CHAPTER 8

Wounds from the Past

Integrating Historical Trauma into a Multicultural Infant Mental Health Framework

Chandra Michiko Ghosh Ippen

The wounds from the past last
Think caste, slaves, mass graves
We hurt each other in so many ways

Too many to count
How many generations to surmount
The trail of tears

Broken bones
Broken homes
Wounded souls
Different goals

Thrive?
Survive?
Stay alive.

Who carries the blame?
Who wears the shame?
Who feels the pain?

For those of us who seek to heal
Wounds caused by a past that
Society would bury and conceal

Saying it was long ago
Forget all that your souls and bodies know

A question inside us does arise
How does healing happen in the face of lies?

—Ghosh Ippen (2016)

I was fortunate enough to write the chapter for the previous edition of this handbook on the topic of culture and diversity (Ghosh Ippen, 2009). That chapter addressed the need to incorporate a multicultural focus into all aspects of our work and to consider how context shapes culture, values, and interactions. It highlighted the need to understand how intersections among diverse aspects of identity, including but not limited to race, cultural background, socioeconomic status, gender, sexual orientation, ability, and religious affiliation, must be incorporated into a multicultural perspective. This multicultural perspective is embraced in the Irving Harris Professional Development Network diversity-informed infant mental health tenets (St. John, Thomas, Noroña, & the Irving Harris Foundation Professional Development Network Tenets Working Group, 2012), a set of aspirational principles created to encourage the infant mental health field to "intentionally and mindfully engage in standards of practice that promote and strive for a just and equitable society" (Irving Harris Foundation, 2012). Each tenet acts as a beacon, identifying values our field is striving to adopt and encouraging us to understand not only how a family's cultural background and context may shape response to services and providers but also how our own culture, biases, and stereotypes may affect who we serve and how we serve them.

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Culture includes attitudes, values, beliefs, and behaviors that are passed on from generation to generation (Matsumoto, 1997), often without explanation, an "unconscious transmission of adaptive childrearing mechanisms" (Lieberman, 1990, p. 103). In time, we forget why we do what we do, and we take for granted that this is the way things should be. Just as families have cultural beliefs and values, we, as practitioners, are influenced by implicit, unconscious values from both the culture of our families and our professional disciplines. When we work with families whose sociocultural context, culture, and experience differ from our own, our deeply held values may lead us to craft interventions that overlook their views and reality. For these reasons, it is heartening and critically important that through efforts such as the writing and dissemination of the diversity-informed infant mental health tenets, our field is attempting to explicitly outline our cultural values, to dialogue about personal values, and to become aware of how our biases and blind spots as individuals and as a field may affect our actions (Ghosh Ippen, Noroña, & Thomas, 2012; St. John et al., 2012).

Attachment, Culture, and Trauma

As we think about forces that shape a family's and a practitioner's values, biases, interactions, and culturally influenced socialization goals, it may be helpful to reflect on the interactive model *attachment, culture, and trauma (ACT),* introduced in the previous edition of this volume (Ghosh Ippen, 2009). As can be seen in Figure 8.1, common thoughts, such as "Am I safe?"; "Am I lovable?"; and "Am I capable?" are influenced by complex interactions among these forces. Core parent behaviors that may be the focus of infant mental health interventions, including discipline and emotion socialization, are also shaped by the historical interplay of ACT. Consider, for example, the universal early childhood task of learning to deal with anger and the following questions: Is it okay to express anger? How should we express anger to other children? How should we express anger to adults? What do we do when we are angry? Young children learn about emotions and emotion regulation in the context of attachment relationships. Reflect for a moment on what your family taught you about anger. Caregivers socialize children to exist within a cultural context (Bronfenbrenner, 1977). Emotional experience and emotion socialization are culturally constructed (Mesquita, Boigner, & De Leersnyder, 2016). The cultural context, however, is not static, and is constantly evolving through contact with other groups, migration, advances in technology and social change (Chen, Cen, Li, & He, 2005; García Coll, Akerman, & Cicchetti, 2000; Greenfield, 2017). As the context changes, behaviors that may have been highly adaptive for a given cultural group may no longer provide the protection they originally offered. Equally important to recognize, different cultural groups experience different contexts even when the live side by side. Thus, the same behavior may have different meanings depending on the context of each group.

Trauma, experienced by caregiver and/or child, also influences emotion socialization. For example, a caregiver who has experienced violence may respond to a toddler's angry tantrum with fear and with a pattern of either withdrawal or responding in a harsh, punitive way in an attempt to stop the anger, which may trigger a traumatic memory or be perceived as dangerous. A young child who has seen anger turn to violence within the family may have greater difficulty finding safety in the arms of caregivers when upset and may have more challenges in learning how to regulate when angry because he or she has learned that anger can lead to great harm and may seriously damage relationships.

However, it is not only trauma within families that may shape development, but also community racial trauma and hostile ecological contexts experienced by certain cultural groups. Weathering, the cumulative toll of ongoing exposure to toxic racial environments, negatively impacts health and well-being (Geronimus, Hicken, Keene, & Bound, 2006) and may shape cultural beliefs and values, and alter the ways caregivers respond to and socialize children. García Coll and colleagues (1996) identified three aspects of context that negatively affect the development of children in multicultural groups: (1) social position (race, social class, ethnicity, and gender); (2) racism, prejudice, discrimination, and oppression; and (3) segregation (residential, economic, social, and psychological). Ogbu's (1981) cultural-ecological model suggests that parents are aware of hostile contexts. They want their children to survive and thrive, so they teach them the skills necessary to navigate their environment. In a situation in which bul-

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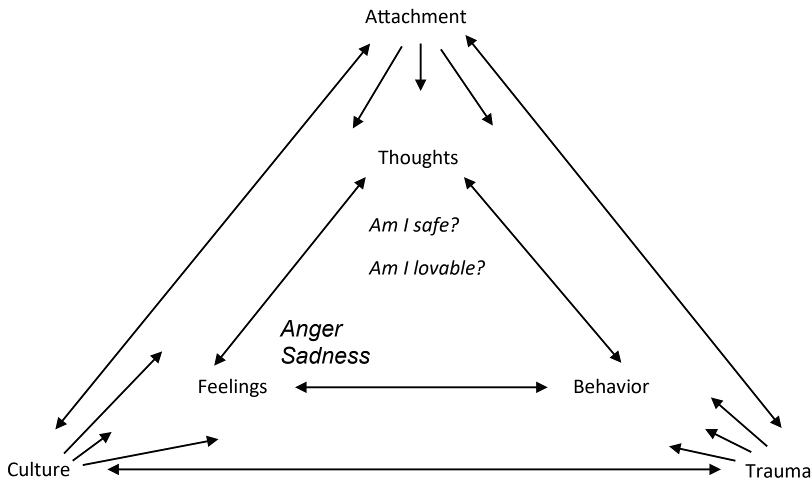

FIGURE 8.1. The ACT model.

lies physically assault children in the absence of adult protection, parents may teach their children to fight. If they expect that people will one day judge their children based on skin color or the texture of their hair, they may teach the children about that reality and socialize them to be tough enough to withstand the barbs that they expect their children to endure.

