UAIMH Newsletter

Utah Association for Infant Mental Health

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http://www.uaimh.org

President's Corner

As UAIMH approaches the 10-year anniversary marker, a brief review of our history, mission and aims, as well as our current activities may be helpful to the reader.

The Utah Association for Infant Mental Health was created out of the need to keep awareness of infant mental health to the forefront of pediatric care and service delivery following the work of the 2001 Expanding Options for Infant Mental Health statewide initiative. In 2003, Janet Wade, at the time representing the Baby Watch Early Intervention Program, was instrumental in working with the World Association for Infant Mental Health (www.waimh.org) to bring affiliate status to Utah. Since its creation, the Utah Association for Infant Mental Health (UAIMH) has attracted many knowledgeable professionals to its board. The founding board members were: Adrienne Akers, M.S., R.P.T.; Glenna Cooper Boyce, Ph.D.; Ilse de Koeyer, Ph.D.; Kristina Hindert, M.D.; Mark Innocenti, Ph.D.; Aziele Jenson, M.Ed.; Janice McCaffrey, M.S.W.; and Nick Tsandes, L.C.S.W. Janet Wade acted as executive secretary taking care of all the administrative duties. Janet and Ilse continue as active board members. Over the years UAIMH has sponsored two full-day conferences featuring national speakers and several mini conferences.

Our mission is "to promote a unified understanding of infant mental health across disciplines and programs..."

Dr Ilse DeKoeyer-Laros provided the following information about past conferences and our upcoming event.

"For example, we held a highly attended mini-conference on sleeping problems with Martin Maldonado, MD, who has worked with the Kansas Association for Infant Mental Health. Another successful mini-conference was held with Suzi Tortora, Ed.D., BC-DMT, C.M.A., LCAT, LMHC. Suzi is a world-renowned expert on movement and nonverbal expressions and the role they play in mental health. She gave a very interesting presentation on how we can use nonverbal means to connect with and help young children. We have also organized several smaller events, such as a delightful meeting with the late Dr. Agi Plenk, who shared with the UAIMH community how she came to Utah, saw great need in the population of young children, and founded The Children's Center. Currently, we are organizing a workshop on January 12 with Dr. Shefali Tsabary who wrote the highly acclaimed book The Conscious Parent. Dr. Tsabary will present the model of conscious parenting, talk about how professionals can support parents in parenting with more awareness, and show us how to become more mindful in parenting."

Contents

What is Infant Mental Health (IMH)?

Infant mental health is reflected in appropriate cognitive, social, emotional, and physical development, while recognizing the unique characteristics of each infant and family, their circumstances, and culture. Infant mental health changes and develops within the context of relationships between infants and caregivers, families, communities, and cultures. The importance of IMH is evident in these descriptions. Good mental health for children (0-5 years) is characterized by:

- Secure attachments
- Positive relationships
- Confidence
- Curiosity
- Effective communication
- Increasing self-regulation
- Social competence
- Self-awareness
- Expressions of love and happiness

What is our mission and how do we describe our aims in promoting IMH?

Our mission is "to promote a unified understanding of infant mental health across disciplines and programs and to develop a statewide system of resources in support of infant mental health for all families living in Utah." UAIMH aims:

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- To promote the understanding of infant mental health issues and the development of programs to enhance infant mental health.
- To discuss and share questions, problems, issues, information, and theories regarding the mental health of infants, their parents, families, and other caregivers through meetings and other formats.
- To disseminate research and to educate health care professional who study and/or care for infants.

How do we promote Infant Mental Health?

We work towards these goals through active community connections: starting with our Newsletter, community partnerships/planning committees and sponsorship of pertinent conferences and workshops.

We are now on Facebook, thanks to Dr. Ilse DeKoeyer-Laros' work. http://www.facebook.com/UtahIMH.

Our longstanding website continues and is in process of reconstruction. http://www.uaimh.org

Judy Ahrano Kittel, MD, developmental pediatrician, past UAIMH president, and current UAIMH Newsletter Editor and contributor, is also active in the medical community to address and support mental health in daily pediatric and family practices.

I am presenting on *Reflective Supervision* at the Early Education Conference on November 1, 2012. Reflective supervision promotes mindfulness in our practices and provides strength-based support, reflection, and renewal as we work with children and their families. (UAIMH Newsletter: Reflective Supervision: Issue 17, Spring/Summer 2012)

In January 12, 2013, we will have an opportunity for continued study of mindfulness in our family relationships and work practices. UAIMH is sponsoring Shefali Tsabary, Ph.D., for a conference—open to parents and professionals—on her unique conscious parenting style http://theconsciousparent.com/. We hope to see you there.

