bye, no bye." During the first assessment session the mother described Joaquin as being "in another place," often staring into space; calling out for his father in his sleep and throughout the day; thrashing in his bed during restless sleep; not eating; and showing fear of the dark, intense separation anxiety, and fear of the police. The mother said that for her the experience at the border had evoked early memories of growing up without a father and witnessing community and domestic violence. She found herself unable to be emotionally present for Joaquin because of depressive symptoms and sudden panic attacks. She attributed her emotional state to the separation from Joaquin's father, the threat to their lives in their country of origin, the dangers of the journey to the US, and her fears about the future. She said that meeting and marrying Joaquin's father had given her hope that she could overcome the fear and sadness she had experienced as normative throughout her life, and she was now hopeless that they could be reunited and afraid that her child would also grow up without a father.

During the second assessment session, the mother arrived unexpectedly with her husband, who had been released and able to join them after about 3 months in detention. They recounted that Joaquin had turned away when the father had arrived a few days earlier, and since then he had alternated between clinging to the father and pushing him away. The father, who was overwhelmed by the frightening migration experience and subsequent detention and had anticipated a joyous reunion with his family, felt demoralized by his wife's

depression and his son's ambivalent reception. Both parents were eager to tell the therapist about their recent traumatic experiences and became very emotional when the therapist offered an explanation of Joaquin's responses as a reflection of his longing for his father and his fear of losing him again. They expressed amazement that the behavior of such a young child could have such deep meaning, and they agreed to joint sessions involving both parents and child. In a session with Joaquin and the parents, the therapist used dolls to describe to Joaquin the scene of the separation from his father at the border. She said that his mommy and daddy loved him very much and his dad did not want to say goodbye, and added that they were now together and his parents would help him eat and sleep and play and not be so scared. Joaquin responded by putting the mother and father doll in the same bed and then putting the baby doll on top of them. The therapist invited the parents to respond to what they thought Joaquin was trying to show them. The parents were touched by their child's clear expression of his wish to be together and said how good it felt to sleep all together again after being apart. Joaquin responded, "Always sleep together." He then moved to enact a scene of his father being hurt by wild animals—expressing perhaps both his fear of what happened to his father and his anger at him for the separation. The play themes in sessions that followed showed Joaquin's confusion about who was good and who was bad, who was safe and who was dangerous. A family of dolls and a family of panda bears were attacked by lions, the lions were attacked by dinosaurs, and the dinosaurs were run over by planes and cars. Nobody was safe, and efforts to save them were ineffectual. The parents' initial reaction as they observed this behavior consisted of efforts at socializing Joaquin, telling him to "be good," "don't hit," and "be gentle. As they allowed themselves to identify with Joaquin's anger for what had happened to them, they joined in his play, at first tentatively and later with increasing gusto, punishing the "bad guys" and rescuing the "good people." Joaquin's play became progressively less chaotic, with more recurrent safety themes and greater delineation between good and bad actors. The therapist continued to provide developmental guidance about Joaquin's behavior and psychoeducation and about the impact of trauma on the parents. She also helped the mother practice somatic experience exercises to identify and prevent impending panic attacks and to become more regulated. Treatment ended after 6 months when the family relocated to live with relatives in a rural area of the country, with Joaquin's symptoms significantly reduced and increased parental self-confidence in the midst of ongoing uncertainty about their future.

Conclusion

Separation and its sequelae pose an ongoing threat to young children's mental health and developmental progression. Treatment should focus on helping caregivers provide the child a truthful description of what happened and give space for the expression of the child's fear, sadness, and anger, while providing a protective environment and correcting the child's pathogenic beliefs. There is no guarantee of a "happy ending" when family

life is derailed by social conditions and public policies that endanger safety and continuity. Against this backdrop of ongoing adversity, "speaking the unspeakable" in supportive ways and implementing to the extent that is possible concrete demonstrations of love and predictability can help regulate affect, build trust, learn, and cope adaptively with stress by showing young children and their parents that they are allowed to know what they know and to feel what they feel.

Acknowledgment

The authors would like to thank the Substance Abuse and Mental Health Services Administration and the Irving Harris Foundation for their support in the development and implementation of Child-Parent Psychotherapy. Correspondence concerning this article should be addressed to Alicia F. Lieberman, Department of Psychiatry/Child Trauma Research Program, UCSF/San Francisco General Hospital, 1001 Potrero Ave, Building 20, Ste 2100, San Francisco, CA, 94110. E-mail: alicia.lieberman@ucsf.edu

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maternal depression, and other risk factors. She has developed and led the creation of the evidence base for Child–Parent Psychotherapy, which has shown efficacy in comparison to other interventions in five randomized studies with young children and their mothers. She currently directs the Early Trauma Treatment Network, a four-site center of the National Child Traumatic Stress Network (funded by the Substance Abuse and Mental Health Services Administration). She has authored a book on toddler development, two treatment manuals, and numerous articles and chapters on risk and protective factors for mental health in infancy and early childhood, child–parent attachment, and cultural competence in intervention and treatment. She was born in Paraguay and received her professional training in Israel and the United States. This cross-cultural experience informs her commitment to closing the mental health services gap for low-income and minority young children and their families.

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GROUNDBREAKING NEW INSIGHT INTO THE PSYCHE OF VERY YOUNG CHILDREN



Does Time Heal All? Exploring Mental Health in the First 3 Years

By Miri Keren, Doreet Hopp, and Sam Tyano

The notion that a baby might develop symptoms of psychological distress and that these can be diagnosed and treated is still a matter of great international debate.



Not a guide, nor an ordinary textbook, *Does Time Heal All?* weaves together complex case and treatment descriptions that focus specifically on the interplay between genetic, biological, psychological, and cultural variables present both in the child and his or her environment. The resulting insights will fascinate and enrich all who seek to trace the thin line between normative behavior, even if extreme at times, and abnormal behavior caused by a psychological disorder requiring therapeutic intervention.

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Parent Loss From the Baby's Perspective

Molly Romer Witten

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Abstract

The recent headlines about parent and child separation at the U.S. border has raised concern about the impact of such experiences on young children. In this article, the author provides the children's perspective of parental separation and loss and their experience of mourning during infancy and early childhood. Three vignettes illustrate how different children expressed their grief and the role of a sensitive adult to help them process and cope with the trauma of loss and mourning.

When the federal "zero tolerance" immigration policy led to the separation of parents from children and husbands from wives, many adults in the US felt disbelief and concern for the children and families, and then a state of frantic problem solving for which there was no straightforward solution. As distressed as the adults have been, imagine how the "separated" children experienced the rupture in their relationships with their parents and family members who were emigrating with them.

What happens in the mind and body of a young child when she experiences parent loss? Imagine it from an adult perspective of having the vocabulary, and life experience, and the ability of mindful organization of thoughts and feelings. Then try to imagine it without words, without the wisdom of years of experience, without your parent or beloved caregiver to relate to and to help you organize your thoughts, feelings, wishes, and fantasies. The trauma of parental separation and loss during early childhood has the potential to create significant and sustained mental health concerns.

The Child's Drive to Be Near Their Caregiver

Children under 5 years old have very little concept of time, or understanding of the meaning of probability, such as, "You'll see your mother/father/sibling soon." They experience any

unanticipated, spontaneous, unexplained separation from a parent as a "parent loss"—as in "My parent is lost," or, "I am lost, and I HAVE to find my way back to my parents." This highly anxious feeling of persistently working one's way back to one's beloved caregiver forms an overwhelmingly anxious motivation for young children. For children under 3 years old, there is a driven quality to the need to be near a parent or other beloved caregiver. Emotional calmness and physiological balance depend on close physical and emotional contact with a beloved caregiver. If children 5 years or older have individual differences that affect their rate of development, they can continue to experience this compelling need to look for and seek out their parents in whatever way available to them. The need to find one's beloved caregiver can drive a child to distraction. Nothing makes sense, absent the relationship with one's parent or other, beloved caregiver (Witten, 2008).

The beloved caregiver's role involves digesting the young child's experience and then moderating how quickly or slowly, how deeply or superficially, the child comes to understand what she is experiencing. By "predigesting" experience for the baby or young child, the beloved caregiver affords the child an opportunity to organize the world into which he wakes up every morning. Without the parent's intercession, and sharing of affect, a young child can feel easily overwhelmed by their interoceptive experience. Feeling overwhelmed, the infant or young child will disconnect from people and development will stop. It feels as though this world really is a blooming buzzing confusion, as William James observed of a baby's experience (Witten, 2008).

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Through their close attention to their child's needs and experience, parents and beloved caregivers create a felt sense of safety for every young child. With an abundance of research into the function and substance of development of relationships (Bowlby, 1951; Burlingham & Freud, 1944; Spitz, 1946), the field of clinical work with babies and young children has amassed a deep understanding of the effects of parent loss on an infant, toddler, or young child. This large body of research over the last 70 years has demonstrated that even brief, forced separations are harmful to the health and mental well-being of both the children and their lost parents. Parent loss puts a child's future in jeopardy (Garber, 2008).

The Child's Experience of Loss

When a baby, toddler, or young child experiences parent loss, she goes into a sequence of behaviors motivated by her wish to reunite with her lost parent. If the parent and child do not reunite, over a matter of just a few days the child begins a process of mourning and disconnecting from the lost parent. As adults mourn, their minds find ways to take memories of the lost beloved and assume some specific meaningful characteristics of the lost beloved within their sense of self.

However, in children, there is no possibility to accomplish that transformation of remembering and taking in, because they do not organize their experience reflectively, or with a sense of on-going memory. They are too young to have on-going organized memories tagged to verbal language. Their memories are episodic, sensation- and motor-based, and easily dislodged by new experiences. As they become emotionally and physically overwhelmed by their loss, they lose behavioral function, and their developmental rate slows down and sometimes becomes distorted.

For babies and young children, the first phase of mourning entails compliant protest within interaction with whomever is caring for them. In the second phase, the children become oppositional and defiant as their anxiety and frantic sense of loss overwhelm their internal capacity to regulate their emotions thoughts and fantasies. The children in this stage of parent loss may feel as though they are being prevented from reuniting with their beloved caregiver, or they may feel that they have done something bad or monstrous to cause the beloved to abandon them so precipitously. They either turn their anger outward, on those assigned to care for them, or inward, onto themselves. As the children become more and more emotionally overwhelmed, they lose the desire to relate with others, and they move into a physiological, depressive state in which basic processes of eating, eliminating, and sleeping become affected. Relating and communicating diminish as the children see less and less reason to respond to or initiate relating. Each of these relational junctures of "giving up" also signals the loss of developmentally appropriate cognitive and motor skills. The children's future development as well as their capacity for enjoying life are endangered. And the children can do nothing to put themselves back on developmental course by themselves. The only hope is that adults who take up the role



Photo: Twin Design/shutterstock

The trauma of parental separation and loss during early childhood has the potential to create significant and sustained mental health concerns.

of caregiver for these children have the patience, reflective capacity, and life experiences to support the children rather than punishing them for their ill-fated attempts at keeping developmental processes working, which may include oppositional behavior, defiant behavior, ignoring, or shutting down all forms of relating.