Consistent with this proposition, research shows differences in the ways that Black mothers, compared to White mothers, socialize their young children with respect to emotions. Although maternal support for the expression of negative emotions is typically associated with positive outcomes in White children (e.g., it is okay to be angry), Nelson and colleagues (2013) found that maternal support of negative emotions was related to poorer academic performance and more negative peer relationships among Black children. Perhaps this is because society tends to view Black children who express negative emotions as "problematic" or "dangerous." Given this, it makes sense that the Black mothers in their study were less likely to support the display of negative emotions in public and private settings than White mothers (Nelson, Leerkes, O'Brien, Calkins, & Markovitch, 2012). In a study assessing emotion awareness, Black mothers' experience of racial discrimination, when coupled with lower resources and supports, contributed to heightened awareness of emotions during picture-book interactions with their 24-month-old toddlers (Odom, Garrett-Peters, Vernon-Feagans, & the Family Life Project Investigators, 2016). The authors suggested that without the benefit of strong maternal supports, experiences of racism may result in greater attention to others' emotions, perhaps related to the need to gauge interpersonal safety, and that this emotional vigilance may be transferred to the child during parent–child interactions. Together, these studies offer support for Dunbar, Leerkes, Coard, Supple, and Calkins's (2017) conceptual model integrating racial/ethnic and emotion socialization. Within their framework, emotion-centered racial coping, which may include the suppression of negative affect, is viewed as a type of emotion socialization that prepares children to adaptively cope with experiences of racism and oppression. Thus, we see links between ACT elements in that a potentially hostile environmental context can shape the way that parents of a particular cultural group socialize children with respect to emotions.

As noted by Ogbu (1981), different contexts require different skills. You can't "judge" a skill without knowing its context. Thus, before we attempt to change parental behaviors that are not consistent with the way we want things to be, behaviors we might label as "controlling," "intrusive," "withdrawn," or "resistant," we must understand that they likely evolved as protective mechanisms and may continue

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to serve an adaptive function. As we develop and deliver interventions for diverse groups of young children and their families, we need to be aware of differences in the experience and context of those who develop and deliver the interventions, and those who are intervention recipients.

Placing Historical Trauma in the Forefront of Our Conceptualizations

As we attempt to address challenges in present-day interactions, parent-to-child or parent-to-provider, it is critical to honor that these challenges are often rooted in historical trauma and that "problematic" behaviors we might see in certain cultural groups may have been necessary for survival in hostile environments. As an example, in her book, *Post Traumatic Slave Syndrome,* DeGruy (2017) tells the story of a Black mother, who, in response to a White parent's praise of her son, responds, "Oh girl, he's such a mess at home. Sometimes I could just strangle him." DeGruy then goes on to detail other "challenging behaviors" often seen in African Americans, including parents' reluctance to praise children, inhibition of young children's exploratory instincts, and friends not being able to celebrate the successes of their peers. She discusses how these behaviors developed as adaptations to the past traumas of slavery. The mother's statements about her son makes sense in a historical context in which Black children with "potential" would be exploited and sold away from their parents by their slave masters. A friend's advancement is linked to potential threat through a history in which slave owners often promoted slaves to overseers, then ordered them to beat or punish their friends. These wounds from the past may be lasting, and this past is carried into our present through ongoing community racial trauma that must be addressed in all our systems. In the Racial Injustice and Trauma: African Americans in the U.S. NCTSN Position Statement, the National Child Traumatic Stress Network (NCTSN; 2016) highlighted the urgent need to address the impact of historical trauma.

Embedded institutional racism associated with these traumas is not yet adequately addressed in child trauma care and continues to shape current policies and attitudes. To address this legacy and to work toward ending the cycle of trauma and violence, it is necessary to acknowledge how both racism and oppression are embedded in American society, and to understand how the massive historical trauma of slavery continues to shape the lives of individual children, families, communities, and the systems with which they interact. Such acknowledgment requires self-examination, self-awareness, overcoming the challenges of open communication on these issues, and ongoing dialogue. As with all forms of trauma, the human tendency is to avoid or split off awareness and emotions related to a traumatic past. A critical part of trauma intervention is about overcoming such taboos and making the unspeakable speakable.

My team developed child–parent psychotherapy (CPP), a dyadic treatment for children under age 6 years who have experienced trauma (Lieberman, Ghosh Ippen, & Van Horn, 2015). One of our guiding mantras is that "we speak the unspeakable," which "includes the tactful but open exploration and acknowledgement of the adversities, stressors, and traumatic events that the child and the caregivers experienced and their possible links to the presenting problems" (p. 14). Our work is guided by the common phrase, "It's not what's wrong with you. It's what happened to you." As we move forward, we are seeing that it is critical to extend this thinking to cultural groups: "It is not what is wrong you, but what happened to your people." As we attempt to partner with families, to support them in raising their young children, we begin by acknowledging that historical trauma and ongoing oppression and racism are connected to current struggles for many multicultural groups.

Historical trauma's legacy persists in sociocultural contexts fraught with poverty, racism, discrimination, and oppression. Incorporating an understanding of how historical trauma shapes present-day interactions between cultural groups is a critical growing edge for the field of infant mental health. In their chapter "From Safe Spaces to Brave Spaces," Arao and Clemens (2013, p. 136) encourage us to rise to "the challenges of genuine dialogue on diversity and social justice issues." For this reason, this chapter, written 8 years after the original chapter, places historical trauma in the forefront of the chapter and of our consciousness, in the hope that our field begins to speak openly about its impact on the lives of many cultural groups,

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its influence on the way we intervene with certain cultural groups, and the importance of its inclusion in our infant mental health frameworks. This chapter also began in a nontraditional way, with a poem written to help us connect to the discomfort we feel when addressing the legacy of historical trauma. For years, many cultural groups have suffered and have carried the shame and pain silently. It is time that we all feel the discomfort because from discomfort there often comes movement and change.

This chapter explores the legacy of wounds from the past, highlighting the importance of bringing to light and acknowledging intergenerational and historical trauma as a core part of diversity-informed practice, reflecting on the ways that history shapes culture, the ways adults socialize and raise children, and intervention processes, such as engagement and the cultural values and perspective that we as interveners hold as we work with families. The burden of historical trauma has been disproportionately carried by culturally diverse families, particularly those whose groups were the victims of systemic, sanctioned historical violence, and who have yet to find safety within current times. As we seek to work with them, to address the challenges we see them facing, it is critical that we place current challenges and suffering in a historical context, that we open our minds to horrible realities and jointly carry the burden.

The Past Informs the Present

A core principle of infant mental health is that the past informs the present. Fraiberg, Adelson, and Shapiro (1975, p. 387) taught us that "in every nursery there are ghosts" and that in some, the baby is "burdened by the oppressive past from the moment he enters the world" (p. 388). Lieberman (1997, 1999) illuminated mechanisms through which babies become the carriers of a distressing past. This path is diagramed in Figure 8.2 and illustrated in the following vignette.