Susan Dickinson, MS
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The (Un)Conscious Parent

In the middle of the kindergarten playground my almost 6-year-old was having a meltdown. I cannot recall what it was about exactly, but I remember his despair and my own inner thoughts and sensations. He was crying passionately about something, but anytime anyone was asking what was the matter, all he did was shake his head vehemently and cry, "No, no, no." When I tried to talk to him—same reaction. The more I tried to engage him in sensible conversation, the more he started to cry, thrash his arms around, and shake his head. He dropped himself to the ground and stayed there…

Inside of me, a whirlwind of feelings and thoughts emerged. Some were based in empathy and my desire to help, "Why is he so sad?" "How can I help him?" "What should I do?" Others, though, came from a darker place—that of my own anxiety and fears. "This has to stop; people are staring at us." "He is too big for this now." "O, my gosh, I feel ashamed of myself; I should be a better parent." "It's my fault, I should have taught him better emotion regulation skills." In my body, my heart was racing, breathing becoming shallow, and a blush on my cheeks. Help!

Then, it suddenly dawned on me—stay calm and it will help him calm down as well. Do not be worried about others' reactions, or it may feel to him as if you are rejecting him. I paid conscious attention to my own breathing, calmed myself down, and just held my child. I reminded myself that he was more important than what others might be thinking. Still upset, he now started to tell me the story. He was worried about a friend not being his friend anymore, and somehow did not want to leave the playground (I guess he thought that the problem might be solved there, but not if we left). I just sat with him, listened, and continued to work on keeping my own body relaxed and calm.

You might think it is not rocket science that a parent should stay calm in order to calm their child. Surely, this was not the first tantrum he ever threw. Indeed, I am aware (cognitively) of the importance of teaching children emotion regulation. I know that a parent should stay calm in the face of distress, in order to teach the child that this, too, shall pass and that it is not horrible to feel engulfed by emotions. Likewise, I know it is essential to set clear boundaries and maintain clear rules as a parent. I know all of this—but not at all levels. I have a lot of academic knowledge about child

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development: how children learn, how they relate, how emotions are the bedrock of development, and how relationships are what children develop out of as independent beings. Logically speaking, I know that the basics of good parenting amount to "love and limits." Yet, this is not the whole story. There is another type of "knowing" that lies deep down and that we are not necessarily conscious of: the knowledge of how things used to feel when we ourselves got upset as a child; the bodily memory of feeling engulfed by emotions and not seeing any way out of them; the feeling that the world was going to end right there and then, in the midst of all of this distress.

Yes, I have grown. I have been educated. I thought I had left those feelings behind me, for the most part, and that I would be able to deal with any of them that would still sneak up. But then I had my baby. Since then, I know—those feelings (the ones we had as children but never really were able to process fully) do not just go away on their own. There is no better way for them to re-emerge as by having to deal with your own infant's distress. Again, education does help; knowing that this is something to expect can help a new parent to prepare somewhat; use techniques to stay calm; practice soothing techniques and later limit-setting techniques. Libraries full of parenting books have been written about parenting techniques and they are very valuable. However, all the techniques in the world still cannot prevent old childhood pain from surfacing at the distress of one's own baby. These are the famous "*ghosts in the nursery*," as described by Fraiberg and her colleagues. How are we ever going to be able to chase these ghosts away?

...The basics of good parenting amount to "love and limits."

One answer would be therapy; the kind of infant mental health therapy described by Fraiberg and many others since. However, such therapy is difficult to come by and generally only used for those for whom the ghosts are most stubborn. Other parents, who are aware of their ghosts but still not fully conscious of how and when they enter the parent-child relationship in the here and now, can turn to parenting classes or parenting books. Yet, without awareness of what stands in the way, techniques can be applied but can they break the pattern? They may for some, but not for me. So after attempting to apply my knowledge, after trying to learn new techniques unsuccessfully, finding Shefali Tsabary's book *The Conscious Parent* came as an epiphany for me. She writes,

> *"Whether we unconsciously generate situations in which we feel the way we did when we were children, or we desperately struggle to avoid doing this, in some shape or form we inevitably experience the identical emotions we felt when we were young. This is because, unless we consciously integrate the unintegrated aspects of our childhood, they never leave us but repeatedly reincarnate themselves in our present, then show up all over again in our children." (Tsabary, 2010, p. 15)*