In each stage of mourning the baby and young child will demonstrate specific cognitive and relational deficits. These deficits are linked to ways the baby's mind attempts to protect itself from the self-fracturing sadness of loss. Below are three vignettes that illustrate how a child in each of the three stages of mourning demonstrated his or her grief (all names and other identifying information have been changed to protect the privacy of the child and his or her current family). It doesn't look like the grief adults can feel and reflect on. But then, babies and young children have a repertoire unique to them, unlike that of adults.

Phase One: Compliance but Consistent Attempts at Protest

Alejandro was 25 months old when his mother was killed as he and she slept in separate bedrooms at night. When the police found him, he was playing on the bed next to the body of his dead mother. He was put into the care of his maternal grandmother, with whom he had a life-long relationship and deep affection. His behavior seemed within normal limits, eating, sleeping, communicating and playing with his grandmother as well as peers. It was unknown who had killed Ale's mother. The police thought that maybe he knew, but they didn't know how to elicit the information from him.

His grandmother claimed that Alejandro had been speaking in sentences for the last few months. But, when he played with me (the police hoped that I could help him talk about what he had experienced), he spoke only in single words to label objects and people. He demonstrated no capacity for communicating cause and effect in sentences. While he seemed to play and relate



Emotional calmness and physiological balance depend on close physical and emotional contact with a beloved caregiver.

with both his grandmother in the room and me, I wondered about whether his experience of losing his mother had affected the level of his fantasy play. So, I got out some blocks and made an object that looked like a "ball," rolled it to him, and asked him what it was that. Smiling, he chuckled, "Ball. A ball." I then made some form of a car out of blocks and asked him again what it was, as I rolled the car to him. He again engaged and replied, "Car a red car, a car." I then took some more blocks and made a sort of knife (his mother was stabbed to death) and asked him what it was. Ale looked up and hesitated, looked down, away, and then his face showed an expression of sadness. He then responded, "Blocks, just blocks." I repeated this play with clay, making a ball, a car, and a knife out of clay. His response pattern was a repetition of his responses to the block play. All the while we were playing, he was happily touching base with his grandmother in the room and exploring toys. He expressed his sadness at the loss of his mother only when there was a physical reminder of the circumstances surrounding her death. The significance of our conversation occurred when he demonstrated cognitive blunting, lack of fantasy play, and somberness when I showed him the "knife." Although he was in the care of his grandmother, with whom he had a deep and affectionate relationship, when his memory was stimulated to recall his mother's death 2 days earlier, his demeanor changed, and he expressed subtle but robustly evident loss of cognitive capacity. He could no longer represent the feelings or fantasy prompted by the object but only the concrete substance of the object.

Phase Two: Open Protest, With Oppositional, Defiant, Risky, Behavior

Tori's mom, Ann, brought her to me when she was 30 months old. Along with her mother and brother, Tori had lost her father to suicide 4 months prior to meeting me. The process of her father's suicide was not part of Tori's experience. She had no idea what happened to her father. He went to work one morning and never returned in the evening to shower her with hugs and kisses and roughhousing. Shortly after father's death,

Tori's mother went into a profound depression. Although Ann lived in the home with Tori and her brother, she was emotionally unavailable to help Tori through this difficult period of living without her father. Tori was referred to me because she kept trying to jump out of high windows (smashing windows in the family apartment to do so) so that she could "fly up to heaven and be with Daddy," and, when thwarted in any way, she flew into a tantrum that could last up to 45 minutes.

Ann reported that it seemed that, prior to her husband's suicide, Tori had had emotionally secure relationships with both parents. However, once she lost her father, and her mother was too emotionally unavailable to notice her daughter's needs, Tori seemed to become prematurely independent and self-possessed. Her behavior was different from the "terrible 2s" that her older brother had gone through, and different from a young child's developmentally appropriate strivings for independence. She attempted to think through problems in isolation and without the support or feeling of reliance on her mother. Understanding and organizing her own intense loss and emotional pain was much too complex and abstract for this 2½-year-old, so she attempted to control her environment. Her mother also reported that Tori's image of herself seemed to take a turn toward self-loathing. Tori referred to herself as a monster.

For the first 7 months of Tori's bi-weekly visits to the playroom in my office, she began each session by ferreting out dolls of any sort and throwing them in the trash can, calling them "bad babies" and "monster babies." I understood her behavior as reflecting her attempts at coping with the pain of her rage at her father's absence for which she had no easy understandable explanation.

She experienced her father as abandoning her. As I came to understand through her play, her fantasy of why her father abandoned her was that she had done something to force her father to leave. She felt that she held such bad thoughts and wishes to have Mommy all to herself, that she "made" her father "go away, up to heaven." Her repeated phrase was a repetition of an explanation given her by the adults around her at the time of her dad's funeral.

Over a 3-year period, as we worked through these terribly painful feelings of abandonment, fearful of her own rage, and, as her mother got the psychological treatment that she needed so that she could resume being emotionally present for her toddler daughter, Tori came to understand the meaning of the loss as being outside her control and not the result of anything she had thought, felt, or done. We came to understand together that the pain she felt at the sudden loss of her father was not a reflection of her own badness or monstrous rage, but was part of her attempt to hold on to her memories of her father while trying to figure out how to recapture him by trying to "fly up to heaven." Tori did resume her development but entered preschool a year late because of a slowed developmental rate during the first year of her therapy. Eventually Tori did resume a more rapid developmental rate characteristic of her history prior to her father's death.

Phase Three: Physiological Depression, Cessation of Relating and Communicating, Loss of Self-Regulatory Capacity

Noah, the third child in his family, was referred to me by his parents when he was 4 years old. Two and a half years earlier, as a 29-month old boy, he had lost his beloved nanny, Rodriga, when she was forced to go back to her country without warning. From his parents' perspective, the government asked her to leave immediately, and there was nothing they could do about it. They did not think about what Rodriga's leaving would mean for Noah, only that they needed to find someone else to fill the role for Noah and his older brother and sister. Noah stopped talking completely over the course of the next 2 weeks.

His parents became quite anxious when he stopped talking. They could tell that something was wrong with him, but had no idea about the cause of his sudden transformation into a silent, reticent, shy toddler. So, they had him evaluated and within 2 months, at 31 months old, he received the first of many diagnoses of autism and developmental delay. As soon as it could be arranged, Noah was placed in an early childhood special education setting for children with autism. I did not meet him until he was turning 4, almost 2 years later. At the time of our meeting, Noah was considered by his parents, his teachers, and his therapist, to be a child with high-functioning autism.

However, upon hearing about his history of losing his beloved nanny and watching his warm (but silent) relatedness with his parents and siblings, the hypothesis formed for me that he was suffering from some sort of infant depression secondary to the loss of his beloved Rodriga. When I met him the first time, Noah spoke only in a scripted mechanical way, vacant of shared feelings. However, his consistent nonverbal, visual regard, following his parents visually, and his responsively expressive face led me away from an autism diagnosis and toward some form of relational issue.

At my request, and with due respect for the relationships he had developed in his special education classroom, Noah was slowly shifted out of the autism center and placed in a small, regular education classroom. Because of his obvious functional developmental delays, his parents sought out relationally oriented pragmatic speech therapy and therapeutic occupational therapy group services. His intervention services focused on his play with peers and members of his family, as well as with the therapists. After 1 year in the new setting, his developmental rate had improved an impressive 18 months, and he recovered function developmentally. However, Noah's parents complained that he solopistically required that family life revolve around his demands. For example, when he was thwarted, he expressed his displeasure through coercive self-isolating behavior, which sent his parents into high anxiety that he was again becoming depressed and therefore needed to be "spoiled" and given his way, at everyone else's expense. He also had no close buddies in preschool and expressed disdain at playing spontaneously with other children from his classroom or his neighborhood.



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Parent loss and caregiver loss leave a child feeling lonely, hopeless, and unable to cope.

To understand his continuing coping strategy of self-isolation and tantrums (which immediately distanced others from him) as a relational weapon against his parents, older siblings, peers, and teachers, I requested that Noah begin a course of psychotherapy with me. Intervening in psychotherapy in a way consistent with inhibited capacity for satisfaction within relationships, as well as unrealistic expectations for having his own way, rather than developmental delay, Noah made up the 2 years of emotional delay within the next 18 months. By the time he completed first grade, his functioning was above his chronological age in all developmental spheres, and he functioned well in a bilingual educational setting, fully committed to affiliating with his classmates at school and with his parents and siblings at home. He showed a full range of affect in his relating and working above grade level both intellectually and academically.

However, because Noah continued to express a seriously inhibited range of feelings, both his parents and I decided to continue his therapy. During this year Noah and I began to explore together his queries about maps: where he "fit" in any map. I wondered, was he trying to figure out how to keep both himself in mind, as well as where his parents and brother and sister were? I wanted to know about the meaning of his passion for maps. His incessant questions focused on finding me: "Molly, do you live in your office?" "Is this your home?" "If it's not your home, where's your home?" "Can I see where your home is on a map?" "Is your home far from my home?" "How do we get from my home to your home?" "Can I come to your home, not your office?" When I asked what it meant for Noah to only meet with me in my office, he brought clarity to the issue. He explained "Yeah, but if I don't know where your home is, I won't be able to find you if you go away." Finally, we came to understand that his passion for understanding maps was a means for him to seek out and find his nanny, Rodriga, whose loss 3 years earlier, when he was only 29 months old, set him on a distorted

developmental and emotional course. At 29 months old, he had none of the capacities he showed currently. Noah now alternately expressed deep sadness at losing Rodriga, fury that she would abandon him, and a sense of hopelessness borne of his immature capacity to understand the circumstances of her abrupt departure.

Conclusion

As demonstrated in these vignettes, babies and young children have memories but cannot organize them to cope with loss. They have a wide range of feelings but cannot self-regulate their experiences to feel safe in their own bodies when they experience caregiver loss. Without an adult helping them work through the myriad of feelings that come up for them, children will quite understandably create a fantasy that puts them at the center of the cause of loss and pain. They do not have enough experience with shared, modulated loss to understand that it is not always within their control, or anybody's. Parent loss and caregiver loss leave a child feeling lonely, hopeless, and unable to cope. It stops the child's development. It causes the child to

experience such high unremitting anxiety that they often shut down their perceptual capacities altogether. These children need their relationships with their parents and beloved caregivers in order to cope, and in order to learn to cope for the future.