Kiara and Malik

Kiara Jackson, age 19, sits in the park with Vivian Davis, her infant mental health clinician. They watch as Kiara's son, Malik, age 20 months, dumps handfuls of sand into a water wheel. They are all African American. Kiara smiles as she watches Malik, and for a moment, the veil of her depression seems to lift, but then, as Malik gets frustrated and starts banging on the toy, a cloud comes over her face. Vivian watches Kiara and feels her stomach tighten. She had hoped they could have a nice time out and help Kiara and Malik connect, but now she anxiously waits for Kiara to repeat her unwelcome rant. "How come Malik's gotta be so aggressive. He's just like his daddy. He's just like

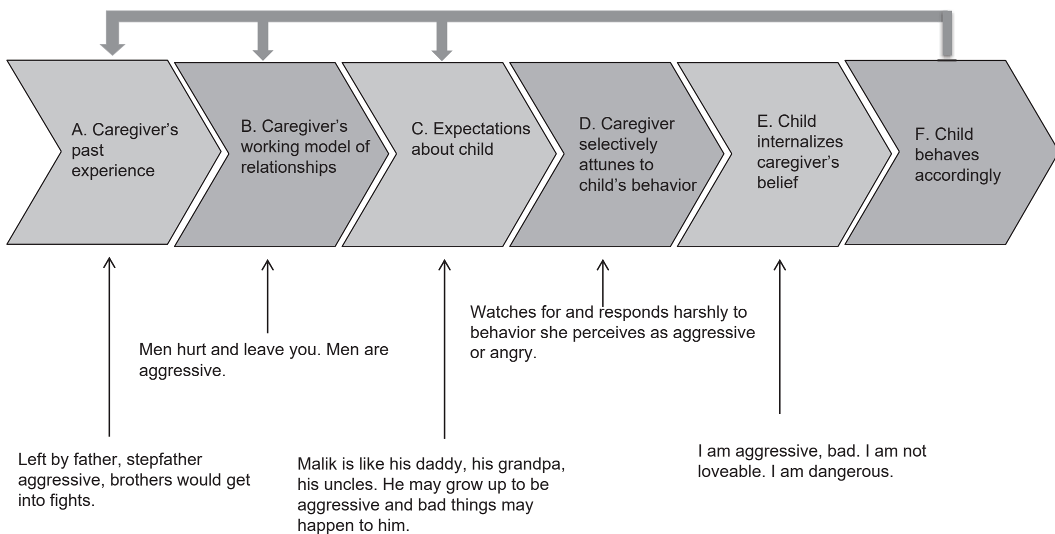

FIGURE 8.2. Kiara and Malik: Connection between past and present (Ghosh Ippen, 2016).

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my brothers. What's the point? Ain't nothin I can do." Vivian prepares to listen and feels stuck. She feels close to Kiara. She understands that Kiara's fears come from a childhood history that included abandonment by her father and witnessing aggression on the part of her stepfather and brothers, but she worries about Malik. He is only 20 months old, but he listens, and he understands. What is it like for him to have his mama talk like that about him?

In the diagram (Figure 8.2), as we move from A to B, we see the connection that Vivian makes between Kiara's past and her view of relationships. When Kiara was little, she watched her father change after his little brother's death. His brother made it through two deployments and had been back for just 1 month when he was killed in a fight. Kiara's dad had helped raise him and was devastated. He began drinking and had serious mood swings. Kiara's mom said that after a while, her dad did not think he was any good anymore, and he did not want his kids to see him broken, so he left. Kiara's mom tried her best, but after a couple years, she got together with a man who beat her. Her mom tried to shield her children from the violence, but they knew what was happening. With time, Kiara's brothers got progressively more rebellious. Their neighborhood was dangerous and offered few positive activities. After her oldest brother spent time in juvenile hall, her mom sent him and Kiara's younger brother down South to be with their grandmother and grandfather. She hoped they could straighten the boys out and felt they would be surrounded by a loving family and community. Kiara stayed with her mother. Her mom's new husband was sometimes "okay," but when he drank, Kiara could hear him abuse her mom, and she vowed she would never let anyone treat her that way. As Kiara watches Malik, she worries that Malik may leave her just like her dad and her brothers (see Figure 8.2, A–B). She sees his aggressive behavior as a prophecy and fears that Malik's future will be similar to that of other men in her life (B–C). She is hyperalert to Malik's every potential aggressive action (C–D), and her body-based reactions and vocalized fears are beginning to shape Malik's reality. Malik grows up in the shadow of his mother's fears about who he might become (D–E). The danger, as Vivian sees it, is that over time, Malik will internalize these words and act accordingly (E–F).

As infant mental health practitioners, many of us may enter into Kiara's and Malik's lives. Malik may need speech and language services because his language is delayed, perhaps related to his mother's stress and depression, or because his sleep and development are impacted by the noise and violence in the neighborhood. He may have health problems. When he begins day care or preschool, we may notice stress in his relationship with his mom, and we may be concerned about how this affects his development. He may come to the attention of mental health professionals if he internalizes and acts out his mother's fears. As we begin to work with them, what happens if we see only challenges, negative relationship patterns, delays, and behaviors that we would like to change? What if we do not attempt to learn family and cultural strengths? What if we do not hold a complex historical view of the family, similar to that which Vivian (Miss Viv as Kiara calls her) is beginning to build? What if we do not appreciate the role that historical trauma may have played in shaping family and "cultural" values and behaviors that we might like to address?

The Impact of History and Context on Engagement

When we begin to work with a family, we often feel pushed to move fast and effect change quickly. There are certainly times when families join us as partners in this endeavor, but often, initial engagement efforts fail. Research shows that 10–30% of families invited to participate in home visiting programs either do not enroll or drop in the first month of services (Ammerman et al., 2006; Duggan et al., 2000). Attrition rates from outpatient services are even higher, ranging from 30 to 60% (Staudt, 2007). Similarly, data from parenting programs suggest that nearly 25% of potential participants fail to enroll and another 26% drop out before completing the program, with half of those who drop out doing so after the first session (Chacko et al., 2016). Diversity-related conflicts linked to historical power dynamics may contribute to early engagement failures and may, in turn, play a role in racial, ethnic, and socioeconomic disparities seen in multiple systems (Alegria, Vallas, & Pumariega, 2010; Boyd, 2014; Dovidio et al., 2008; Harris & Hackett, 2008; Hill, 2007; Satcher, 2001; Wang et al., 2005).

As we begin to work with families, here are some questions we might consider:

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- How do we feel if they do not readily accept our services?
- How might we understand their perceived lack of engagement?
- How do multicultural factors such as race, age, socioeconomic status, sexual orientation, immigration status, and education level affect our perceptions and our response?

If we were to work with Kiara and Malik, we might also ask ourselves these questions:

- How would we create a relationship in which Kiara might share the parts of her life that she shared with Miss Viv?
- What would it be like to work with Kiara and see her child's struggles without understanding Kiara's history?
- How might the history of Black boys in America affect both Kiara's cultural beliefs and the way she perceives and responds to Malik? Would this be important to talk about?

