MATERNAL POST-TRAUMATIC STRESS AND RESPONSE TO TODDLER DISTRESS

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Three different programs of research launched by myself and colleagues over the past decade (Schechter et al., 2006; Schechter et al., 2007; Schechter et al., 2008; Schechter & Willheim, 2009; and Schechter et al., in press) support the overarching hypothesis that mothers who have experienced interpersonal violence and who suffer from related post-traumatic stress disorder (PTSD) tend to have particular difficulties in the regulation of their own emotion and arousal, especially when faced with helpless states of mind in their young children or themselves. These difficulties, which can be viewed at the level of maternal mental representations and self-reported stress, behavior, physiology, and neural activity, are associated with impairment in their parental function of assisting their young children with regulation of their emotion, arousal, and aggression. As a result, some children showed dysregulated aggression, increased anxiety, avoidance and withdrawal as well as less coherence concomitant with severity of maternal PTSD symptoms. Similarly, there was a robust link between maternal PTSD diagnosis and disturbances of attachment as observed by clinicians. Therefore, young children can represent a threat to mothers with PTSD and a mother's fear-response can present problems for her child's social–emotional development.

A current study underway in Geneva, with support from the Swiss National Science Foundation, is seeking to understand what contributes to individual differences in behavioral expression in the mother, child, and the mother-child relationship, especially for the child over time. It is important to note that an experimental intervention, the Clinician Assisted Video-feedback Exposure Session(s) (CAVES), contributed to a significant change in the way mothers have viewed their children (i.e., less negatively) in both studies. But it remains to be understood if these changes are sustainable—given varying “doses” of this intervention, and if so, for whom. Researchers, including myself, Sandra Rusconi-Serpa, Francois Ansermet, and others on the University of Geneva Hospitals Department of Child and Adolescent Psychiatry Research Team, are working on this and other questions such as whether any such changes translate into caregiving behavior and its neurobiological correlates, and whether these changes carry over effects to the child.


TRAUMA AND LOSS IN ADOLESCENT PREGNANCY

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Adolescent pregnancy often involves experiences of trauma and loss and requires specialized services and supports for this vulnerable population. The Colorado Adolescent Maternity Program/Young Mothers' Clinic (CAMP/YMC) at the University of Colorado and The Children’s Hospital is a program for pregnant and parenting adolescent girls less than 21 years old. Pregnant teens receive their obstetrical care in the clinic and, once they deliver, both they and their babies continue to receive primary care services from the same team of medical providers. In addition, clinic patients have access to mental health providers including social workers, psychologists, and psychiatry coverage.

The teens in CAMP/YMC are predominately low income (85% enrolled in Medicaid) and slightly more than half live with one biological parent. About one third of the adolescents are African American, 44% are Latina, and 16% are Caucasian. Nearly one third have dropped out of or are failing school. Between 30%-40% of patients have some mental health concern and, during pregnancy, rates of depression are approximately 20% (Sheeder, Kabir, & Stafford, 2009).

The CAMP/YMC program recognizes that teens are at higher risk of pregnancy
complications and has designed services to meet these needs. For example, teenagers are more likely to deliver prematurely, to have low birth weight babies, to develop high blood pressure during pregnancy, and to become anemic, among other medical complications (de Vienne, Creveuil, & Dreyfus, 2009). Many of these complications arise from lack of regular prenatal care or lack of commitment to stopping activities, such as substance abuse and smoking, which are harmful to the baby. Adolescents are also typically unprepared to cope with and face difficult issues when they arise due to their own developmental level. In addition, although teens are not allowed to make medical decisions regarding their own care, they are the only ones who can consent to their babies' medical treatment. Adolescents who have not finished high school and are forced to make complex medical decisions without really comprehending the risks to their babies—frequently without support from a medical team who understands their unique issues—can be traumatized by these experiences. The final outcomes, even when they are considered positive outcomes, are ones that these mothers are not prepared for—such as babies who require oxygen at home or who need tube feedings. For example, an 8-month-old Caucasian infant is followed both by CAMP/YMC and Pulmonary Medicine due to chronic lung disease. By the time she was 6 months old, the baby had been hospitalized 6 times and ultimately was determined to need oxygen at home. Her mother, a 17-year-old, has had difficulty recognizing the signs that the baby is struggling with breathing or understanding the critical necessity of oxygen, and often removes the nasal cannula because she thinks the baby doesn't like it.

The vast majority of pregnancies in CAMP/YMC are unplanned and unwanted. The patients who choose to continue their pregnancies must deal with altered relationships with partners and family members, particularly when their parents were unaware they were sexually active or their partners want them to terminate their pregnancies. Many of the activities they participate in—parties, drinking, drug use—must change as a result of the pregnancy, which ultimately may mean changes in social interactions and peer groups. In short, the pregnancy itself causes huge losses in multiple areas. In addition, the pregnancy may also bring up issues around previous sexual traumas, and retraumatize the patient as she is once again faced with an experience of her body that she cannot control. In response to these challenges, CAMP/YMC provides integrated mental health services with obstetric, specialty, and pediatric primary care services, leading to better outcomes for adolescent parents and their babies.


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KATHLEEN FITZGERALD RICE and BETSY McALISTER GROVES

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