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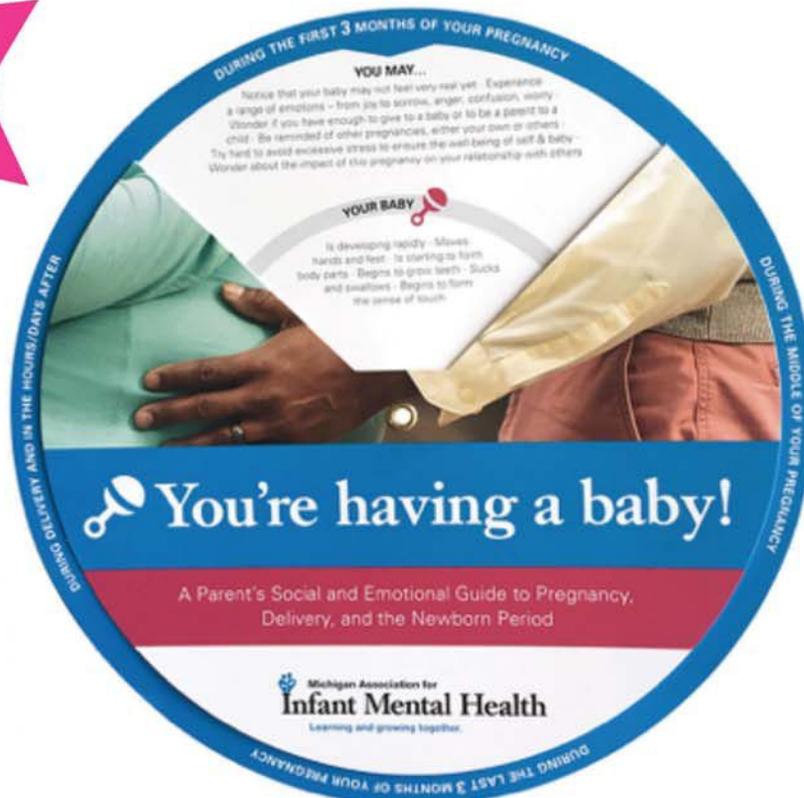


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Separating and Reconnecting

Family Relationships Across Military Deployment and Reintegration

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Abstract

Military deployments can necessitate prolonged family separations. The strain of separation is particularly acute for very young children and their parents. Reunions bring joy as well as challenges. The authors draw from their work with military families with young children to explore experiences of separating and reconnecting and the supports that can help families as they reestablish relationships, roles, and routines. The accounts of military families offer a unique lens for examining the impact of family separations. They demonstrate that, even with careful planning and strong supports, the implications of separation are great and the process of reuniting is complex.

Attachment theory (Bowlby, 1969, 1973, 1980) and supporting empirical research (National Academies of Science, Engineering, and Medicine, 2016; National Research Council & Institute of Medicine, 2000) indicate that stable, nurturing, parent–child relationships provide the most advantageous context for early development and foundation for development across the lifespan. Parent–child relationship disruptions in early childhood pose risks to social, emotional, physical, and cognitive development (Shonkoff et al., 2012). Abrupt separation poses particular risk to children’s sense of safety and security, but even when separation is anticipated, it is profoundly challenging to children and parents. Military deployments can demand extended separations of service members and their families, and the accounts of military families offer a unique lens for examining the impact of family separations. The experiences of military families demonstrate that, even with careful planning and strong supports, the

implications of separation are great and the process of reuniting is complex.

In this article, we draw from our work with military families with young children to explore experiences of separating and reconnecting and the supports that can help families as they reestablish relationships, roles, and routines. Across multiple studies, we’ve spoken with dozens of mothers and fathers who serve and deploy, as well as parents who have remained home and served as primary caregiver to their children while enduring separation from their spouse or partner¹ (Dayton, Walsh, Erwin, Muzik, & Rosenblum, 2014; Dodge, Gonzalez, Muzik & Rosenblum, 2017; Lee et al., 2013; Walsh, 2017; Walsh, Dayton, Erwin, Busuito, & Rosenblum, 2014). Their accounts demonstrate the resilience and coping abilities of military family members and families as a whole. But they also demonstrate the great toll of prolonged separations for children and parents. Here, we present common themes that have emerged in our interviews and focus groups with military-connected parents of young children. We begin by describing experiences prior to, during, and after an extended period of separation due to deployment. Then we describe what we have learned from our Strong Military Families (SMF; Rosenblum et al., 2015) program about the potential for healing and repair of relationships.

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¹ For brevity, we’ll use only “partner” throughout the rest of the article.

Pre-Deployment: Anticipating and Planning for Separation

Even before getting orders to deploy, parent-service members are keenly aware of the possibility that they might deploy. This knowledge is a source of worry and also an opportunity to plan for how the family's needs will be met in the event of a deployment. Immediately upon receiving orders, service members and their partners focus on getting affairs in order and making any necessary arrangements, in particular child care arrangements. For deploying mothers, who are more likely than deploying fathers to be primary caregivers or single parents, the need to make plans for their children is particularly urgent. In the words of one deploying mother of two young children, "Everything was challenging, because I was a mom, right. ... with me being gone, how would they manage?"

In addition to practical preparations, parents make emotional preparations and try to emotionally prepare their children for separation. Some parents describe their efforts to make the most of the time prior to deployment and create memories that will help to sustain themselves, their partners, and their children during deployment. Others acknowledge beginning to distance themselves, either inadvertently due to heightened demands on their time or intentionally as a way of psychologically preparing to be parted. Parents describe talking with their children about deployment and attempting to allay their worries and offer reassurance. They recognize signs that even infants and young toddlers seem to be responding to the change that is coming, picking up on parents' stress and manifesting their feelings of insecurity in their behavior.

During Deployment: Enduring Separation

Parents describe many effects of separation on their young children and themselves. Young children have difficulty understanding their parent's absence and may have difficulty adjusting to new care arrangements. Children may fear for their missing parent's safety and may cling to the at-home parent. Some children demonstrate the stress they are experiencing by withdrawing or regressing, while others show increased aggression.

Both deployed and at-home parents experience multiple stressors, including worry about the safety of a deployed partner or how a partner at home is managing, and worry about how children are coping with their grief and fear. In the words of one deployed mother, "I pretty much was in a total panic for the entire time... [The planning I did] sounds fantastic except that you just can't prepare for everything." Deployed parents describe continuous awareness of the time they are missing with their family and recognition that this time has particular meaning in the lives of their young children due to the rapid development that characterizes early childhood. Deployed service members and their partners are at heightened risk for emotional symptoms and distress during and after the period of deployment, and very young children are especially vulnerable to the family context of disruption and distress (Eaton et al., 2008; Flake, Davis, Johnson, & Middleton, 2009; Seal et al., 2009).



Photo: Kiwi Street Studios

Even very young children are quite attuned to the presence, absence, or unavailability of their caregiver.

Deployed parents frequently worry about what will happen when they get home. In the words of one military father, "I deployed with a 1-year-old. My biggest worry was that when I came home she wouldn't recognize me or come to me or let me hold her." They acknowledge and appreciate efforts made by the military to support sustained family connections, for example, making computers and internet available for video calls and facilitating opportunities to record bedtime stories to share with children at home.

Post-Deployment: Reintegration Into Family and Civilian Life

The end of deployment and the parent-service member's return home brings relief and joy. Yet, reunification is also stressful as family members begin the extended process of reestablishing relationships, roles, and routines. This process is especially difficult with very young children, who undergo significant developmental transitions during lengthy separations. Parents speak with great regret of their child responding to them as though they are a stranger, of needing to get to know their child anew and develop new parenting skills to respond to their child's new developmental stage. In the words of one parent who left an infant and returned home to a toddler:

It was frustrating trying to deal with a toddler without knowing their signs. Like, with my daughter, you know when she got to that age, like she may not be using words but I knew the kinds of things she usually wanted and whether or not she's, you know, pointing at the right thing or what, I could figure it out. ... With him I had no idea... and that was probably the biggest struggle, just trying to get to know this little person and understand what he needed.



Photo: Kiwi Street Studios

Reunification is also stressful as family members begin the extended process of reestablishing relationships, roles, and routines.

Reconnecting takes time and commitment. One father remarked several months after his return home, "Our bond has gotten stronger... but it hasn't been really long enough for us to really, you know, bond as strong as I'd like it to be." Years after his last deployment, another father said, "I still think [my daughter] is closer to [my partner] than what she is me... because [my partner] has always been there." Children are often fearful that their parent will leave again and have difficulty tolerating even brief separations. Parents describe intensive efforts over an extended period of time as necessary to rebuild trust and strengthen relationships, including marital relationships as well as parent-child relationships. In the words of one father, "Because I was away so much, you know, our marriage is like there's a big strain in the marriage." At the same time, many parents recently returned from deployment describe reliance on their partners to help them reengage with their family. The same father observed, "[My partner] is pretty good about calling me out for being off in wherever land... here physically [but] not mentally."

The process of reconnecting is even harder when family members are experiencing trauma or other mental health symptoms. One father with posttraumatic stress disorder (PTSD) described his response to hearing his toddler cry: "At times I just feel like going outside just so I don't have to hear it cause it just, sometimes it just gets to be too hard to bear... all that stuff plays back into my PTSD." Though the period following deployment is also difficult, extended family and community support is

generally more available during deployment, and many families face struggles without adequate support.

"Finding That Reconnect": Disruption and Repair in Everyday Life and Reconnecting After Deployment

As described, deployment typically represents a significant disruption in relationships, and the period of reunion following deployment often requires attention to repairing the disruptions that have occurred in the parent-child relationship. In the words of one father, this is a period of "finding that reconnect."

In this section we draw attention to the ways in which military family experiences give reason to hope that children and families can recover following lengthy separations. Our work with military families has indeed revealed the potential for repair following disruptions. We draw from our work with service members, veterans, their partners, and their young children in our SMF program (Rosenblum et al., 2015), and we describe how our attention to processes of disruption and repair in the context of the intervention itself help to create opportunities for recovery following deployment.

A focus on processes of disruption and interactive repair is not new for the fields of infant mental health and child development. Disruption and repair processes have been extensively studied—spanning from studies taking a "micro-analytic" approach to the dynamic unfolding of attention and affective exchanges in parent-child interactions. Some of these studies look at how infants and parents "match" or "mismatch" in their affective expression or attentional focus on a second-by-second basis. In these studies, careful observation of the "back-and-forth" interaction between parent and child highlights the ways in which, even in very early infancy, parents and infants cycle between patterns of "matching" and "mismatching" states, which can be seen as a form of disruption (mismatch) and repair (match; Tronick & Beeghly, 2011). In these studies, it is noteworthy that infants and parents vary, as a function of individual difference, developmental capacity, or both, in regard to who in the dyad leads or follows in the process of returning to a matching state. Thus researchers have referred to this as a "mutual regulation" process, a dynamic unfolding of microdisruptions and microrepairs that characterize everyday parent-child interaction. Furthermore, the quality of how disruptions and repairs are negotiated is often understood to reveal something about the quality of that parent-child relationship, as it reflects the capacity of the dyad to engage in an effective mutual regulation process. For example, two common methods for assessing early relational processes, the "Still Face" (Tronick, Als, Adamson, Wise, & Brazelton, 1978) and "Strange Situation" (Ainsworth & Wittig, 1969) procedures, both impose brief disruptions and opportunities for repair. In the Still Face, parents engage in face-to-face play with their child, then are asked to disrupt this more typical pattern of interaction by holding a flat, emotionally unresponsive, still face, followed a few minutes later by a return to responsive face-to-face play. In the well-known Strange

Situation procedure to assess infant–parent attachment, the dyad engage in a series of interactive episodes that involve brief physical separations from one another and periods of reunion.