Unearthing unconscious reactions by observing myself with consciousness is an approach that speaks to me deeply. It is a difficult task. After all, how can I see what I am not aware of? However, clues are offered. Sometimes, a perceptive other adult can point out the effects that a particular parent has on a particular child ("See how she clammed up as soon as you mentioned her failure at her math test?"). However, our best teachers are our children themselves. My son frequently gives me feedback, "Mom, your voice is starting to sound angry" or "Mom, you are starting to have that face again; you look mad." These observations come even before I myself am noticing the increased strain in my voice and face. Of course, preverbal infants and young children are not yet able to express themselves so eloquently. However, they show other signs that can awaken us: a sudden frown on their face, a cry, or even an angry push that they send us. Accepting these behaviors as a gauge (in our children) of our own inability to stay calm does not mean that we should accept all behaviors; we can make clear that aggressive behaviors are not acceptable. At the same time, however, we can still remain open to what our children are telling us about our own ghosts.

"Mindful parenting" consists of parents bringing moment-to-moment awareness to the relationship with their children.

Since recent research has started to come out to support the potential benefits of mindfulness practice for our health and well-being, and the practice of mindfulness is even being applied to parenting research. Duncan, Coatsworth, and Greenberg (2009), for example, propose mindfulness as an important ingredient of optimal parenting that can be integrated into existing parenting programs. They suggest that "mindful parenting" consists of parents bringing moment-to-

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moment awareness to the relationship with their children. This is basically the same as what Dr. Tsabary means by "conscious parenting." Duncan and colleagues further propose that parents do this by "developing the qualities of listening with full attention when interacting with their children, cultivating emotional awareness and self-regulation in parenting, and bringing compassion and nonjudgmental acceptance to their parenting interactions" (p. 255). Other research has found that long-term mindfulness practice engages frontal cortical structures in the brain, to dampen automatic activation of the amygdala (which resides in the "emotional brain" or limbic system; Chiesa, Brambilla, & Serretti, 2010). In this way, parental emotion regulation is enhanced and parents can learn to refrain from immediate emotional reactions, which is an essential parenting skill. It does not come naturally to everyone! Mindfulness is not a magic word; it does take practice. It might help to practice in a group, or to be guided by a therapist. However, by becoming more mindful (or conscious) parents, we can finally come to meet our ghosts and let them go…so they no longer stand in the way of the uniqueness of our relationship with our child(ren).

On that beautiful spring day, after my son had his tantrum on the playground, I gently coaxed him to start walking away from school, consciously paying attention to the sensory experiences in the world around us. "Look, an ants' nest. Let's see what the ants are working on." "Hey, look at those beautiful flowers. See their colors. Shall we smell them?" Slowly, he regained his connection to the immediate world around him and his composure of his own emotions—and so did I. All the while we were sharing experiences. Practicing conscious parenting during this episode also helped me to remember this particular episode so vividly (I was not dissociating from the distress). I know other challenging moments are ahead of me in the journey of my parenthood. But I know now that change is possible. Children are truly able to wake us up and help us develop into better parents, as long as we are willing to listen.

...Our best teachers are our children themselves.

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Practicing Brazelton's Touchpoints: The Intersection of the Intentional Caregiver and the Conscious Parent

The title of Dr. Tsabary's book *The Conscious Parent* reminds me of a term that has come into vogue in the early childhood world in the past few years, The Intentional Teacher or Caregiver. The book jacket for *The Conscious Parent* states,

> *"Dr. Tsabary shifts the epicenter of the parent-child relationship away from the traditional parent-to-child 'know it all' approach to a mutual parent-with-child relationship in the parent learns alongside the child…. Instead of being merely the receiver of the parent's psychological and spiritual legacy, children function as the ushers of the parent's development."*

Similar in tone to conscious parenting, the practice of intentional teaching also rises from internal desire to make a difference in the lives of children by being in relationship. It goes well beyond just getting through the day, completing a checklist, or "covering" certain activities or curricula. This desire to make a positive, meaningful difference, coupled with a healthy ego that can withstand the uncertainty, not always being right and not always knowing what will happen next, allows for being in a "power with" relationship with a child rather than a "power on" relationship. The younger the child, the more critical this is as their own concepts of self are still being formed largely based on the reactions of and interactions with the (m)other.

