Historical Trauma: Supporting Mental Health in Head Start and Early Head Start Programs

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Maria Eugenia Vazquez Betancourt: Welcome, everyone. Welcome to our Facebook Live session called Historical Trauma, Supporting Mental Health in Head Start and Early Head Start Programs. I am Maria Eugenia Vasquez Betancourt, training and technical assistance specialist at the National Center on Health, Behavioral Health, and Safety. I will be your host today during this session.

I'm accompanied by our guest speaker, our colleague, and partner, Dr. Brenda Jones Hardin. She will be talking about the meaning of historical trauma and ways we can navigate traumatic racial experiences with staff from Head Start and Early Head Start programs. Now, I'm going to let Dr. Jones present herself. Dr. Jones?

Brenda Jones-Harden: Hello, everyone. I'm so happy to be a part of this session. Head Start is dear to my heart and my head. Anything I can do to help – and this particular issue, I think, is critical for us to consider as we move toward helping children of minoritized backgrounds get the kind of supports they need to have a positive developmental trajectory.

As I often say, my day job is at the University of Maryland, where I'm a faculty member teaching early childhood educators, teaching social workers about the import of early childhood development. But I also like to say my real job is working with programs like Head Start to be the best they can be for the children they serve.

Maria Eugenia: Thank you, Brenda. I'm really excited having you today, and for me to be the host is a great honor. We're going to be discussing today trauma-informed care and historical trauma and discuss how these concepts relate to Head Start and Early Head Start services. Our conversation is really intended to raise awareness about staff wellness and mental health and reduce barriers of bias.

Before we jump in, we want to recognize what a big topic this is. We only are going to be spending about 15 minutes together, we're just going to be kind of scratching the surface today. Because of that, I will encourage you all to review many sources available to explore this topic further. We encourage you, listeners, to explore those resources on ECLKC – and in MyPeers community – and also on the Center of Excellence for Mental Health Consultation.

For some people, talking about mental health challenges or concerns as taking place within the individual, without taking into account the factors of that person's history, that child's history, the history of the children's family, for example, the context and the environment. For that end, Dr. Jones, how do historical trauma and experiences of inequity impact mental health?

Brenda: Sure, very, very critical question. First of all, let's think about some definitions. When we think about historical trauma, we really are talking about trauma that transcends the generation. It's happened in a multi-generational way.

It's usually trauma that is specific to a particular group. For example, African Americans, I know the most about because I come out of that culture, but also because the majority of the families with whom I work are from African American cultural groups. Although I do work a lot with families who are Latina, also. You have to think about what those multi-generational experiences have been like for a particular group. You can't really think about it across groups. It's really about within that particular group.

Let's focus on mental health, since we're talking about mental health awareness. It's very, very complex because sometimes, the disparate experiences have different kind of implications. For example, there is research about the under-diagnosis of certain kinds of mental health disorders for African Americans and other minoritized groups.

For example, think about autism spectrum disorder, which is certainly something in early childhood mental health we think about a lot because that's when children typically are diagnosed, in the early childhood years. Well, we know that there is an under-diagnosis of African American children. Not only do they not as often get the diagnosis, but when they get it, they get it later. Also, we know that when they get the diagnosis finally, they are not given the same types and quality of services – early intervention services and beyond, that children from white families are.

You see how complex it is, but on the other hand, there are certain kinds of mental health challenges that are over-diagnosed among African American and other minority groups. For example, we know that African American male children in particular are much more likely to be over-diagnosed with behavior problems and much more likely to receive a more punitive response from whatever child-serving system they happen to be in because of that.

Then we look at Latino children a little bit, and we see lots of under-diagnosis in that group as well. Now certainly, people have talked about the Latino paradox, and how even though Latino children might be experiencing poverty, they tend to have better outcomes, but from a mental health perspective, what we know is oftentimes, those children are undiagnosed.

That means if you have an internalizing disorder – which more often is under-diagnosed because most times, people are concerned about kids with behavior problems and things like that – but Latino children who might be experiencing depression, for example, or depressive symptoms, were not as likely to diagnose those children. There's some research that that happens with Asian-American kids as well.