So what do researchers learn from these disruption–repair tasks? First, even very young children are most often quite attuned to the presence, absence, or unavailability of their caregiver, even when these disruptions are quite brief. Second, frequently these disruptions are experienced as undesirable or even stressful for the young infant, who under typical circumstances will experience physiological and/or behavioral responses that reflect this discomfort and will seek reconnection. And third, interactive repairs are possible. On reunion the dyad can engage in a mutual regulation process that reduces the distress. This is not an instantaneous process. For example, Still Face research has clearly demonstrated that during the episode following the still face (the “repair” episode) infants often display very mixed emotions—positive and negative—as they work to return to a positive affective state. Patience and persistence on the part of caregivers supports children’s efforts to recover from the distress of the disruption. Often, though not always, if the infant or young child becomes significantly distressed and his coping is overwhelmed, these reunions must be initiated, or “led,” by the parents.

Separation during deployment is obviously a more significant challenge as it spans not minutes but months, and yet nonetheless can be understood as a more “macro” version of these processes of disruption and repair. Repair processes during reunion often require a caregiver who is willing and able to help engage the child, patiently, in a process of re-establishing relationship. Given the young child’s more limited capacity for cognitive understanding, this repair process is typically not accomplished through verbal explanations, but rather, through day-to-day experiences of a caregiver meeting his or her child’s needs and finding opportunities on a smaller scale to engage in interactive repair. Through this process, children experience mutual regulation and develop trust and reconnection in their relationship with their parent(s).

In the SMF intervention, we recognize the power of daily “small interactive repairs,” to help heal the larger disruptions that occurred in deployment, and we build intentional opportunities for re-experiencing smaller disruptions and repairs into the process of the group. The SMF, described in detail in a prior issue of the *ZERO TO THREE Journal* (Rosenblum et al., 2015), is a 13-session manualized multifamily group for service members, veterans, their partners, and young children. The intervention includes an attachment-based parenting curriculum with attention to children’s responses to separation and reunion, supporting parents in strategies for self-care and stress reduction, building social support, and connecting to community-based resources. There are five core pillars to this intervention, corresponding to the Strengthening Families Protective Factors Framework (Harper Browne, 2014). One of these, the Parent–Child Interaction pillar emphasizes the opportunity to support practice of new parenting strategies learned in the psychoeducation component of the intervention.



Photo: Kiwi Street Studios

Repair processes during reunion often require a caregiver who is willing and able to help engage the child, patiently, in a process of re-establishing relationship.

Given the likely significant impact of deployment for young children and their parents, we focus our practice around opportunities for negotiating separations and reunions. During the SMF weekly session, the opportunity for practicing “disruption and repair” arises when parents and children separate following the shared multifamily meal so that parents can attend a parenting group while children are cared for by the child team (thus, a period of “disruption”). After these separate groups, parents and children reunite (permitting a process of “repair”). During the parenting group, the process of disruption and repair is addressed explicitly. Group leaders share developmental research regarding young children’s typical emotional experiences around separation from their caregivers. Parents are encouraged to wonder about their young child’s experience of not only deployment, but also of this more recent, smaller separation for the group, to understand how children’s behavioral responses to separation might convey something about how they are feeling and what they need from their caregivers. The SMF curriculum is not prescriptive regarding “what to do,” but rather, encourages and supports parents in learning how to link children’s behaviors to their likely feelings and to meet children’s



When parents understand their children's experiences of separation and work to meet their children's needs, children feel a growing sense of trust and connection, and parents feel an increasing sense of competence.

needs both in the process of separating, but also importantly, during the process of reuniting. Group leaders facilitate discussion about possible strategies for meeting children's needs and "leading the dance" as parents try to facilitate an interactive repair on reunion. In addition, staff actively support parents and children during the reunion to support this process, and, in the following week's session, encourage parents to reflect back on how it went and to determine what they would like to repeat in the new session as well as what they might want to try to do differently.

Learn More

Serving Military Families: Theories, Research, and Application
K. R. Blaisure, T. Saathoff-Wells, A. Pereira, S. M. Wadsworth, & A. L. Dombro (2015)
New York, NY: Routledge.

Military and Veteran Families Resources From the National Child Traumatic Stress Network
<https://www.nctsn.org/what-is-child-trauma/populations-at-risk/military-and-veteran-families>

Military and Veteran Families Support From ZERO TO THREE
<https://www.zerotothree.org/parenting/military-and-veteran-families-support>

Strong Military Families
<http://m-span.org/our-programs/strong-military-families/>

Not infrequently, parents indicate that a key reason for participating in the SMF program was to find ways to help their young children and support reconnection following deployment (Dodge et al., 2017). Often service members and veterans will share that they received "briefings" on the return trip home, during which they were encouraged to understand that the process of reconnection may take time, though notably non-deployed partners share that they do not always get this same information. Some parents may minimize the impact of deployment and may be confused about why children are acting out, or not connecting, in ways that were not anticipated. Others may be worried about whether healing and full reconnection will occur, about the possibility of lasting damage from the separation, or that there is something they should do, or say, to help facilitate children's comfort and trust.

In our experience with the SFM groups, parents and children often find comfort and relief when they learn about children's normal experiences of disruption. It is particularly helpful to understand that healing after large disruptions, including deployment, often comes with the repeated opportunities parents have to offer support around disruptions and repairs in every-day life (mutual regulation). When parents understand their children's experiences of separation and work to meet their children's needs, children feel a growing sense of trust and connection, and parents feel an increasing sense of competence.

Indeed, our evaluation revealed significant improvement in parents' sense of confidence regarding their ability to help their young children manage feelings about deployment. This finding, coupled with substantial evidence that participation in the group leads to significant improvements in parental reflective capacity—that is, their ability to consider their own and their child's perspective and emotional experiences—clearly indicates that despite the challenges of deployment, healing and reconnection are possible (Dodge et al., 2017; Julian, Muzik, Kees, Valenstein, & Rosenblum, in press).

Conclusion

Separating and reconnecting are complex processes, and young children and their parents experience significant stress before, during, and after deployment. Support for families across the deployment cycle, including during the extended process of reintegration, is essential. Reconnecting with a young child involves learning about her growth and development during the period of separation, learning about age-typical reactions to grief and loss, and adapting parenting to meet the children where they are. Parent-child relationships can recover following disruptions, and support for reconnection following deployment can help to mitigate the impact of deployment-related stress on families.

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Safe Harbor

Use of the Reflective Supervisory Relationship to Navigate Trauma, Separation, Loss, and Inequity on Behalf of Babies and Their Families

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Abstract

Infant and early childhood mental health (IECMH) practitioners working with infants and young children and their caregivers who are impacted by the trauma of separation, loss, and unpredictable reunification require access to reflective supervision/consultation (RS/C) to mitigate vicarious trauma and compassion fatigue, and to ensure thoughtful best practice and a commitment to cultural humility. Through the lens of the Reflective Interaction Observation Scale (RIOS™), the authors provide a case study of a reflective supervisory relationship to highlight the significance of authentic support when working with traumatized young children separated from their parents, and in addressing the effects of racism and historical trauma.

In the presence of infants, young children, and families, it is normal for infant and early childhood mental health (IECMH) practitioners to have strong emotional reactions to the pain, vulnerability, and risk at hand. Some of these reactions may be positive. Others may be intense and negative. When working with infants, young children, and families who have experienced or been impacted by the traumas of separation, loss, and unpredictable reunification, it is likely that the feelings evoked in the practitioner will be even more heightened. Witnessing very vulnerable infants, young children, and families living unfathomable experiences is a great burden. Practitioners may encounter a range of emotions and responses including uncertainty, sadness, ambivalence, anger, hopelessness, and hostility,

among others. In turn, practitioners are perpetually at risk of compassion fatigue, vicarious trauma, and burnout, which increases the risk of poor staff retention and compromised practices (Gilkerson & Kopel, 2005). Direct service practitioners often cite a lack of supervisory support as a primary contributing factor in changing jobs (Barak, Nissly, & Levin, 2001).

IECMH practitioners are encouraged to remain attentive to their emotional responses and to use those feelings and responses as clues that can help them better understand the emotions and needs of their clients. As much as practitioners try to remain attentive, any effort to do so in isolation is often not enough; processing experiences and feelings in a relationship with a reflective supervisor/consultant is more effective. In the presence of a reflective supervisor/consultant, practitioners can wonder together, "Where might these feelings be coming from? How can they help me to understand the baby's experience?" Having a place and a person with whom to share those burdens can provide relief and foster a feeling of being

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less alone in the work. Imagine this space as a safe harbor, to shelter from the storm of emotions that arise when faced with vulnerable children and families who are impacted by trauma, separation, loss, and inequity. While anchored in this harbor, a course is charted and skies clear, allowing the practitioner to move forward.

Like most supervisory models, reflective supervision/consultation (RS/C) aims to support best practice for clients, while simultaneously supporting the professional development of the practitioner. Often described as a relationship for learning (Fenichel, 1992; Shahmoon-Shanok, 2009), RS/C develops through a compassionate, authentic relationship, in which thoughts, feelings, knowledge, and wonderings are cultivated on behalf of a deeper understanding of the infant, young child, and family; of the practitioner; and of a relationally driven, developmentally appropriate, culturally responsive intervention approach. While the field of IECMH has promoted RS/C as an essential component, other disciplines are beginning to turn to the model as a means of best practice. Of particular note to practitioners and systems working with infants, young children, and families impacted by traumatic separation, RS/C has been considered a Trauma Informed Practice (Badeau, 2015); an approach to mitigating vicarious trauma as well as staff turnover, and a means to ensure best practice. It is critical that children and families experiencing trauma and separation receive service provision from practitioners who value and practice cultural humility in place of seeking to achieve an elusive cultural competence. *Cultural humility* is a dedication to lifelong self-evaluation, identification, and rectification of power and privilege imbalances in the practitioner–client relationship as well as the supervisor–supervisee relationship, and a cultivation of mutually beneficial partnerships with communities on behalf of individuals (Tervalon & Murray-Garcia, 1998). Cultural humility mirrors RS/C processes in supporting practitioners’ commitment to self-reflection, self-awareness, and openness to learning from others about themselves, and can positively contribute to the RS/C working alliance (Hook et al., 2016).

More than 30 years of clinical experience and empirical evidence indicate that RS/C increases the quality of IECMH services by reducing vicarious trauma, staff turnover, and bias while increasing practitioner knowledge and improving practice, job satisfaction, efficacy, and responsiveness (Gilkerson & Kopel, 2005; Harrison, 2016; Virmani & Ontai, 2010; Watson, Gatti, Cox, Harrison, & Hennes, 2014). This research has led to a general consensus in the multidisciplinary field of IECMH that RS/C is inextricably both a best practice and an essential component for those providing relationship-focused prevention, intervention, and treatment (Michigan Association for Infant Mental Health [MI-AIMH], 2017).