We might not typically reflect on these questions, yet, when we are desperate to help small children, and we perceive their parents as not ready or as unwilling, these are times when negative emotions may rule, stereotypes gain power, and power dynamics may intensify and become destructive and toxic (Ghosh Ippen, 2016; Ghosh Ippen & Lewis, 2011). When the power dynamic replicates historically toxic power dynamics between cultural groups, conflicts, which may be expressed in different ways (e.g., overtly, passively, internally), are likely to intensify. As we attempt to maintain benevolence, we might, with sadness, describe caregivers as "resistant" or "not yet ready" when they do not engage. This stance places the responsibility for the engagement failure in the hands of parents and relieves providers of responsibility, but it does not help us reflect on either the families' perspective or the complexity of their circumstances. As we are learning, it is critical that we broaden our lens to look beyond individual caregiver factors to environmental factors and to ourselves (Bronfenbrenner, 1986; Cicchetti & Lynch, 1993; McCurdy & Daro, 2001).

Environmental factors, such as community violence, community health, and poverty have been found to interfere with engagement and access to services potentially due to increased family stress, lack of trust in others, and an increased sense of hopelessness (McGuigan, Katzev, & Pratt, 2003a, 2003b; McKay, Pennington, Renan, & McCadam, 2001; Osofsky, 1995). In addition, engagement appears to be a bidirectional process that is influenced by both the caregivers' and the providers' emotions, biases, and reactions (Buckingham, Brandt, Becker, Gordon, & Cammack, 2016; Korfmacher et al., 2008). McGuigan and colleagues (2003b) found that a caregiver's odds of remaining in a home visiting program for at least a year increased by 79% for every 1-hour increase in monthly supervision the home visitor received. The implication is that supervision may change something within the provider that leads to better perceptions and more engagement on the part of families. It may be worthwhile to pause and think about this finding with a colleague.

- What might supervision be changing?
- How might this affect a family's capacity to trust us and become receptive to us and to intervention?
- What does this mean for our work and our systems?

Interviews with caregivers (e.g., Buckingham et al., 2016; Woolfolk & Unger, 2009) teach us important lessons about the potential pitfalls of trying to initiate rapid change, the negative power dynamics that may be established early on in relationships, the potential for bias or at least perceived bias, and the need to attend first to the development of an empathic relationship.

> "The first day [the provider] came to the house she changed everything! . . . She came in wrong. So, there's nothing for her to say to me because I don't trust her." (in Buckingham et al., 2016, p. 3707)

> "A lot of times education and degrees tries to speak down to people. . . . Automatically you're looked at as a project. . . . I think that should change—their perception of who is walking in. . . . They put us in a box." (in Buckingham et al., 2016, p. 3709)

> "It shows you who really cares, because some people come in here and just do the child development and then they can leave, because they did what they had to do. I'm just saying some people come with their agenda, just getting the job done and leaving. Let me tell you, some folks act like they just never been down before, and I can't stand that. Like they've always been—you know, you're not better than nobody else." (in Woolfolk & Unger, 2009, p. 194)

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As we strive to work with diverse families, it is critical that we hear caregivers' voices and reflect on times when our actions may run counter to the goals that initially led us to work with young children and their families. Perceptions of bias and misunderstanding are common across systems and are especially prevalent among multicultural groups. For example, within the medical field, Blacks, Latino(a)s, and Asians have been found to be more likely to perceive bias and a lack of cultural competence in the health system, to believe they would receive better medical care if they belonged to a different race/ethnicity, and to feel that medical staff judge them or treat them unfairly based on their race/ethnicity (Johnston, Saha, Arbelaez, Beach, & Cooper, 2004). Disparities in health care appear to begin in early childhood. In the National Survey of Early Childhood Health, parents of ethnically diverse children ages 4–35 months reported poorer child health status, less access to insurance, and less satisfaction with their pediatric providers in general and in terms of feeling that their childrearing preferences were understood (Flores, Olson, & Tomany-Korman, 2005). Miller, Cahn, and Orellana (2012) conducted focus groups with child welfare professionals, community partners, and families, and learned that these participants felt that multiple factors linked to bias, including lack of trust, negative perceptions of client's behavior, and bias embedded within institutional structures, synergistically contribute to disproportionality and disparities evidenced in the child welfare system.

Lieberman, Chu, Van Horn, and Harris (2011, p. 402) encourage us to broaden Winnicott's (1964) dictum, "There is no such thing as a baby. . . . A baby cannot exist alone, but is essentially part of a relationship" (p. 88) to "There is no such thing as a family. . . . A family cannot exist alone, but is essentially part of a social, economic, and cultural system." As we strive to understand how the greater sociocultural context shapes families' responses to providers and to intervention, it may also be helpful to recognize that "there is no such thing as a provider. A provider cannot exist alone, our reactions and interactions with families are shaped by a social, economic, and cultural system." Sometimes our particular ecological context supports us so that we are able to slow down, connect with families, and gain an understanding of their perspective, their family and cultural values, the path that families and their cultural group traveled prior to meeting us and their view of their own future path. Other times, the context stresses us. We feel as though we are under pressure, and we pass that pressure along to families because we urgently need them to engage and change. When we intervene with limited dialogue, we may unwittingly impose our values and beliefs upon them. If our ecological context differs significantly from theirs, our context may blind us to the everyday challenges and realities they face and may lead us to view them as the source of the problems rather than address ecological and historical challenges, and acknowledge the tremendous strength it takes to endure.

The Importance of Reflecting on Our Own Cultural Histories and Values

As we work across systems to serve families better and reduce systemic disparities that are common in all child and family service systems, how do we partner with families in ways that do not replicate historical power dynamics or current systems of oppression? This journey is one that we need to undertake as a system, and one that is deeply personal and unique for each individual in the system. The first Diversity-Informed Infant Mental Health Tenet (St. John et al., 2012) asks us each to reflect on our experiences and path, and ways that our history influences our values, beliefs, and biases.

> Tenet 1: Self-Awareness Leads to Better Services for Families: Professionals in the field of infant mental health must reflect on their own culture, personal values and beliefs, and on the impact racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression have had on their lives in order to provide diversity-informed, culturally attuned services on behalf of infants, toddlers, and their families. (p. 15)

In my 2009 chapter for the previous edition of this handbook, I began by introducing myself because I recognized that any perspective I offered was biased by my experience, that all our views stem from our experiences, so as I began to share my point of view, I thought the reader had the right to know a little about me and where my values and beliefs come from. Now, this chapter has a historical context, so that as I reintroduce myself, my history carries a different meaning for me than it did in 2009. I am half East Indian (Bengali) and half Japanese,

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the child of immigrant parents who moved to the United States as adults and worked as Child Protective Services workers. I grew up with my parents' stories, and they became a part of my historical experience. My father's stories, in particular, shaped my worldview. His family was bombed out of Burma when he was 8 years old. He lost everything, and his family arrived by boat to Calcutta as refugees. Because of my family history, I think a lot about what it means to be a refugee and what it would be like to be a small child who is denied or whose parent is denied entry to our country perhaps because "our group" sees "their group" as potentially dangerous or somehow less than.

My father told me stories of life under British colonial rule, in which it was common to see signs that read, "No dogs. No Indians." When he was 13, the British partitioned India, and he watched as people he knew, people who had lived side by side as friends and neighbors, became enemies and began killing each other. "The Great Calcutta Killing" lives on as one of many powerful moments in history that leaves a trace on all those whose lives it touched and shows that within each of us lies the capacity to judge, harm, and even kill those we perceive as being different. During World War II, my dad learned that differences, racism, and inequities can kill in less direct ways. Two of his brothers signed up for the British army. One died because his plane failed. It was a common belief that the British gave the Indians broken-down planes. The other died in the army of appendicitis due to inadequate medical care.