At the intersection of the intentional teacher/caregiver and the conscious parent lies Dr. Barry Brazelton's *Touchpoints.* Brazelton defines Touchpoints as "universal…predictable times that occur just before

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a surge of rapid growth in any line of development—motor, cognitive, or emotional—when for a short time, the child's behavior falls apart." As he described, "The child often regresses in several areas and becomes difficult to understand. Parents lose their own balance and become alarmed." Brazelton views the Piagetian flow of equilibrium and disequilibrium as something that happens to both children and parents in relationship to one another. The role of the doctor, caregiver, or other service provider is to support the parent-child relationship as these natural, predictable ebbs and flows occur. Rather than demonizing the parent or child or even instructing, advising, or fixing anything, the consultant/caregiver really hears the parent as they relate both information and emotion. Their task is to help the parent stay afloat in their changing relationship with the child as they navigate through these more difficult periods. Coming from a foundation of relationship, based in seeing the parent's needs as well as the child's, and offering a means to self-reflect on the experience of parenting, Brazelton's Touchpoints method becomes the vehicle of communication between the conscious parent and the intentional caregiver.

The role of the doctor, caregiver, or other service provider is to support the parent-child relationship....

This book first published in 1992, like many other of his publications, has become a cherished point of reference for many parents and caregivers. It has also sparked a trademarked curriculum that has made its way to Utah and is currently offered through six regional child care resource and referral agencies. These courses review developmental milestones, but also model how to be in relationship with parents as we share the unfolding development of their child and the predictable undoing of a harmonious parent/child relationship. The instructors have visited Boston for a week-long training working with Brazelton and his colleagues to learn method more than content. Each course has a visit from a parent and child when the instructor gently demonstrates an interview technique. Without being didactic or rushed, and by observing the child and his/her interactions with the parent, the instructor notes the children's development and opens the parent up to discuss their emotions about this and the effect on the parent and family. Often pertinent topics or questions emerge from the parent's narrative that allow for support and/or resources to be offered in a natural, parent-initiated framework.

Trying something new is not easy—for parents or caregivers. The old adage defining stupidity as doing the same things and expecting different results has some truth to it, but sounds harsh to me. Especially when things are not going well or seem ineffective, we must really take the risk to try something new. However, our reluctance most likely signals fear or something less than intentional, conscious caregiving/parenting. The key word is **practice**, as in trying to learn a new skill through repeated effort. So we practice conscious parenting. We practice intentional caregiving. We practice using Touchpoints in our work. I do not disbelieve another old adage, "Practice makes perfect." When what we are practicing involves close-up, personal interaction with humans large or small, the complexity rarely, if ever, results in perfection. I do believe practice can make better and that practice can make bolder. Practice, it is an expectation I have for myself, my colleagues, and parents everywhere as we look for better ways to care for young children.

I believe that practice can make better and that practice can make bolder

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Pediatric Corner

Mindful parenting of a child is a challenging endeavor. The challenges are witnessed daily by pediatricians in their practices and may be experienced by themselves in their own families. In a sense, the principles of mindful parenting are analogous to the pediatrician's role of fostering, mentoring, and supporting parents in their work—even when situations and patterns of responses have escalated toward abusive parenting. Mindful pediatric care in the context of the family requires a special consciousness on the part of the pediatrician. In every encounter the pediatrician should be mindful of their own biases. This requires an honest awareness of one's own experiences throughout childhood with parents, other family members, and friends. There may also be memories of encounters with their own pediatrician and other physicians and mentors along the way

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We cannot care for the child in a vacuum but can only adequately care for the child in the context of the child-parent relationship. In some situations that may mean assisting the parent in getting whatever support they need to be successful. A major portion of pediatric practice, supporting the healthy growth and development of a child, involves knowing, understanding, supporting, and mentoring the parents to perform well the most important vocation of their lives.

Research has indicated that parents are aware of what their children's pediatricians *do not* ask in a well-child visit, and the parent leaves feeling that the problem has not been addressed. Often parents are afraid to bring up their difficulties with parenting as they fear losing the professional's positive regard for them. At the same time, parents yearn for their trusted pediatrician to provide a compassionate context in which they may speak openly and safely of their own personal difficulties with parenting their child. If the pediatrician does not act on a hunch or subconscious instinct, inviting the parent to disclose their own feelings, difficulties, guilt, sense of failure, the parent will not be likely to bring up their concern. A precious opportunity of preventive mental health care for the child and the family will have been missed (Rhodes et al.,2012).