The multidisciplinary human service fields that work with infants, young children, and families impacted by traumatic separation must consider policies and practices that will strengthen trauma-informed, culturally responsive support,



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Reflective Supervision/Consultation develops through a compassionate, authentic relationship, in which thoughts, feelings, knowledge, and wonderings are cultivated on behalf of a deeper understanding of the infant, young child, and family.

advocacy, and intervention. Given the mounting research and clinical experience, valuing and increasing access to RS/C may be one of the most critical advances professionals can make across sectors. In this article, the authors qualitatively examine a reflective conversation between a supervisor and supervisee to understand the essential role RS/C has played in supporting one practitioner’s work as an IECMH clinician with infants, young children, and families who have experienced separation trauma. The clinical themes, process, and relational core captured in this case study highlight the immense value of the practitioner’s access to supervision that is consistent, regular, and reflective (Parlakian, 2001).

The Reflective Interactive Observation Scale (RIOS™)

The Reflective Interactive Observation Scale (RIOS; see Figure 1) is a measurement tool developed by researchers at the University of Minnesota, along with leaders in the Alliance for the Advancement of Infant Mental Health, to define and operationalize the process and content of RS/C. The RIOS provides a framework to clarify the experience of a reflective supervision relationship, or “the space between the two” participants (Watson, Harrison, Hennes, & Harris, 2016). Each RS/C session contains varying degrees or combinations of the 4 Essential Elements and the 5 Collaborative Process Tasks that together manifest as the Reflective Alliance, the working relationship at the heart of RS/C. The case study that follows illustrates the four RIOS Essential Elements—Understanding the Family Story, Holding the Baby in Mind, The Professional

Use of Self, and Parallel Process. For information on using the Collaborative Tasks, see Box 1.

Working in the Realm of Separation: A Reflective Supervision Relationship

This case study provides a unique look at a reflective supervision relationship through a dialogue about trauma, separation, loss, and inequity, within a reflective supervision relationship. Megan is an IECMH clinician working with families who have experienced trauma, including separation and loss, and Sarah is her reflective supervisor of 2 years. What follows is a sample of a reflective conversation that explored their internal experiences as they navigated complex feelings and clinical themes.

Reflective Alliance

According to Watson, et al.,

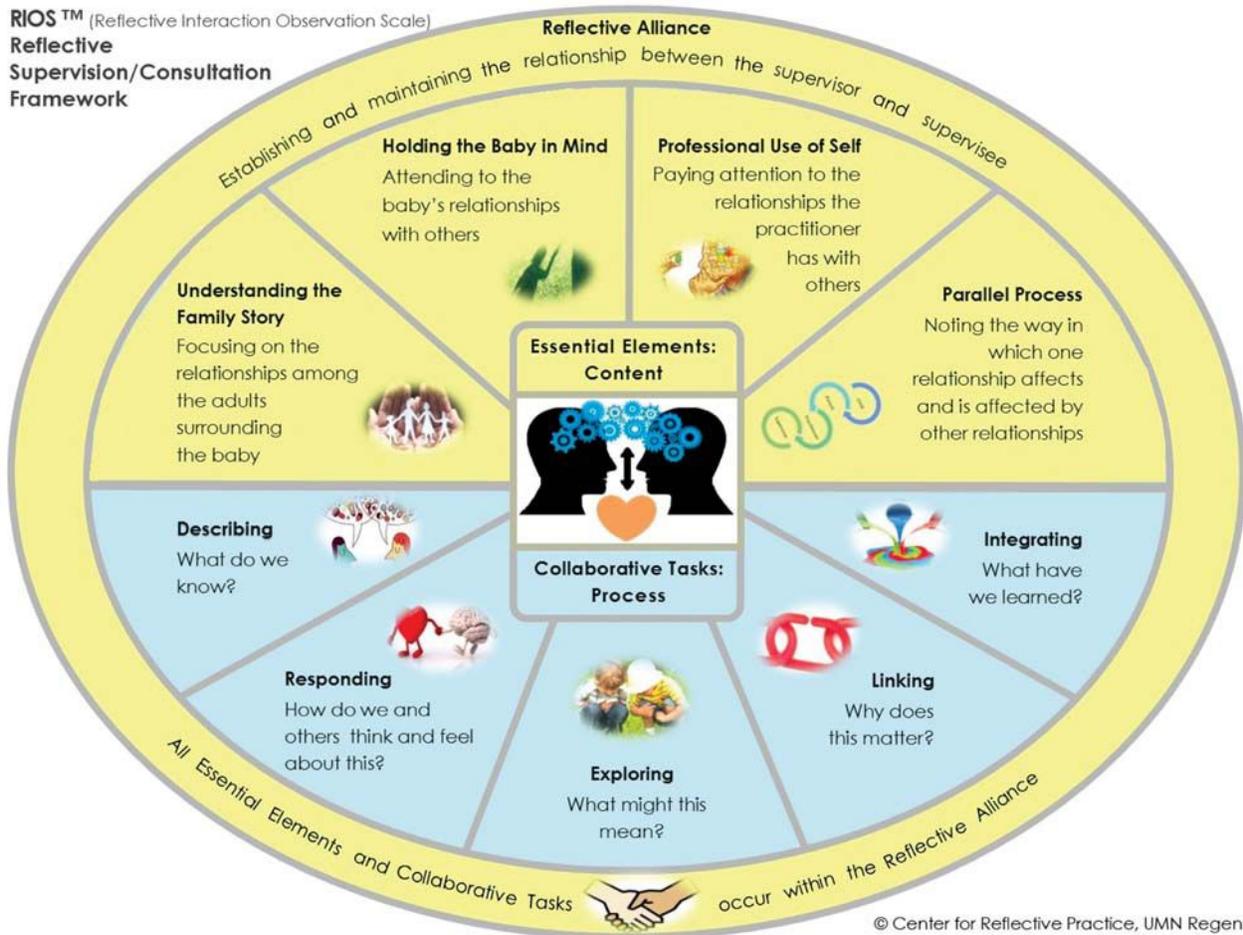
An effective and supportive professional relationship is at the heart of reflective supervision. As a relationship-based approach to professional development, how the supervision happens and the quality of the relationship

developing between supervisee and supervisor are of utmost importance. With some individuals, this relationship will require time to develop, but a successful alliance can also develop quickly between two individuals with no previous relationship. As conceptualized in the RIOS™, the Reflective Alliance is the “vessel” which holds the work of the supervisor and supervisee (2016, p. 17).

Shahmoon-Shanok (2009) described the reflective alliance as “a collaborative relationship for professional growth that improves program quality and practice by cherishing strengths and partnering around vulnerabilities to generate growth” (p. 8).

The reflective conversation summarized in the following sections focuses on themes of trauma, separation, loss, and inequity from an IECMH lens. Additional sub-themes included vicarious trauma, social justice, “ghosts from the nursery,” reunification, doing vs. being, and a sense of agency. The conversation is not a RS/C supervision session, but it illustrates how a supervisor and supervisee might explore these themes. The reflective alliance between Megan and Sarah has developed over the 2 years of their supervisory relationship. Their professional alliance includes hundreds of hours of individual

Figure 1. RIOS™



and group RS/C, a relational history of vulnerability, rupture and repair, compassion, a shared history of how these themes manifest in clinical work, and a commitment to explore these themes together with curiosity.

Understanding the Family Story

Megan began the conversation by discussing how, in her past experiences of work with separated infants and parents, her feelings toward the child's parents could be strongly influenced by whether the work began before or after the separation. In situations in which there is a lengthy opportunity to build a relationship with a biological parent before her separation from the child, there is a risk of colluding with the parent's viewpoint. Learning about the parent's own ghosts from the nursery and her wounds from her own early childhood has the potential to dangerously obscure an accurate view of the present day infant–parent relationship. In contrast, when Megan began working with a family after separation, she often struggled with disproportionate alignment with the infant outside of the context of his biological family relationships. The prominent

emotional pull for Megan in this case is a strong sense of empathy for the loss experienced by the child. In either situation, an unbalanced perspective can cause assumptions and judgments regarding the parent–child relational health and the parent's capacity to care for the infant.

In addition, the majority of Megan's cases involve a power inequity based on race. As a Caucasian woman, Megan felt unsettled about how her clinical knowledge and theory evolved in the midst of bias and cultural oppression, specifically in collaborating with the child welfare system regarding clients of color.

Megan: I sit with a lot of pain around how race is impacting my clinical decisions for families of color. I am a white therapist, and all of my knowledge and training is derived from white teachers and supervisors.

Sarah, also a Caucasian woman, concurred, and observed that Megan's thought-provoking stance can be challenging to witness. It can evoke an unsettled feeling in Sarah in return, eliciting a worry that Megan's position could obstruct good clinical decision making.

Box 1. Applying the (RIOS™) Collaborative Tasks While Working With Infant–Parent Separation in Reflective Supervision/Consultation

Describing, "What do we know?"

Literature tells us a great deal about the impact of attachment, separation, and trauma on infants, young children, and families. A clinician will learn a great deal about a family and infant with a thorough assessment. A reflective supervisor should help ask questions that paint the picture of what is known, and what is not yet known, while staying grounded in literature-informed best practices. The process of describing can be a grounding feature of the reflective supervision space, as it is easy to get emotionally swept up in the overwhelming feelings associated with working with trauma, separation, loss, and inequality as an IECMH practitioner. Touching into the reality of what the practitioner has seen and heard from their families and collateral contacts provides orientation and clarity.

Responding, "How do we and others think and feel about this?"

A reflective supervisor must cultivate an environment that can explore thoughts and feelings that are evoked because of the family's story, the practitioner's experiences, and the RS/C relationship including power and privilege dynamics. A reflective supervisor can support this process through invitation and acceptance of thoughts and feelings in the moment, as well as holding longer-term patterns of the practitioner's thoughts, feelings, and experiences in mind. It is essential for the supervisee to give voice to the thoughts and feelings of the infant including the infant self of the parent and the infant self of the practitioner. The "big feelings" connected to being with and witnessing trauma, loss, separation, and structural racism may be felt but are difficult to name. The reflective supervision relationship is a space to bear witness to and contain that process of understanding thoughts and feelings.

Exploring, "What might this mean?"

After describing and responding to the data collected from infants, young children, and families in supervision, practitioners can begin exploring and

hypothesizing about the meaning behind the data. As the thoughts and feelings of those "in the room" are brought forward, exploring meaning assists in deepening connection to the practitioner's self, the therapeutic relationship with the infant and caregivers, and the supervisory relationship. Using RS/C to explore and reflect on clinical decisions the practitioner has made thus far may provide grist for professional development.

Linking, "Why does this matter?"