In the 1950s, my dad left India and came to the United States. Growing up in San Francisco in the 1970s, I heard my dad's stories, stories of an Indian immigrant trying to connect and find his place in the South and in Chicago in the 1950s and 1960s. One image that stayed with me when I was little was that the drinking fountains were labeled "White" and "Colored." My dad knew he was not White, so he reasoned that in that space he must be Colored. If my dad was Colored, I figured I was Colored, too, but oddly I had heard that Asians were yellow, and my mom was from Japan. I remember looking at my skin trying to see the color yellow. I wondered where people drank if they were Colored and yellow.

Other people seemed to wonder a lot about my race and ethnicity. After an initial greeting, the most common question I received was "What are you?" My parents tell me that when I was likely around 3 to 5 years old, I used to respond, "I am a kimono-bean" because I did Japanese dance, played the koto, and wore a kimono; *bean* was my way of saying "being." It was my way of defining myself. By age 5, I would simply say, "I am a human being," which then prompted people to restate the question. "No, I meant where are you from?" "San Francisco," I would respond. "No, no," some would say, "Where are you *from*?" My pat response has always been, "I was born in San Francisco, but my mom is from Japan, and my dad is from India." That response typically seems to satisfy, then leads many to say things that suggest to me they are trying to establish some type of connection: "My son went on a mission in the Philippines" or "I was once stationed in Japan." I recognize that people are curious and perhaps are looking to deepen the conversation, but in these early conversations, it is hard not to think about the history of the Philippines with different missionary groups. My mind goes to the atrocities committed by the Japanese (half my people) toward so many Asian groups with whom people often associate me. I also think about how these are examples of a microaggression that Asians often receive, known as "invalidation of inter-ethnic differences" (Sue, Bucceri, Lin, Nadal, & Torino, 2009). I wonder whether people who repeatedly ask me where I am really from are aware that being an "alien [a foreigner] in [your] own land" is one of the most common microaggressions experienced by Asian Americans (Ong, Burrow, Fuller-Rowell, Ja, & Sue, 2013).

I share these stories and thoughts because they shape my view of myself, my community, my place in my community, and my worldview. Sometimes they influence my initial interactions with people from certain cultural groups. I do not think that we always meet each other with the heavy burden of our group histories in the forefront of our minds, but for many of us, and at different times, this history shapes our initial feelings of safety, our assumption of power dynamics, and our interactions. At other times, I, too, am blind to history that was not taught to me and that I did not later seek out. I am also blinded by my urban, middle-class, two-parent (cisgender) upbringing, so that I am the one who acts without knowledge of the ecological and historical roots of our interactions. From a position of safety and ignorance of history, it becomes too easy to distance ourselves and ignore or deny the reality of those whose lives are not yet safe or

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to even see those who are suffering as to blame for their circumstances.

We all have stories that are the legacy of our ancestors and our parents, and our own personal stories that we pass along to the next generation, stories of our cultural group and of how our cultural group encountered, clashed, and connected with other groups. I have shared some of my stories in the hopes that it inspires reflection and sharing of how each of our stories influence the way we walk in the world and interact with others. Sometimes our stories are spoken and other times they are transmitted in unspoken ways, but we often see that "the body keeps the score" (van der Kolk, 2014) and that the wounds from the past last. As we strive to serve others, it is critical that we are aware of our own stories and recognize that others may be reading from different books. The lens through which we view "reality" was carved by historical forces and has numerous blind spots, so that we are often unaware of the historical and daily experience of so many.

This Chapter's Sociocultural Context

In the wake of the 2016 presidential election and the now publicized brutalization and killings of young Black boys, men, and women by police (Tamir Rice, Michael Brown, Oscar Grant, Laquan McDonald, Eric Garner, Philando Castile, Stephon Clark, Charlena Lyles, Korryn Gaines, and too many others), it has become more difficult to be blind to the inequities and danger faced by numerous ethnic groups. Arab, Muslim, and Latino(a), particularly Mexican, immigrants are in danger of being deported, and immigrant parents are being separated from their U.S.-born children (Davey, 2017; Salam, 2017; WBUR, 2017). Young children with whom we work have nightmares that the government is going to take their parents away. Threats and hate crimes toward Asians, Muslims, and Jewish people have been rising (Andrusewicz, 2017; Chen, 2017; Kuruvilla, 2017). The government is enacting policies that harm people who identify as lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) (Wong, 2017). A U.S. judge denied the motion by Sioux and Cheyenne River Sioux tribes for an injunction against the pipeline at Standing Rock (Hersher, 2017). Mass incarceration continues to disproportionately affect Blacks, Native Americans and Latinos. One in three Black men between ages 18 and 30 is in jail, in prison, on probation or parole (Stevenson, 2012). Incarceration rates have more than doubled since 1991. Though their stories are not as publicized, Native American men are incarcerated at four times the rate of White men, and Native American women at six times the rate of White women. Native Americans are also the racial group most likely to be killed by law enforcement (Lakota People's Law Project, 2015).

Examples of Racial Disparities in Infant Mental Health

While these social justice issues typically involve adults and teens, we need to recognize that most directly affect young children. Mass incarceration, for example, directly impacts the over 2.7 million children who have a parent in jail or prison. Data suggest that nearly one-fourth of these children are under age 4 years (U.S. Department of Justice, 2010). Moreover, there is substantial evidence for the cradle to prison pipeline, which suggests that social inequities begin in early childhood (Children's Defense Fund, 2007, 2009). In a national study, Gilliam (2005) found that the preschool expulsion rate was 3.2 times the rate of that for children in grades K–12, and Black preschool children were twice as likely to be expelled compared to White children. U.S. Department of Education Office of Civil Rights (2014) data also provide evidence for this disparity. From 2011 to 2012, Black children represented 18% of preschool enrollment but 42% of the children suspended once, and 48% of those suspended more than once.

In an effort to understand the role that implicit bias may play in preschool suspensions, Gilliam, Maupin, Reyes, Accavitti, and Shic (2016) asked early childhood educators to watch a series of video clips that included four children interacting together: a Black boy, a Black girl, a White girl, and a White boy. They were given the following instructions.

> We are interested in learning about how teachers detect challenging behavior in the classroom. Sometimes this involves seeing behavior *before* it becomes problematic. The video segments you are about to view are of preschoolers engaging in various activities. Some clips may or may not contain challenging behaviors. Your job is to press the *enter key* on the external keypad every time you

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see a behavior that could become a potential challenge. (p. 6)

Eye tracking data showed that, in general, all teachers spent more time watching Black children, especially Black boys. When asked, the teachers also reported that they spent more time attending to the Black boy. Of note, the video clips did not contain any challenging behaviors. Thus, it appears that when we are primed to look for misbehavior, we may all expect that misbehavior to come from Black children, especially Black boys. A heartening aspect of this research is that once teachers were debriefed and told about the nature of the study, only one asked not to be included. The rest presumably felt that it was important that these biases be brought to light (Turner, 2016).