What we have to think about in the mental health sphere, at least, is whether these children are getting adequately screened, whether they're getting the type of diagnosis that is appropriate, and then whether they're getting access to the type of treatment that – we know from evidence – is best able to help them with those mental health challenges.

Maria Eugenia: Yes, Dr. Jones, I'm so glad that you just brought up the part of psychological effects of historical trauma in children, specifically. Saying this also gets my attention. I'm thinking of what may be the patterns of disciplining and other processes that can be related to historical trauma experiences for children?

Brenda: This is a very complex issue as well. We know that historical trauma leads to certain ways of being, certain ways of parenting that become an ingrained part of your culture. People don't wake up and say, "I'm parenting this way because of historical trauma. "They wake up and say, "I'm parenting this way because this is how I was parented, this is what my grandmother did with me."

That's how you learn how to parent, in the context of how you were parented. Although many of us try to look to the research and go on websites and try to learn better ways – particularly in times of distress – we resort to what we know. What we know is how we were parented ourselves.

I think these cultural ways of parenting – and this is something that I really worked hard on in my own work, particularly with groups outside of my own cultural group, because it is so critical to enter that way, where you say, I am validating who you are. I am validating your cultural way of being. I am validating and appreciating your cultural way of parenting.

You can't go in there and say, "How you discipline is wrong, or how you feed your children is wrong. " You can't go in there that way as a clinician. You go in with humility. You go in and say, "Help me to understand why this way of being is so important to your culture." and thanking them for helping you to understand.

If you think about African American parents, they are worried about their kids' survival. You think about some of the police violence and some of the peer violence in communities. African American parents emphasize things like compliance and conformity to rules and things like that because they want their children to survive, to survive past adolescence.

Those kinds of outcomes that you don't necessarily see in majority families are critical. I think what we have to do as clinicians is join families in those outcomes, say, "I get it." I know you want your kid to listen to you. When you say, "Don't go down there where those other kids are," you want to know that they're not going to go.

Let's think about how we can reach your goal, how we can do the best we can to keep your child safe. That's where I always start with families. You can think about eating, too. Certainly, if you think about historical trauma and what we know about African American families, well, first of all, we know that there's a really high correlation between poverty and being African American in the United States.

The things we know about food insecurity, for example, which we're measuring a lot in the last few decades – think about if we had measured food insecurity throughout the 20th century. We would have seen even higher rates of food insecurity among African American families. You can imagine from a historical trauma perspective, again, with this idea – you want your children to survive particularly past infancy and early childhood.

You want these children to eat. You might say, "Oh, the pediatrician says all they need is formula and breast milk until they're 6 or 12 months. "You go, "Right, no way. I want my child to be robust. I want them to be fat. I want them to survive." You might start introducing solids probably earlier than the AAP says you should. You might be doing other kinds of things that really seem inconsistent with what we recommend for families.

Again, I don't go in saying, let's follow the AAP guidelines. I go in and say, "What's your goal for your child? Yes, I get it. You want your child to be robust. You want your child to survive. Let's think about what your child needs."

"Let's think about what you can do for your child to make sure that he gets there." Again, I'm acknowledging their goals. I'm acknowledging their cultural ways of being, and I'm using that to link it to some of the things that we hope we can help parents with.

Maria Eugenia: I'm just thinking about the part of – we all know that Head Start heals. Head Start strives to always look for the healing process. In that term, how can you understand or address insensitive healing process or healing ways for this?

Brenda: Sure, but let me start by saying that clinicians are healers. We use our relationship with parents, families, and children to help them feel better from a psychological perspective. That said – and I want to get to that a little more – but I want to say at the outset that I think our responsibility to the groups with whom we work in Head Start, which are primarily families from low-income backgrounds and minoritized backgrounds.

Although we serve a lot of children who are from majority backgrounds who are low-income as well, we have to pay attention to the structural issues that give rise to these experiences of trauma. We have to pay attention to that. I think we would be remiss as clinicians to think that that's somebody else's job.