With provocative case material and a myriad of intervention routes, RS/C should help clarify what's salient and why, in order to move forward with services. The practitioner and the reflective supervisor can rely on the large body of supporting evidence to navigate difficult themes and link it back to the experience of the family and issues at hand. Practitioners working with infants, young children, and their families impacted by separation and trauma will always be at risk for experiencing vicarious trauma, including compassion fatigue. Using RS/C to regularly link case information to the significance of its implications may help ensure best practice for clients and reduce potential negative impacts on practitioners.

Integrating, "What have we learned?"

Summarizing discoveries serves the practitioner in tracking progress in long-term cases, or collecting information in the first few weeks of an IECMH-informed assessment. The RS/C process of integration supports the practitioner as a family shifts and evolves, taking time together to plan how to pivot to provide necessary intervention or consider closing procedures, as well as regrouping after a crisis or schism to move forward. In addition, when a practitioner is tasked with making recommendations for an infant, young child, and family post-separation, RS/C can help ensure this is done as accurately as possible by supporting the scaffolding of collected data, the use of literature and theory, and the creation of a synthesized clinical opinion that holds the baby in mind.

Sarah: *I often wholeheartedly agree with your struggle toward cultural humility in these instances. At times, I experience being your counterweight: needing us to rise to the occasion regarding what the baby needs now—not necessarily how they got there. Even if the reason for the trauma, maltreatment, or adversity experiences are, in large part, power, privilege, and systemic racism.*

Because this conversation went beyond the bounds of a traditional RS/C session, the supervisor also shared her individual experiences. Sarah relayed an example from her past clinical work that included themes of culture, diversity, separation, and systemic racism. After having worked with this family system for almost a year, the court asked her to provide the risks and benefits of two different permanency paths for a 16-month old boy of Latino descent. The first was to stay with the foster-adoptive, Caucasian family he was placed with at birth. The second was to live with a biological relative who was unfamiliar to him.

Sarah: *In the context of permanency and attachment-based, developmental needs, what was best for that toddler was to become adopted by his foster parents—the only caregivers he had ever known—rather than with an unfamiliar relative, even though the foster family was a different culture than his biological family, and even though his relative could have provided him with a safe, nurturing home. Having influence on that permanency decision impacted me heavily, and while I knew it was best for the baby, I spent many hours in reflective supervision discussing how unsettled I felt.*

When working with infants and parents affected by separation, IECMH professionals need to take care and make sure that they are using RS/C to understand the full family story: the story from before the parent–infant separation, and foundational multigenerational experiences and influences. While it is critical that clinicians attend to the trauma of separation, it is equally essential to view this experience in the context of the longer family story. Supervisors are tasked with supporting clinicians' ability to consider the family's historical context, as well as attend to the current traumatic event. This includes weighing parents' current ability to protect their child. There can be a tendency to heroicize parents when they have been wronged so deeply. RS/C can offer a safe space in which to paint a full picture that takes injustice into consideration, as well as the parent's capacity to protect and nurture in the wake of the trauma.

Holding the Baby in Mind

"In the process of working with a family, attention cycles back to the baby and the baby's experience and well-being, as well as the impact of the presence of this baby on the others in the story" (Watson et al., 2016, p. 16). In IECMH reflective supervision, "holding the baby in mind" is a foundational concept, as the supervisor and supervisee wonder together about what it might feel like to be this baby in this family.

Megan shifted the conversation to a current case with a toddler and an infant that involved multiple removals and returns

between a biological and foster family. When the children were recently removed from their mother's care for the third time, Megan felt lost in how to proceed with her relationships with this family that never fully developed, particularly with the young children. In past supervision sessions, Megan relied on Sarah's reflective positive regard to make sense of who she is to the children, to the multiple caregivers, and what is needed in this case. They reflected on some of the themes.

Megan: *I used to believe that the only way I could help a child separated from their caregivers was if I had a relationship prior to their separation. I came to realize that starting a clinical relationship with young children post-separation can be just as useful. While I may have to work harder and more creatively to understand the family's story, I can still provide compassionate clinical support and advocacy at a time of significant vulnerability.*

Sarah: *I agree. A pre-existing relationship is not necessarily inherent to the infant mental health clinician's role of supporting children who have been separated from their familiar caregivers. You are still able to hold the baby in mind.*

Megan identified the difficulty of processing themes of infant separation with other therapists on her multidisciplinary team who are not working from an IECMH perspective. After she had shared with her team the current status of the case mentioned above, the feedback Megan received from her team became focused narrowly on the biological mother, who was struggling with a severe addiction, her lack of follow through, and minimal authentic rapport with the clinician. The well-meaning team offered suggestions and reflections that did not hold either the infant or toddler in mind. Megan left the conversation with her colleagues feeling confused and ungrounded. Later, in individual reflective supervision, Megan revisited the struggle, this time with purposeful attention centered on the young children and the currently ambiguous permanency plan. Ultimately, reflective supervision provided a space to hold the baby in mind and led to conceptualizing a clinical plan that included working with the children flexibly across caregiving contexts.

Sarah and Megan discussed how working with families impacted by child welfare-related separation and reunification requires reflective supervision support to "hold the baby in mind." Receiving RS/C also allows the clinician to advocate for caregivers and other systems to "hold the baby in mind" when providing care or making decisions. Themes of power, privilege, and racism rise again for Sarah and Megan, as well as the need to support developmentally appropriate, attachment-informed interventions.

Megan: *Practicing infant mental health with separated infants and parents seems to mean living in the gray area where both what a baby needs, and the impact of structural racism on the baby's parents, are true and real. Sometimes I get very lost in that gray area.*

The etiology of unsafe or inadequate parenting can often be understood through the lens of racial inequality, generational

trauma, and adversity exposure. The understanding that parents may be discriminated against due to their race can leave clinicians and supervisors with feelings of deep empathy and unjustness. Simultaneously, it may be that the best chance for the infant's optimal development is not reunification, even if reunification is what would be healthiest for the parents. This raises a disturbing conflict for supervisors and supervisees.

When working toward reunification with infants and parents who have been suddenly separated, clinicians have to be firm in the commitment to holding the baby in mind. Regardless of any injustice or trauma related to the separation, clinical attention must be paid to the infant's relationship with his surrogate caregiver. Depending on the length, health, and safety of this substitute relationship, and the developmental age of the infant, reunification needs to support giving the infant ample time in transitioning back to biological parents, as he says goodbye to his caregiver.

Sarah: The process of facilitating a healthy and playful separation from a caregiver can be healing and painful, and inevitably evokes discomfort in all the adults, including those of us facilitating it. A reflective supervisor is required to support a clinician in facilitating a developmentally appropriate, attachment theory-driven transition plan.

Professional Use of Self

The *professional use of self*, defined as the intentional use of subjective reactions, perceptions, thoughts, beliefs, and emotional responses to increase understanding of the work with families and promote growth and healing (Watson et al., 2016), is a cornerstone to cultivating authentic relationships between practitioners and clients, and between supervisors and supervisees. It is in large part both dependent on and essential to the strength of the Reflective Alliance. When receiving reflective support focused on the emotionally complex nature of infant–parent separation, families are entitled to a well-regulated, self-reflective practitioner, and this practitioner is entitled to the support of a reflective supervisor.

Megan and Sarah acknowledged a shared personal value around social justice and how it may conflict with their professional training in the context of family history. Megan identified her emotional shift over time, from feeling professionally overwhelmed by injustices her parent clients have faced, to a more regulated and balanced view which helps her have increased capacity to support families. When in the midst of tension like this, Megan's strategy is to frame her values around social justice so that they are not outweighing other factors influencing clinical decisions. Sarah saw a parallel with her own experience of this theme as she described that, even after years of experience, she feels the impact of her need, at times, to disconnect personal values related to social justice in order to work effectively.

Megan: In reflective supervision I can receive perspective and feel into the experience of not being able to DO something, even when my "social justice self" is screaming to.



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When working with infants in the absence of an emotionally available, permanent caregiver, strong feelings, roles, thoughts, and inclinations can become evoked in practitioners.

Sarah offered Megan an opportunity to explore their reflective supervision relationship as it pertains to themes of separation. Megan shared her struggle with a recent "separation" from her supervisor when Sarah was on vacation; Megan had neglected to bring this to supervision for a few months.

Megan: When my professional secure base (reflective supervisor) went away, even temporarily, my childhood experiences of needing a "bigger and stronger" adult to help me regulate and navigate a difficult time were evoked and familiar uncomfortable feelings arose.

Sarah invited Megan to consider what might have prevented her from (a) reaching out to Sarah during her absence, when Megan felt the need, and (b) not sharing this experience with Sarah upon her return, but instead waiting until this conversation. Sarah observed that Megan rarely comments (positively or negatively) about their reflective supervision relationship. Sarah noted that over the course of the relationship, she has observed and wondered out loud if Megan may struggle with labeling their relationship as important or valuable. Sarah asked if reaching out and/or sharing her experience of separation felt too vulnerable, as in doing so, it would demonstrate the importance of their relationship.

Megan shared how her experience of receiving reflective supervision highlights something she missed from her caregivers in her own early childhood. This is a clear example of how a clinician's own "ghosts from the nursery" can be activated in the context of the supervisory relationship (including temporary separation from one's supervisor), and can be used as a tool to wonder about, understand, and navigate a client's experience of separation or loss.

Megan: *My ghosts from the nursery, such as “it’s not safe to have feelings” and “there’s no one bigger and stronger to rely on,” are inherently met through the process of reflective supervision because it is safe to have feelings here and I feel I can rely on your strength. Maybe it’s sad to have those needs met by someone that’s not my parent.*

Megan and Sarah discussed how their relationship has shifted and changed over time as Megan has become increasingly comfortable with vulnerability and emotional reflection in reflective supervision. In their relationship, Megan has had the opportunity to experience someone being able to handle her feelings and not abandon her. Megan has integrated this in her clinical presence and skills, particularly as a professional “secure base” for her clients.

Megan: *Sometimes these themes of trauma and separation get me so stuck, and while I’m treading water and bring it to supervision, things shift somehow—even if it’s not discernable in that moment—when I look back after things have shifted I can trace an invisible line back to that time in supervision where space was held, and I was able to be witnessed in my messiness and confusion.*

Parallel Process

The term *parallel process* refers to the simultaneous relational dynamics occurring in multiple relationships which have the ability to impact how practitioners experience their relationships with others. In reflective supervision, the supervisor and supervisee collaborate to bring awareness to the manifestation of parallel processes occurring in their work with families (Watson et al., 2016).

Sarah invited Megan to consider themes surrounding “doing vs. being” in IECMH, a concept that tends to be challenging to newer clinicians. They also discussed learning content specific to separation and loss in the reflective supervisor relationship.

Sarah: *As clinicians, our goal is often to help parents be what their children need; as a supervisor my goal is to help clinicians be what parents and children need them to be. When I feel compelled to offer advice, guidance, or education to a supervisee, I need to always be weighing the risks and benefits of doing so, and be aware of possible parallels occurring in the clinician–family relationship. My tendency to provide suggestions and knowledge content increases when infant developmental risk is high, specifically regarding attachment disruption, despite knowing that it may impede a clinician’s development.*

Sarah and Megan discussed how the lack of higher education focus on IECMH affects the RS/C relationship, specifically that the clearest source of knowledge and training typically comes from one’s reflective supervisor providing IECMH education in the context of RS/C sessions.