Ghosts in Our Society: Acknowledging Atrocious Cultural Experiences

Earlier in this chapter, when we first met Kiara and Malik, our initial focus was on Kiara's history and the ways that the ghosts from her past might affect her view of Malik and Malik's development. In the years since Fraiberg developed her theory of "Ghosts in the Nursery" (Fraiberg et al., 1975), our field has come to link the concept of "ghosts" to trauma, and we have learned a tremendous amount about the negative consequences of childhood traumatic experiences for relationships and development (Lieberman et al., 2015; Lieberman & Van Horn, 2011). There are numerous organizations working to provide education about the negative consequences of adverse childhood experiences (ACEs) and to support the development of trauma-informed systems (NCTSN, n.d.). Considerable research demonstrates that ACEs are associated with mental and physical health problems, and predict the leading causes of adult death and disability (Brown et al., 2009; Felitti et al., 1998), and that some ethnic groups experience higher rates of ACEs because their ecological context places them at risk. For example, Koss and colleagues (2003) found that Native Americans had over five times the risk of experiencing four or more ACE categories compared to those in the original Kaiser study. As discussed earlier in the chapter, trauma is a force that both influences and interacts with attachment and culture to shape development, so it is critical that we acknowledge its prevalence in our culture, in the lives of young children, and understand how it impacts functioning, families, and systems.

Yet, even while we work to address the impact of trauma on young children (Chu & Lieberman, 2010; Ghosh Ippen & Lieberman, 2008), it is clear that we need to look beyond the "ghosts in the nursery" to the "ghosts in society" (Ghosh Ippen, 2009; NCTSN, 2016). I and my colleague Markita Mays coined the term "atrocious cultural experiences" to name "original" ACEs that we must acknowledge. Table 8.1 lists some of these original ACEs, which include genocide, slavery, colonization, forced family separations, sanctioned attacks on bod-

TABLE 8.1. Links between Original Atrocious Cultural Experiences and Current Adverse Childhood Experiences

Original atrocious cultural experiences	Examples of systemic oppression/ inequities	Current adverse childhood experiences
• Genocide • Slavery • Colonization • Forced family separations • Sanctioned attacks on individuals' bodies • Removal of property/land • Denial of basic human rights	• Police violence • Mass incarceration • Disparities in preschool expulsions • Inequities in access to jobs and housing • Inequities in pay • Inequities in the child welfare system	• Abuse ◊ Physical ◊ Emotional ◊ Sexual • Neglect ◊ Physical ◊ Emotional • Household dysfunction ◊ Mental illness ◊ Incarcerated relative ◊ Mother treated violently ◊ Substance abuse ◊ Divorce

Note. Adverse childhood experiences adapted from the Robert Wood Johnson Foundation (2013). Data from Ghosh Ippen (2016).

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ies, denial of basic human rights. As we examine Table 8.1, how do we connect the dots and link these original ACEs to current systemic oppression and to current ACEs experienced by many cultural groups? How do we think about the way that these experiences shape the development and well-being of the young children and families that we see? How do we prevent the cascade of new original ACEs that is occurring as we watch? Across systems we are learning to ask about and to address trauma. We are attempting to change personal- and systems-level narratives from "What is wrong with you?" to "What happened to you?" As we look at Table 8.1, we see that this phrase clearly applies to groups, and in fact, we should be asking, "What happened to us, all of us?" and "Why does it keep happening?"

As can be seen in Figure 8.3, the original ACEs shape our working models of intergroup relationships and our perception of group hierarchies (A–B), in which one group may be seen as better than another. This phenomenon shapes the views of those on the upside of this hierarchy, as well as those who might be perceived, or who perceive themselves, as being on the downside. Internalized oppression is one of the enduring consequences of historical trauma (Brave Heart & DeBruyn, 1998; Poupart, 2003). These models, in turn, shape our expectations about members of different groups (B–C). They shape our view of whether we see them or ourselves as dangerous, intelligent, valuable, and worthy of love and care. As members of society, we selectively attune to examples that fit our schema, our worldview (C–D). Through the lens of our biases, stereotypes are reinforced (D–E) and oppressive conditions are maintained, justified, and become a part of our cultural experience (F–A).

As we return to Kiara and Malik, this is the "smog" (Tatum, 1997) under which Kiara raises Malik (see Figure 8.4). This "smog" affected Kiara's brothers, father, and uncle. It might affect also affect Kiara's perceptions of Malik's father and whether we attempt to work with him. How do we understand that men, fathers, are often absent partners in the work that we do? Perhaps if we each spent an additional hour a month of supervision reflecting on this, engagement rates might change.

Kiara's parenting and her perceptions of Malik are influenced by this toxic history and should not be viewed without understanding this historical context. Malik is at risk not only due to his mother's history but also because of the way our society responds to children of color. He is at risk because he is a Black boy growing up in America, and he is subject to numerous biases that begin in early childhood and are part of the legacy of slavery, Jim Crow, and mass incarceration (Alexander, 2012).

Tatum (1997) asserts that we are all "smog breathers":

> Cultural racism—the cultural images and messages that affirm the assumed superiority of Whites and the assumed inferiority of people of color—is

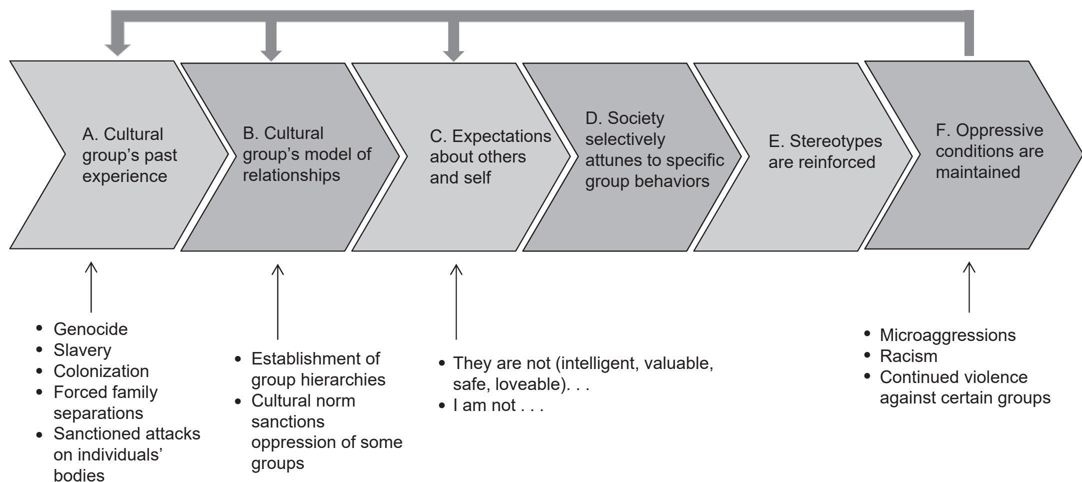

FIGURE 8.3. The ghosts in our societies (Ghosh Ippen, 2016).