Often parents are afraid to bring up their difficulties with parenting as they fear losing the professional's positive regard for them.

The pediatrician is in a unique position to form this kind of supportive relationship due to recurrent frequent visits required from birth throughout a child's growth and development into adulthood. However, if the pediatrician does not take this opportunity to encourage the parent to be open about difficulties, that opportunity will be missed. This is an essential part of the health care of the child. Given the press of time in the average pediatric visit, it is incumbent upon the professional to pay attention to their own instincts/hunches and to ask/comment in a nonjudgmental concerned manner. This gives the parent/caretaker an opportunity to disclose their own conflicts and difficulties in a safe atmosphere. This invitation may provide the only information that can elucidate the forces molding a child's reactive behavior. Unless the situation is dealt with compassionately, sensitively, and competently, the Pediatrician will have missed a beautiful opportunity to prevent devastating damage in the child's rearing. If this opportunity *is* missed, the pediatrician is likely to, in a sense, lose the family—failing to protect the child and missing the opportunity to foster emotional/behavioral healing for all.

The optimal way to manage the situation is to provide an atmosphere and sense of caring that is conducive for the parent to safely confide in their pediatrician and for the child to feel they have an ally. The pediatrician can then support the parent to take corrective steps—even if it requires reporting themselves to the authorities alongside their pediatrician. This then provides a setting and an impetus for healing to take place for the parent, the child. and their relationship.

On one occasion a mother came into the office with her latency-age child. The chief complaint was that of acute unilateral ear pain. Upon examining the ears, the painful one had a linear rupture of the eardrum with no middle ear effusion, erythema, or congestion present. There was a small amount of blood in the ear canal from the rupture. The boy was very quiet and gave no information about anything that had happened to him. When I turned to the mother with a questioning look and asked if he had had any injury to his ear of which she was aware, the mother began to cry. At that point she divulged that she, in anger, had cuffed him hard over the ear with her cupped hand, not knowing that she could damage his ear drum. The injury was clearly an acute rupture from the force of the blow. The mother apologized to her son and told him that she had done something that was wrong. She was very ashamed and saddened that she had hurt her child in anger. I explained to the mother that the ear could be repaired and we would work on improving the relationship with her son. We now shared the responsibility to report the incident to child protective services. I suggested that we do it together. We both got on the phone line and called DCFS together. The mother explained what she had done. The worker asked her a few questions and talked with the son, asking him some questions. The worker then told the mother that it was good that she called to report this herself and advised that if she ever got to the point again of feeling

...Provide an atmosphere and sense of caring that is conducive for the parent to safely confide in their pediatrician...

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so angry she was afraid of physically hurting her child, she should call this same number and get help from a counselor before she got to the point of doing something she would regret. I explained to the worker that I would continue seeing the family regularly in the office and would be following up closely with the mother and son. Mother and child left the office on the path of beginning to heal the rift in their relationship, both relieved and each feeling the genuine care of others in their struggles. Respectful, supportive management of such an incident promotes self-reflection and change for both parent and child.

It is a real challenge for the pediatrician to handle this kind of problem adequately in a 10- to 15-minute office visit. However, think of the hunches that have not been pursued and what would be missed by not dealing directly with one of the most critical aspects of pediatric practice—the parent/child relationship. Here are some suggestions from practice. Stay tuned to your "gut" feelings—do not ignore them, push them away, or move on quickly to another topic, but follow your "gut" with gently verbalized observations/questions for clarification. Ask many questions. "What do you think your child is trying to communicate to you"? As the child, "What do you want your parent to know"? Verbally empathize with the child's and the parent's feelings in a personal way so that they perceive you as being on their side. Offer alternative suggestions as a way of helping the parent and child problem solve by asking, "Have you tried this"? "What would you think if…"? "What if you tried this"? "What if it was like this"? "What-if" questions create novel thinking. Model this for the parents and the child in the visit. Stimulate conversation between parent and child, starting in the moment in the office. Ask the child, "What would you like for your mom/dad to do when she/he is upset with something you have or have not done"? "How would you prefer that your parent ask you/tell you"? The next question for the child is "What would you be willing to do then"?

Stay tuned to your "gut" feelings—do not ignore them.... Ask many questions.