Sarah: *Sometimes I think about what it would be like to supervise a new clinician who is coming in to the field having already been trained in infant mental health theory and*

practice. Would I feel less of an urge to teach concepts and content in the midst of a supervision session?

Megan: *What if I had a supervisor who was all about doing and teaching and not about reflecting on my experience with families? My work would probably look like bringing a developmental chart into sessions and pointing out to families where they were going wrong.*

Sarah shared her experiences of how parenthood and reflective supervision connect.

Sarah: *I am constantly struck by the parallels of parenting and supervising. I strive for similar ways of being in both: authenticity, compassion, sensitivity, the right amount of scaffolding, an eye on the developmental trajectory and reflective capacity. I also feel humbled by the tremendous honor in being witness to the growth and unfolding of supervisees, just as I am with my children. I also know that the relationships I cultivate with both create ripples in the world, for generations to come, with people I will never meet. This is both awe inspiring and, quite frankly, terrifying at times.*

When working with infants in the absence of an emotionally available, permanent caregiver, strong feelings, roles, thoughts, and inclinations can become evoked in practitioners. In the case of clinical work, the void of a parent’s regular presence can place clinicians in the role of the only consistent, caring adult, or the most emotionally attuned advocate, or the person holding the most knowledge about a particular infant’s experiences, symptoms, preferences, challenges, and needs. Infants require primary caregivers, and when a vacuum exists in this realm, IECMH clinicians can relationally and practically find themselves filling the gap. In these cases, a reflective supervisor is tasked with providing understanding, empathy, and grounding as they support clinicians navigating through these justifiably complex professional–personal relationships with separated infants.

Megan described how she once found herself over-identifying with a family’s experience, which led to significant vicarious trauma. This manifested as a felt sense of helplessness and powerlessness, and feeling “stuck” in the system.

Megan: *Stepping out of the sharp focus of a trauma narrative and being able to ground in the big picture with my supervisor is what I needed to gain perspective.*

Sarah noted the impact of working with young children separated from their parents and its particular effect on Megan. What came to mind were times when Megan expressed feeling overwhelmed, lost, stuck, hopeless, and helpless. Sarah reflected that Megan has experienced moments of feeling dysregulated, dissociative, and described flashes of uncharacteristic harshness with young children and parents impacted by separation. Megan shared that Sarah was helpful in navigating and resolving these symptoms of vicarious trauma, by providing regulation, empathy, normalization, and contextualization, as well suggesting new boundaries for Megan’s well-being.

Reflective supervision can be a forum for increasing a practitioner's reflective capacity. Engaging in an authentic, attuned relationship in the context of reflective supervision allows a practitioner and caregiver to cultivate a shared agenda while remaining flexible to all parties' needs (Weatherston & Barron, 2009). The supervisory relationship ultimately benefits infant health and healing.

Megan: *When I come to reflective supervision my bucket is filled so that I can fill the family's bucket to make sure baby's bucket is full.*

Conclusion and Recommendations

When ships are under attack or facing inclement weather, they seek safe harbor. Safe harbor provides calm waters for anchoring in and shelter for battening down the hatches. The stillness of the calm water allows for reflections that are more clear. The "space between the two" (Watson et al., 2016) in RS/C provides that safe harbor for the practitioner who is navigating the difficult themes of trauma, separation, loss, and inequity. Practitioners may feel under attack from the sensations of vicarious trauma, or lost in the storm of attachment disruptions and ghosts from the nursery. The case study presented in this article demonstrates the way in which these themes intersect with the personal and professional selves, providing insight into the work with infants, young children, and families. The outcome of RS/C is that families experience an equanimous, regulated practitioner who can bear witness to their experiences and assist them in navigating to their own relational safe harbors.

IECMH professionals share a commitment to support best practice and professional development across the full spectrum of the IECMH field. By attending to the needs of the IECMH practitioners, the providers of their RS/C, and their relationship, the IECMH field can more effectively respond to infants, young children, and families who have experienced traumatic separation, loss, and unpredictable reunification. IECMH professionals miss opportunities to meet the ongoing workforce development needs of IECMH practitioners when they shine the light only on the clients.

All IECMH practitioners working with infants, young children, and families who have experienced traumatic separation, loss, and unpredictable reunification need access to knowledge, training, and skills in RS/C specific to their work. The *MI-AIMH Competency Guidelines for Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant & Early Childhood Mental Health*[®] (2017) defines the knowledge and skill standards that can be used as a map to assist practitioners in determining what they need to know to demonstrate competence in the domain of reflection. This knowledge and skills include contemplation, self-awareness, curiosity, professional/personal development, emotional response, and parallel process (MI-AIMH, 2017). They can provide the foundation for any training or professional development experience related to RS/C. In addition, the *Competency Guidelines*, now licensed for use in 29 states and 2 countries, include requirements for individuals to receive RS/C, from a qualified provider, in order to

earn the Infant Mental Health or Early Childhood Mental Health Endorsement[®] credential.

Building capacity for the development of qualified providers of RS/C for the IECMH workforce is immensely important. Growing practitioner's capacities in contemplation, self-awareness, curiosity, professional/personal development, emotional response, and parallel process through RS/C is critical as they are asked to support families who have experienced complex trauma. The "safe harbor" is crucial in allowing practitioners to feel heard, validated, and affirmed in the work, and to address the strong feelings evoked when faced with the pain of family separation in the context of systemic racism and social injustice.

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The Center for Reflective Practice at the Center of Early Education & Development at the University of Minnesota
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for Infant Mental Health (NYS-AIMH). She is honored to work and learn from national infant and early childhood mental health leaders to advance the field, ensure fidelity, and increase capacity. Above all other training, education, experience, and licensure, Sarah has been most deeply enriched, challenged, and inspired through her roles as mother and daughter.

Megan M. Smith, LCAT, MT-BC, IMH-E®, Infant Family Specialist, is an infant/early childhood therapist in the Family Trauma Intervention Program at The Society for Protection and Care of Children in Rochester, NY. Megan is also co-founder and executive director of the 501(c)3 Alice's Encore: Community Music & Mindfulness, Inc. Megan received a bachelor's degree in music therapy from Nazareth College and a master's degree in creative arts therapy from Drexel University. As a music therapist, she has experience working with people across the lifespan in educational, medical, behavioral health, and private settings. In her current role, she is most inspired and challenged by working on behalf of young children in families with histories of multigenerational, complex trauma, in a community-based setting. Her clinical and academic research has included *Group Music Therapy for Empathy and Self-Esteem Development in Children* (2014), and *Development of a Model for Music Therapy in the Pediatric Emergency Department* (2013). She presents on and provides experiential co-training in the topics of infant and

early childhood mental health, structural racism, music therapy and mindfulness, and trauma at the local and national levels. Megan currently sits on the Training and Education Committee of the NYS Association for Infant Mental Health.

Ashley McCormick, LMSW, IMH-E®, Infant Mental Health Specialist, is newly serving in the role as endorsement and communications director for the Alliance for the Advancement of Infant Mental Health. Ashley is dedicated to promoting workforce development standards for all professionals who work with infants, young children, and families through the promotion and use of the workforce development tools, the *Competency Guidelines®* and Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant and Early Childhood Mental Health®. Ashley has been doing this work for the last 5 years. Ashley is endorsed by the Michigan Association for Infant Mental Health as an infant mental health specialist and also currently provides in-service training and reflective supervision/consultation to professionals in the infant- and young child-family field. Ashley's previous professional experience includes 5 years working as an infant mental health home visitor in Detroit-Wayne County. Ashley's training includes a bachelor's degree in psychology and child development from Central Michigan University and a master's of social work from the University of Michigan.

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The Traumatic Effects of Child–Parent Separation and the Importance of the Relationship

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Abstract

Adults need to recognize and understand the importance of the parent–child relationship in supporting infants and young children who are exposed to traumatic events. All children need the support, security, and safety that come with a consistent, emotionally available relationship. For young children who have a more limited understanding and ability to cope with trauma than older children do, their sense of security in relationships is even more important. For optimal development, a young child depends on trusting, nurturing relationships with parents or caregivers who are available to understand their behavior and protect them by providing physical and emotional safety (Bowlby, 1988).

Understanding Adverse Childhood Experiences (ACEs)

One of the largest investigations of childhood trauma including abuse and neglect and the effects on later health and mental health was the CDC-Kaiser Permanente Adverse Childhood Experiences (ACES) study (Centers for Disease Control and Prevention, n.d.; Felitti et al., 1998). The findings showed that experiences in early childhood played key roles in later childhood and adult health, social and psychological well-being, and functioning. The data showed clearly that as the number of ACES increases, so do the risk factors for negative outcomes including diseases and mental health symptoms and diagnoses throughout the life course. For example, in a study of more than 1,500 urban children, Jimenez, Roy, Schwartz-Soicher, Lin, and Reichman (2017) found that ACES occurring before 5 years old as well as between 5 and 9 years old were associated with attention deficit hyperactivity disorder (ADHD) at 9 years old. When the investigators controlled for early childhood ACES

and ADHD at 5 years old, the association in middle childhood was still significant. The association between early trauma and a diagnosis of ADHD is common; however, many individuals, including clinicians, do not necessarily pay attention to or obtain knowledge about the child's early traumatic experiences when making the diagnosis. Yet, individuals diagnosed with ADHD are more likely to have poor health outcomes, increased behavioral health problems, difficulty with peer relationships, poor educational outcomes, and increased psychiatric problems when compared with individuals without ADHD (Barbarese et al., 2013).

ACES include stressful or traumatic events in childhood encompassing physical, emotional, and sexual abuse; physical and emotional neglect; and household dysfunction such as mental illness, separation and divorce, domestic violence, incarceration of a household member, and substance abuse. The original ACES study was later extended to include stressful traumatic events for children living in a racially and socioeconomically diverse urban population such as racial discrimination and exposure to community violence (The Philadelphia Urban ACE study, 2013). With these items added, the prevalence of standard ACEs were higher than in the original study.

All of children's early experiences influence brain development and also have an effect on their social, emotional, and physical

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All children need the support, security, and safety that come with a consistent, emotionally available relationship.

health. Predictably, positive experiences promote favorable infant and early childhood mental health development and negative environmental experiences adversely impact brain development (National Scientific Council on the Developing Child, 2007). Research in infant mental health and early development, as well as clinical literature, has elucidated the different behaviors and emotions that result from positive or negative environmental influences. When young children feel safe, they can leave their parents' arms temporarily to explore the world. However, being curious about the world and being able to explore is only possible when children have stable, nurturing relationships with their primary caregivers. In contrast, exposure to negative experiences is likely to activate their "fight or flight" responses which interfere with their willingness and trust in safe exploration as they have learned that their world may be a dangerous and frightening place. Much is known based on research and clinical work to influence policy related to the long-term impact of early experiences on a young child's development (Shonkoff et al., 2012).