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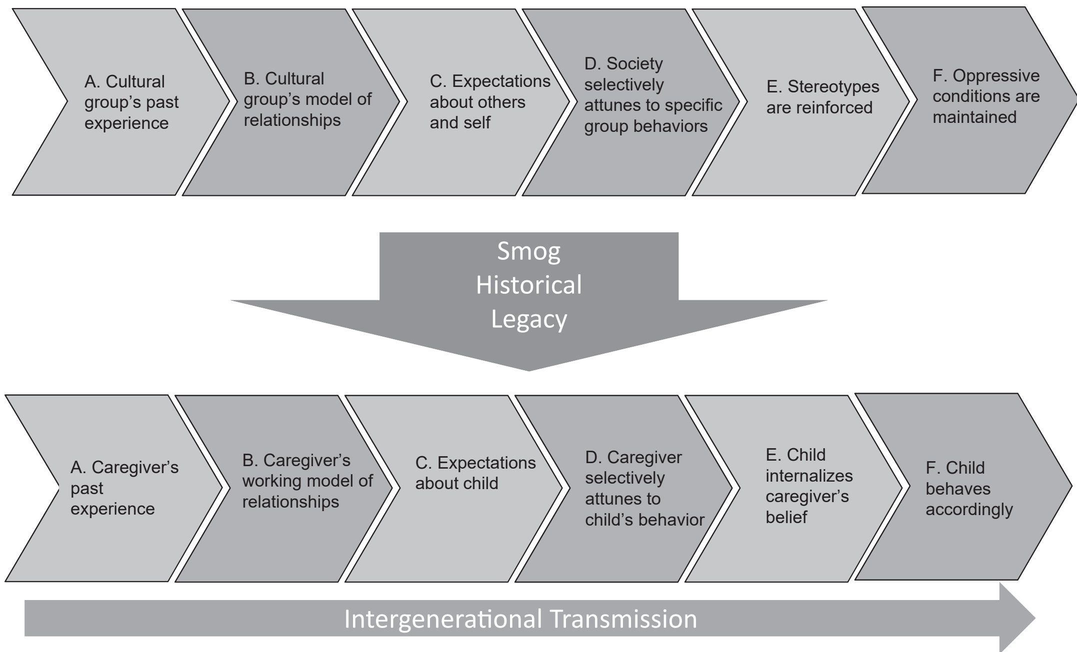

FIGURE 8.4. The smog: The legacy of historical trauma (Ghosh Ippen, 2016).

> like smog in the air. . . . If we live in a smoggy place, how can we avoid breathing the air? If we live in an environment in which we are bombarded with stereotypical images in the media, are frequently exposed to the ethnic jokes of friends and family members, and are rarely informed of the accomplishments of oppressed groups, we will develop the negative categorizations of those groups that form the basis of prejudice. (pp. 6–7)

Tatum (1997) uses a metaphor of a moving walkway at the airport and emphasizes that to combat these historical forces, we cannot continue to passively follow the movement of the walkway. "Unless [we] are walking actively in the opposite direction at a speed faster than the conveyor belt—unless [we] are actively antiracist—[we] will find [ourselves] carried along" (p. 12).

Breaking the Cycle

The third Diversity-Informed Infant Mental Health Tenet serves as our call to action and asks us each to become aware of when we are being pushed in an oppressive direction so that we consciously motivate ourselves to move in the opposite direction.

> Tenet 3: Work to Acknowledge Privilege and Combat Discrimination: Discriminatory policies and practices that harm adults harm the infants in their care. Privilege constitutes injustice. Diversity-informed infant mental health professionals work to acknowledge privilege and to combat racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression within themselves, their practices, and their fields. (St. John et al., 2012, p. 15)

At the Child Trauma Research Program at the University of California, San Francisco, where I have worked for the last 16 years, we work with many families who have experienced intergenerational and historical trauma. We have learned that traumatic experiences become embedded in a person's brain and body (Pynoos, Steinberg, & Piacentini, 1999), and our treatment involves working dyadically with caregivers and children and "speaking the unspeakable," "talking," and "playing" with families about their experiences of traumatic events (Lieberman et al., 2015. When caregivers have harmed or failed to protect children, we believe that healing is promoted and children are best helped when caregivers can acknowledge what happened, offer a clear statement that it was wrong and that they are sorry, then show

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children the ways that they are acting to change things and ensure safety. Yet we must be aware that our society has not fully acknowledged the harm suffered by Blacks, Native Americans, and so many others. "We haven't confronted the narrative of racial difference . . . and our silence has condemned us" (Stevenson, 2017). We are haunted by ghosts, but we do not seem to see them. As Fraiberg and colleagues (1975, p. 388) noted, "Ghosts who have established their residence privileges for three or four more generations may not, in fact, be identified as representatives of [our country's] past." We are also not able to affirm that our society is acting to change things and ensure safety for all. Daily news reports suggest that so many groups—Latinos, Arabs, Muslims, Native Americans, Blacks, LGBTQ individuals, Asians, immigrants, and those with disabilities—are in the crosshairs of systemic oppression.

I began this chapter with a poem to acknowledge and bring to light the wounds from the past. As infant mental health practitioners, a question we need to ask is: How do we acknowledge history and act to restore safety and justice within our current infant mental health systems? Within CPP, the treatment model developed by our team, specific goals guide our intervention. I have listed some of these goals below in the hope that they may help us identify cross-system goals for our field that may guide this endeavor. A core task is to determine whether the following goals fit our systems and our work, and to identify additional goals (Ghosh Ippen, Van Horn, & Lieberman, 2012):

- Discuss ways that contextual risks (e.g., poverty, community violence, immigration-related risks, inadequate or unsafe housing, and inadequate access to services) affect child and family functioning.
- Consider the impact of racism and historical trauma on child and family functioning.
- Understand difficult behavior given past history and the current context.
- Understand caregivers' mistrust of providers and reluctance to engage in treatment in light of their past history and current experiences with potentially punitive systems.
- Acknowledge past history of risks to safety.
- Foster the caregiver's ability to socialize the child in ways that are consistent both with the caregiver's cultural values and beliefs and the family's context.
- Identify factors that may interfere with a caregiver's capacity to socialize a child, including environmental circumstances, strong negative emotions (e.g., guilt, fear, feelings of worthlessness), and prior relationship history.
- Acknowledge effects of the child's and the caregiver's experience of trauma and historical trauma.

As we work to address these goals, we seek to acknowledge and help caregivers find words for emotional experiences. We tolerate strong emotions, and we appreciate that righteous anger is a normal consequence of injustice. The opening poem asks us: "Who carries the blame? Who wears the shame? Who feels the pain?" For too long it has been certain groups and certain families. How do we work together to jointly shoulder the burden, to acknowledge what has been and what continues to happen, and to actively work to ensure safety? In their article, "Ghosts in the Nursery," Fraiberg and colleagues (1975, p. 419) asked, "What it is it . . . that determines whether the conflicted past of the parent will be repeated with his child?" The answer, they suggest, lies in the individual's capacity to connect affect to experience. Perhaps as we ask, "What is it that determines whether the conflicted past of our people is repeated with this generation?" we might acknowledge that it is critical that as individuals and as a society we feel the pain associated with our country's history and work to break the cycle.

The Path Forward

This chapter ends with two vignettes and two additional tenets of infant mental health (St. John et al., 2012) to guide our work and foster reflection about the path before us and ways to address historic wounds and current systemic oppression that continue to impact the well-being of young children and families with whom we all work.