We have to think about what poverty does because – there's one of my favorite lines from one of Gandhi's books about, poverty is the worst form of violence. In other words, we have to think about poverty as a traumatic experience that compounds the historical trauma that a lot of minoritized groups have experienced.

We have to think about what that means, how it puts families in socioeconomically and racially-segregated neighborhoods, where their children are more likely to be exposed to community violence, and inadequate schools after they get out of Head Start, and poor quality housing, and the lack of a critical mass of adult and positive peer mentors – all these things that end up affecting families.

As clinicians, we have to pay attention to that. We have to recognize it. We have to talk about it with families in our clinical work. But we also have to advocate for a different set of experiences. And I mean our ethical obligation to advocate writ large for social change and the reduction of child poverty and all those kinds of things.

I also think in our clinical work – in my mind – you can't work as a clinician with families from low-income backgrounds without attending to these structural things that affect them.

In Head Start, we're very fortunate that we have a group of family engagement staff who can help us think about, can we make sure that, if there are housing issues, that kids are exposed to lead, that we're doing something about that, that we're complaining to the landlord, that we're calling the housing office in the city, those kinds of things.

We have to do that because otherwise, our clinical efforts will be for naught because we're just putting a Band-Aid on a problem that's much bigger. That's … I really feel it's important to say

that at the outset because those environmental experiences end up leading to some mental health issues that really are a concern for us.

For example, we know that women from low-income neighborhoods are much more likely to be depressed. In the Early Head Start study a few years ago, they found at the beginning of Early Head Start entry, I mean, these were when mothers have babies. They were struggling, but the rate was like, one out of two women were reporting.

We know that people tend to under-report, but these were reporting clinical symptomatology of depression. When they finished with Early Head Start, it got down to about 1 to 3, 1 out of 3. Still, that is epidemic proportions when you think about the typical population and the rates in the typical population.

We got to do this because those structural factors affect mental health. I wanted to say that at the outset. To get back to your question about healing and what we do in the context of our work, again, I think humility is the word that I want to keep raising. I know we talk about cultural competence and all these kinds of things.

I'm not sure that I ever would say that I can be confident about all the cultures in the world. I can be a student of those cultures. I can be a humble partner with my families to help us think together on our healing journey together about how their culture affects their well-being. I can't be competent at every culture under the sun.

I want to start with that word of humility. Then I want to start from really validating, validating, validating what families bring to us about historical trauma, about current trauma. Because we know that families who've experienced historical trauma are more likely to experience contemporary trauma.

I want to validate that they're willing to trust me with this knowledge. We are holders of that knowledge together, as we think about the things that, as mental health clinicians, we think about.

Maria Eugenia: You were talking a lot about clinicians and infant early childhood mental health consultants and the programs, but also how we can encourage staff to engage and learn to break through their own discomfort of these conversations and be more sensitive about talking about trauma, historical trauma.

Brenda: The first thing I would say is that we have to be as self-reflective as possible. That's what I say to my social work clinicians that I am working on training now. The best clinician is the clinician who can reflect on themselves and how their own experiences affect their work.

The second thing – and I've learned this from a lot of my colleagues who do this work on inter-group relations and how to help children be more respectful of other groups – that staff has to be exposed to the breadth of families who are from certain cultural backgrounds.

As a supervisor, one of the things I would want to do is make sure that my staff had these experiences, but not only with the clients, but with people who defied their perceptions of certain kinds of cultural groups.

For example, if they're working primarily with families from low-income backgrounds who are African American, that they need to be exposed to middle class people in the African American community, or if they're working primarily with families who are low-income from Latina communities, they need to be exposed to middle class communities – really just having connections.

I think you can do this through professional development opportunities, but also through more informal opportunities among the staff. The other thing is really to help staff understand data. I'm a researcher. And I'm also a clinician. I like to think about how research can inform what we do.