The Trauma of Separations

When young children experience trauma, such as being separated from their primary caregivers, their developing ability to have trust in relationships is threatened. Further, if they are the target of or witness to violence—such as a traumatic separation—by those they depend upon for protection, the consequences will not only be negative for the young child leading to dysregulation of their emotions and behaviors, but also, they may blame themselves for the bad things that have happened to them—as if they have caused them to happen by their behaviors or bad thoughts. One interesting finding came from early studies during World War II, when children were separated from their parents and sent to rural areas in an effort to protect them from the bombing in London. Research showed that the separation from their parents was more emotionally

wrenching than the risk of being exposed to bombing attacks in London. In a 12-month study of the effects of separating the children from their parents, Anna Freud and Dorothy Burlingham (1943) found that the separation from parents was much more difficult and traumatizing for the children than being exposed to bombing, much of which was relatively unlikely to happen in London. Unlike the current immigration separations that have been occurring in the US, even with planning and good intentions, these investigators found that being separated from their parents, especially abrupt separations with no explanation, was a much more difficult situation than being exposed to war activity with the presence and protection of their parents. Freud and Burlingham (1943) concluded that separations that disrupt family life uproot the first and primary emotional attachments. A striking conclusion to this study done many years ago was that supposed improvements in the young children's lives to protect them actually did more harm than good because of the separation from the protection of their families.

In the current immigration context, separating children from caregivers and then, after the traumatizing separation, exposing young children to unfamiliar situations with strangers, interferes with their ability to cope emotionally. While this experience happens with some frequency in the child welfare system in order to keep children safe, an innovative new program being implemented in many juvenile courts in the United States, the ZERO TO THREE Safe Babies Court Teams Program, works to make necessary separations less traumatizing for both the young child and the parent and for safe and secure reunions to occur whenever possible (ZERO TO THREE, 2018). Repeated exposure to trauma and chronic stress for young children may influence them to anticipate that they will have repeated negative experiences and a poorer sense of self-esteem. For young immigrant children, who may already have been exposed to violence and trauma in their native countries due to the political situation, during the journey to the United States, or in their homes if there has been domestic violence, being abruptly separated from their primary caregivers is not only very confusing but also traumatizing and disorienting. As noted, the next traumatic experience for these children is being placed in an unfamiliar setting with strangers with uncertainty about reunion. As noted, the effects of chronic stress and trauma on young children will not only impact on their behavior and emotion regulation, but also their brain development and, as mentioned previously, will activate their fight or flight response. Children will experience this new, strange environment as dangerous and frightening. Further, given their age and limited cognitive understanding, young children may also feel that they have contributed to the negative things that are happening and blame themselves for their parent or caregiver not being with them. In the 1950s, Joyce and James Robertson found that young children separated from their parents for even a brief period of time experienced a range of emotions from sadness to anger and aggression (Robertson & Robertson, 1971). They noted the negative effects of even brief separations and emphasized the importance of a consistent, sensitive, caregiving environment to mitigate these negative effects.

Developmental research as well as brain research emphasizes the importance for both short- and long-term recovery of reuniting the young child with their parent or caregiver as soon as possible. The evidence is clear that a consistent, caring, nurturing relationship is crucial for healing and supporting the child's positive developmental trajectory.

What then happens when the young child is finally reunited with the parents? Unfortunately, like their children, the parents may also have been traumatized by earlier exposure to violence and trauma related to the political situation, domestic violence, or other factors, as well as the trauma of being separated from their children. All of these experiences may contribute to both symptoms of depression and posttraumatic stress which may make it more difficult for them to be emotionally available to their children and supportive to them. Both the young child and the parent share this common trauma of the separation, which may also influence the parent either to become more protective or to show hesitation in being close. Common reactions in infants and toddlers exposed to such traumas include regression to earlier behaviors with more crying, clinging, and fears of separation, aggression, and sleep or feeding problems. Preschool children exposed to trauma may lack self-confidence and be aggressive, anxious, and fearful. They may act out in social situations, have difficulty separating, imitate the behavior they have experienced or witnessed, complain of somatic anxiety symptoms such as stomachaches or headaches, and show increased fear around adults. Exposure to trauma can also interfere with development, particularly social and emotional development. For all of these reasons, it is important first to not separate young children from parents or caregivers if at all possible. If separations must occur, an abrupt separation with no preparation will be traumatizing for children of all ages, but particularly young children, and efforts should be made to create more consistency and predictability.

The Trauma of Hurricane Katrina: Developmental Impact on Young Children

When disasters impact children, families, and communities, few consider the traumatic experiences that young children experience, including the effects of separation and losses. The assumption is that parents and other adults will protect them, keep them safe, and shield them from the negative events. However, with large-scale disasters, it is not possible to shield them from losing their homes, toys, pets, neighborhoods, preschools, and the meaningful adults whom they see every day and have come to know and trust. They may have to evacuate to temporary shelters, or crowded facilities. Because of the chaotic circumstances, caregivers may have lost jobs and income, with limited resources contributing to stress and arguments as well as unpredictability related to housing and schools. For all of these reasons, the short- and longer-term needs of young children frequently receive limited attention during response and recovery.



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Children's early experiences influence brain development and also have an effect on their social, emotional, and physical health.

During the recovery following Hurricane Katrina, the Harris Center for Infant Mental Health and the Louisiana Rural Trauma Services Center, (a center in the National Child Traumatic Stress Network), at Louisiana State University Health Sciences Center provided training on the effects of trauma on young children, consultations, and services at New Orleans area Head Start Centers, preschools, and early childhood classrooms throughout the highly impacted region. An interesting and important fact that became clear in providing support and services to the young children, most of whom were at or below the poverty line, was that those who were born closer to the time that Hurricane Katrina hit were at higher risk for developmental problems than those born 2 years post-Katrina. As was reported in an earlier article, of 1,060 Early Head Start and Head Start students screened when they were between 6 weeks and 5 years old, 18% met criteria for developmental concerns (J. D. Osofsky et al., 2016).

Longitudinal data was collected in collaboration with schools and preschools for more than 6,000 children under 8 years old. In that group, 89% experienced storm-related neighborhood destruction, 87% were displaced from their homes and neighborhoods, 67% lost their personal belongings, 16% had family members injured, and 12% had family members killed (H. J. Osofsky et al., 2009). Many of the survivors reported mental health symptoms including posttraumatic stress, anxiety, and depression (Centers for Disease Control and Prevention, 2006; Galea, Tracy, Norris, & Coffey, 2008; Harville et al., 2009; Harville et al., 2011; Kessler et al., 2008; Kronenberg et al., 2010). For young children who experienced losses and displacement, it was difficult at times for their parents to be able to provide them with a safe and secure environment. And, given the parents' own traumatization, it was difficult for them to be emotionally



When young children feel safe, they can leave their parents' arms temporarily to explore the world.

available to their children. In these situations, mental health needs also increased.

The Relevance of Disaster-Related Trauma for Young Children Experiencing Separation and Loss

Disasters and subsequent recovery stress, like separations during immigration and other traumas for young children, can lead to increased risk for developmental, social-emotional, and behavioral problems. Although direct and indirect exposure to the trauma of disasters is negative for many children and families (DeVoe, Klein, Bannon, & Miranda-Julian, 2011; J. D. Osofsky, 2011), it is essential to recognize that, with protection and support, most children will be resilient (Masten, Narayan, Silverman, & Osofsky, 2015; Masten & Osofsky, 2010). Unfortunately, with disasters that cause so much family disruption, it is often difficult to provide children with the safety and nurturant support that they need. For example, after Hurricane Katrina in 2005 and the 2010 Gulf Oil Spill, the traumatic experience reported most often by the parents of young children was separation caused by the destruction of homes, neighborhoods, schools, and communities (J. D. Osofsky, Kronenberg, Bocknek, & Hansel, 2015; J. D. Osofsky, H. J. Osofsky, Weems, King, & Hansel, 2015). It was noteworthy that the trauma of separation as compared to other traumatic experiences resulted in the greatest percentage of children meeting cut-off based on reported symptoms for mental health referral, consultation, and services. Further, our data indicated that the trauma of separation contributed even more than other ACEs to the persistence of behavioral health symptoms and difficulties.

Conclusion

Research and clinical evidence clearly demonstrate the negative effects of abrupt separations and losses for the short- and long-term development and behavioral health of young children. Further, supportive and therapeutic services in infant

and early childhood mental health have been shown to be effective in helping children and families following traumatic events resulting in mental health symptoms and developmental concerns (J. D. Osofsky, 2011; J. D. Osofsky, Stepka, & King, 2017). There is good evidence for recognizing and supporting the resilience of individuals and families following traumatic experiences such as disasters. However, research also indicates the need for increased awareness of the potential for young children who experience early traumas, such as the separation and losses that occur with disasters and immigration, to set the stage for both short-term and longer-term developmental problems related to early traumatic experiences. Given that situation, trauma-informed supportive interventions and treatments should be implemented to prevent more serious mental health and developmental issues based on these ACEs. Clinicians have an obligation to use the knowledge gained from other situations about the effects of traumatic early experiences on young children to reunite children as soon as possible and provide this crucial parental and caregiver support as well as trauma-informed therapeutic services at this crucial time in children's development.

Joy D. Osofsky, PhD, is a clinical and developmental psychologist, Paul J. Ramsay Chair of Psychiatry and Barbara Lemann Professor of Child Welfare at Louisiana State University Health Sciences Center in New Orleans. She has published widely and authored or edited: *Treating Infants and Young Children Impacted by Trauma: Interventions That Promote Healthy Development* (American Psychological Association, 2017), *Clinical Work With Traumatized Young Children* (Guilford, 2011), *Young Children and Trauma: Intervention and Treatment* (Guilford, 2004), *Children in a Violent Society* (Guilford, 1997), and *Violence and Trauma in the Lives of Children: Two Volumes* (Praeger, August 2018). In 2017, she co-authored *Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System* (National Council of Juvenile and Family Court Judges). Dr. Osofsky is past president of the World Association for Infant Mental Health and of ZERO TO THREE. She is clinical consultant to ZERO TO THREE for the Safe Babies Court Teams Program and is on the leadership team for the Quality Improvement Center for Research-Based Infant-Toddler Court Teams. She has played a leadership role in the Gulf Region following Hurricane Katrina and the Deepwater Horizon Oil Spill and was clinical director for Child and Adolescent Initiatives for Louisiana Spirit following Hurricane Katrina. She serves as co-director of the Louisiana Mental and Behavioral Health Capacity Project, part of the Gulf Region Health Outreach Program following the Gulf Oil Spill, and co-principal investigator for the National Child Traumatic Stress Network Category II Terrorism and Disaster Coalition for Child and Family Resilience. In 2007, Dr. Osofsky received the Sarah Haley Award for Clinical Excellence for trauma work from the International Society for Traumatic Stress Studies and in 2014, she was recognized with the Reginald Lourie Award for leadership in infant mental health and outstanding contributions to the health and welfare of children and families.

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