For a younger child, it is of course helpful to have toys and materials appropriate for different ages to draw pictures for self-expression, or to play out the experience while you are talking with the parent. A young child often uses creative play as a means of expression of some event, experience, or concern. Observation, without interruption, of the play while conversing with the parent is important and can disclose critical information. A whiteboard, with nontoxic erasable markers, can be hung in each exam room on a small blank wall at child level for both younger and older children. This a great tool for gaining access to significant aspects of a child's life (Dixon & Stein, 2005). Observe carefully what they have or are creating, while talking with the parent, then ask the child to tell you about their picture or construction. On many occasions, while the child and parent are waiting, the child will draw something that has significant meaning for them. It does not take long to ask a child to tell you about their picture they are drawing when it is finished. Often with an open-ended question the child will spontaneously divulge what their experience has been and how it made them feel. If they are reluctant to do so, the pediatrician may pose nonleading open-ended questions like "What is happening here"? or make somewhat vague open observations, in the form of a question, about what you see in the construction or drawing. I once learned, from a chalkboard drawing of an early elementary-age boy, that his teacher had physically hit him and knocked him down. The picture showed a large adult female figure with a large fist held straight out. Directly below the hand, on the ground was a little boy figure lying flat. When asked about the picture he explained in detail his experience. This was investigated and the teacher was dealt with appropriately.

Model this approach for the parent in your interactions with the parents and children. Follow with questions to the child "What would you rather have mom or dad do or say when he/she is upset with you or something you have/have not done"? Pose the same question to the parents so the child can hear. Suggest to parents that they should see themselves as a teacher/guide rather than as an enforcer. Necessary, absolute limits can be imposed for safety, but can be done in a matter of fact manner without an emotionally charged investment from the adult—unless, of course, it is a critical moment and the parent has to provide immediate protection of the child. If the parent does not feel good about how they have handled something, suggest that he/she say so to

Suggest to parents that they should see themselves as a teacher/guide rather than an enforcer.

the child and ask the child how they wished the parent had handled it. This will discourage their need to react impulsively. Encourage the child to say when *they* do not like something or it does not feel good to them. (You can have them practice doing this in the moment in the visit, with you present.) Then it can be explained by the parent with some empathic words like, "I know this isn't much fun but we can do it together…." Words to express feelings are, of course, far more positive and empowering than negative, out-of-control behavioral reactions. Suggest to the parents to not be reluctant to apologize and state their intent to handle things differently. Then the parent can require the same of the child, if he/she says something in anger that does not feel good. Model this yourself in the office if you have to do something the child does not like—such as a throat swab or an injection.

True empathy is a powerful ally and generates energy for change.

We have to be careful that our advice is complete and consistent, addressing the heart and soul of problems encountered and their solutions. Our task is to meet the needs of the multiple relationships involved by helping the parents the way we help their children—treating them with positive regard, respect, and compassion; acknowledging who they are and their experiences of being parented; acknowledging nonjudgmentally their mistakes; and encouraging/supporting them to meet their goal of being a "good-enough" parent (Winnicott, 1992). I have never met a parent without that basic desire, even though they may have made costly mistakes. True empathy is a powerful ally and generates energy for change. New knowledge about the effects of long-term toxic stress and ways to intervene to help bring about changes in child and parent interactions from birth, in every encounter during health and illness, are reason to reflect on our practice with the parent-child dyad. Consider how different we may feel ourselves about our work when we employ this approach.

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Announcements/Upcoming Events

October 29-30, 2012, Hilton, Salt Lake City, UT: ***Critical Issues Facing Children and Adolescents***.

November 1-2, 2012, Marriott, Provo, UT: ***Early Childhood Education.***

November 12-14, 2012, Layton, UT: ***Joining Forces: 25th Annual Conference on Child Abuse and Family Violence***. (Prevent Child Abuse Utah)

November 16, 2012 (9:00 a.m. to 12:00 noon), Hilton, Salt Lake City, UT: ***Summit on Trauma with Lt. Governor Bell*** --no charge to attend.

January 12, 2013, Time and Place to be announced: ***Conscious Parent by Shefali Tsabary, Ph.D.*** (UAIMH)

February 2013, Salt Lake Public LIbrary: ***Bridging the Gap.*** (The Children's Center)

UAIMH Website

The UAIMH website is being updated. Access continues to be via http://www.uaimh.org. You may join UAIMH or continue to renew your membership by:

1. Clicking on the "Join UAIMH" link on the left side of your screen and completing the *Membership Application and Questionnaire Form* on the UAIMH website, and then
2. Print and mail your membership form with your check for $10 made payable to UAIMH to the address below:

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