There is a lot of evidence, for example, about implicit bias among even early childhood teachers, like Walter Gilliam's work and other people's work in that domain, where they look at how Black teachers and white teachers – it's not just white teachers – have this implicit bias against Black children, in particular, Black male children, and expect them to have more behavioral problems.

We need to be in touch with evidence like that – that teaches us that we have to really work against those biases – and try to understand even from a trauma perspective, why are children presenting those behavior problems? It's not just about my expectation that because he's a little Black boy, he's going to act out.

First of all, can I move beyond that expectation and really work hard to see those children as children who are growing and learning and active and all those kinds of things? I'm not going to start from my misguided perception that they're going to be problematic, but also, I'm going to value what they bring.

If there are children who do present with these behavioral problems – and there should be a small percentage, really – I'm going to try to understand the reason behind it and not react in a punitive way.

I also want to say something about teachers' relationships with parents – because in early childhood in particular, it is really important that teachers have a solid relationship with parents. As clinicians, we're sort of trained to understand that and bring them in and help them think about home, school linkages, and how they can support the child's positive behavior at home, and all those kinds of things.

We have to say to parents as staff in Head Start programs that we're going to give you – and when I say, I mean in our behaviors and our words. "We do not see you as the world might see you." "We see you in a very different way." "We see you in a positive way." "We value you." "We care about you." "We want you to be the best you can be in your own life and the best you can be for your children."

Jeree Pawl, who was a famous infant mental health person, called it, "providing parents with an emotionally corrective experience" to let them know that we're not there to devalue them, to sort of punish them for what they've done with their children. We're there to celebrate them and to help them reach their own goals for their children.

If you ask any parent, their goals are for their children to be the best they can be. We're joining them with that goal and really trying to use the strategies that they have – along with the strategies we have – to reach those goals for their children.

Finally, I think we have to acknowledge that these are thorny issues and no matter how well-trained we are or how long we've been in the field, we constantly need help with these thorny issues that elicit emotional reactions. They just do. That's just part of what these issues are. When we think about trauma, many of us in the field have experienced trauma. We know that from the ACE's literature.

We also know that many of us have experienced racism and segregation and discrimination, either directly or vicariously. What happens is we get emotionally aroused about these kinds of situations. We don't even know that we're acting out that emotional arousal in our work with children and parents. All of us need supervision, whether we're teachers, or family engagement staff, or clinicians. We need reflective supervision that allows us to think about how our notions of trauma, how our notions of racism, how our notions of discrimination, how our notions about how we think about the other.

Let's put even discrimination aside, but how we think about the other – how these things are operationalized, activated in our engagement with children in the classroom and our work with parents in their homes, and our decisions about how our Head Start centers would be implemented. We have to think about that.

We have to have a safe place for it where we know we're not going to be penalized for being honest and authentic about our feelings, and where we can really use those safe spaces to move to interventions for children, whether they are clinical or educational or family-centered or home-based or center-based. Where our interventions for children respect who they are, respect the families where they come from, respect the fact that trauma is insidious and stays across generations – and as we know from some of the physiologic research now, gets under the skin, lives in our bodies, in children's bodies, in mothers' bodies.

We have to understand that and use that knowledge to be – just like we're asking parents to be the best they can be for children, that we can be – the best we can be for children and for the parents who are intimately involved in their positive developmental trajectories, and will be there even after the children are out of Head Start programming.

Maria Eugenia: Thank you very much, very much, Brenda, for such an informative conversation, for the great examples, considerations about historical trauma that are going to work with children and families, and all the great strategies to approach this difficult topic of trauma, historical trauma, and all these experiences.

Thank you all for joining us today in this session. I said goodbye for the day, from the National Center on Health, Behavioral Health, and Safety. Remember that for more information about talking with staff and families, check out the links to resources in our notes from this session.

Remember to share any questions or comments into the chat box, to which we'll be responding shortly today. Thank you, Brenda, again. Thank you very much. Thank you once again.

Brenda: Thank you, Maria Eugenia. Good to see you.

Maria Eugenia: Same here, good to see you.