Kiara, Malik, and Vivian

Miss Viv sits with Kiara and Malik in the sand. Viv breathes. "You don't like it when he's aggressive." Kiara tosses a handful of sand, "No, I don't." Viv looks directly at Kiara and says softly, "Bad things happen to Black boys who are aggressive. They've been happening for too long. It's not right." "Yeah," says Kiara, "I

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worry what people will think about him, and I worry about what might happen."

"Yeah," says Viv. "You have to worry. It's not right that you have to worry. Malik's just getting frustrated with a toy like any little baby, but you've got all this pressure." Kiara sighs. She cries, and she and Viv begin to talk about her fears for Malik and his future.

Carlos, Deisy, and Sarah

Sarah is a home visitor. She is White, but she speaks Spanish. She recently began working with Carlos and his 3½-year-old daughter, Deisy. Carlos is an immigrant from Mexico. He came to the United States after his cousin was killed for standing up to a cartel. Before that, he lived in a border town that was impacted by the trafficking of drugs to the United States. Deisy was born in the United States, but her mother had problems and left her with Carlos when Deisy was 15 months old. Sarah was supporting Carlos as he dealt with Deisy's numerous developmental delays and medical problems. Deisy was born with drugs in her system and was exposed to significant violence while in the care of her mother. Sarah wonders how Carlos is doing in the wake of recent immigration laws and news of U.S. Immigration and Customs Enforcement (ICE) officials detaining people in their area. Deisy is experiencing more problems in preschool. She is more clingy, and her day care provider told Sarah that Deisy said bad men would take her daddy. Sarah wonders whether and how she should talk about this. As infant mental health providers, each of us should consider what we might do if we were to work with this family.

Opening a Door: Identifying Diversity-Related Ports of Entry

In our field, we often intervene with families through "ports of entry" (Stern, 1995), key moments in which we have the opportunity to reflect and interact with a caregiver and child in a way that may result in constructive change. In these moments, it is as if a door has opened to a potential conversation or to a number of possible dialogues. For example, during interactions with caregivers who are frustrated by their toddler's aggressive behavior or their child's separation anxiety, there are a number of different doors we might open. We may choose to reflect on the meaning of that behavior for the caregiver. We may explore fears and feelings. We may offer well-timed developmental guidance related to how these behaviors are common in this age group. We may think together about how the caregiver would like to respond. These are all critically important dialogues and valid pathways. However, as I hope I have highlighted in this chapter, there may be diversity-related ports of entry (Ghosh Ippen, 2016) that we might also identify, and we may need to grow our capacity as individuals and as a field to recognize and open the door to dialogue about power and privilege, cultural values, experiences of racism, and historical trauma (see Figure 8.5).

Miss Viv opened the door to talking to Kiara about how her reactions to Malik's aggressive behavior came both from her own experience with violence and from a society in which young Black men are viewed as dangerous and are harmed with impunity. Together they talked about the way that Kiara would need to raise

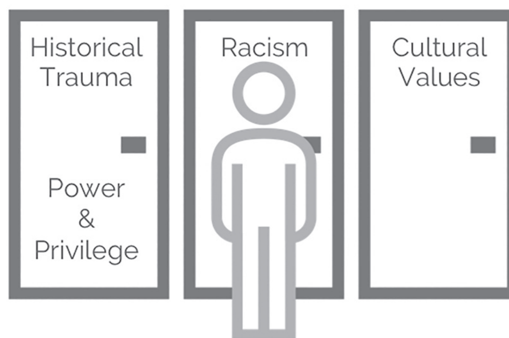

FIGURE 8.5. Diversity-related ports of entry (Ghosh Ippen, 2016).

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Malik to keep him safe from the police and from society. "When," Kiara asked, "will we be able to raise children without telling them that they are in danger because of the color of their skin?" Miss Viv sighed, and they sat in sadness and anger together.

As Sarah worked with Carlos and Deisy, she was uncertain as to whether Carlos would feel comfortable talking with her about his immigration status and the ways it might affect him and Deisy; then she realized that her own discomfort was preventing her from speaking with him about a real source of fear and danger that was impacting Deisy's well-being and development. She met alone with Carlos first to talk with him about how the recent deportations were affecting him. She noted how unjust it was that immigration was targeting Mexicans and separating parents and children. Carlos tearfully shared that he was scared to take Deisy to her medical appointments or even to the park. He knew that all this was affecting Deisy, but he did not know what to say. She was only 3 years old. Her mommy had already left her, and now she worried that bad men would take her daddy. Sarah and Carlos felt powerless to change things. They talked about how this affected Carlos. Even though she was so young, Deisy had already been affected by racial slurs. As Sarah created a space, Carlos was able to talk to her about how he wanted Deisy to understand that her daddy and her people were good, hardworking, loving, and strong. Deisy would need his help to understand and fight against the negative stereotypes about Mexican people that surrounded them. She would need him to explain about "la Migra" (immigration) because she had already heard people talk about it. And, even though they hoped it would never happen, they had to make a plan for what the family would do if someone ever did take Carlos.

These are difficult conversations, but it is perhaps more difficult to not have them and to feel isolated with this pain. A common response to traumatic circumstances we cannot change is to go numb or dissociate. Yet young children need us to come together as grown-ups to acknowledge both the harms of the past and to take action to prevent future injustices. Tenets 2 and 10 of the Tenets for Diversity-Informed Practice serve as a beacon for the path before us as our field works to effect change in systems and policies to allow all young children to thrive and to grow-up in safety.

> Tenet 2: Champion Children's Rights Globally: 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 et al., 2012, p. 15)

> Tenet 10: Advance Policy That Supports All Families: Diversity-informed infant mental health practitioners, regardless of professional affiliation, seek to understand the impact of social policies and programs on diverse infants and toddlers and to advance a just policy agenda for and with families (St. John et al., 2012, p. 15).

Ancestral Angels

Much of this chapter has focused on the importance of acknowledging the wounds from the past caused by historical trauma and understanding their enduring consequences for many cultural groups and for our interactions and interventions with families. Yet, even as we move to acknowledge the existence of these societal ghosts, we must remember to look for the "angels in the nursery" (Lieberman, Padrón, Van Horn, & Harris, 2005) and the ancestral angels (Ghosh Ippen, 2009).

Among cultural groups that have experienced much suffering, it is critical to recognize the tremendous strength it took to endure and survive. As families seek new paths for future generations, cultural strengths, the legacy of their ancestors, accompany them on that journey. *La cultura cura,* culture cures, "is a transformative health and healing philosophy that recognizes that within an individual's, families and community's authentic cultural values, traditions and indigenous practices exist the pathway to healthy development, restoration and life long well being" (National Compadres Network, n.d.). As we move forward, let us embrace the strengths of diverse cultural groups and honor ancestral wisdom. Oyate Ptayela ("taking care of the nation"), a parenting curriculum for Lakota families (Brave Heart & Spicer, 2000), focuses on healing from historical trauma through a return to indigenous beliefs including *Woope Sakowin* ("the seven sacred laws"), *tiospaye* ("extended family"), and *lena wakan heca,* the belief that children are sacred; gifts from the Creator. Within the language of the Lakota, we see the strengths of the people, strengths and values that, as a field, we need to embrace as we partner with young children and families.

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