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President's Corner

The last few years there have been multiple local and world events that have threatened to undermine the sense of well being of families and children in America and around the world. These include active war, terrorism, economic depression, pandemic illness, and natural disasters resulting in hardship, death, injury, loss, and emotional distress. These events superimposed on poverty, domestic violence, mental illness, substance abuse, disability, and inadequately functioning families, have brought us all face to face with our vulnerability and the vulnerabilities of the least prepared of us—our youngest children.

In this issue of the UAIMH Newsletter, we have chosen to highlight a strength in overcoming catastrophe that can be forgotten in the experience of and attempt to recover from hardship. It is possible for the stress of hardship itself to provide the energy for creating even better solutions than might be deemed possible. The requirement for this process, for each person, is to have the capacity to meet a great challenge with "resilience."

What are the elements necessary to support a child's capacity for embracing a traumatic event in life with personal resilience? A central factor is the child's own characteristic temperament that may predispose a particular child to greater vulnerability or greater resilience or both. The next ingredient is the ongoing support of at least one consistent, emotionally responsive, caring adult during the first three years of life. Relatives, friends, teachers, pediatricians, who are emotionally supportive and encouraging, can also bolster the child's strengths and sensitivities and guide him/her in discovering individual unique capacities for positive action, to create something better out of something tragic. The third step is the development of the child's internalized experience, realization, and belief in his/her own potential to act--to do something for him/herself and others that moves a tragic experience toward a more positive outcome. These beliefs, labeled "I AM," "I HAVE," and "I CAN," are what give a child the strength to turn tragedy into something better. These beliefs are most consistently operational throughout life, if firmly established in the first four years. They are internalized, experience by experience, through even the simplest repeated early interactions with caregivers, during infancy and early childhood.

> *These beliefs...are what give a child the strength to turn tragedy into something better.*

Resilience is the essence of the ability to recover from and even thrive following trauma. We know that it is possible for families and their children to survive trauma and to thrive above all. What are the necessary requirements that instill the resilience required to overcome hardship and loss. This is what we hope to begin to communicate in this newsletter-which we dedicate to parents, their children, extended families, and those of us who work with children and their families.

Judith Ahrano Kittel, MD, FAAP
President, UAIMH

Suggested Reading:

Grotberg, E. H. (1995). *A guide to promoting resilience in children: Strengthening the human spirit*. From the Early Childhood Development: Practice and

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Military Families and Mental Health: Raising Young Children in the Face of Uncertainty and Separation

We are at war—in two countries—and most of us don't even think about it *because we don't have to*. We can just go about our lives as if nothing is happening. Because for most of us, it is almost as if nothing is. But for those involved, their lives have been turned upside down. Children are born while their fathers are away. Mothers are experiencing high rates of depression. Fathers and mothers are away from their children and spouses for a year (or more) at a time. Children are learning to walk, read, and drive, all without the presence of one of the most important people in their lives. Children are showing signs of this stress. How can we help them?

Since 2001, almost 1.9 million service members have served in Iraq and Afghanistan. The uncertainty surrounding deployments is quite stressful for families, as they often wonder and worry about their loved one's safety. As of April 2, 2010, 4,391 U.S. service members died for their country in Iraq, and another 31,762 have been injured in the line of duty, with 13, 951 of them not able to return to duty (http://www.defense.gov/news/casualty.pdf). Also as of April 2, 2010, 944 US service members died for their country in Afghanistan, and another 5,392 have been injured in the line of duty, with 3,059 of them not able to return to duty (http://www.defense.gov/news/casualty.pdf).

What is the effect of deployment, injury, and death on families? We do not know the extent of the effect, as there is little research available to understand what is happening to military personnel and their families (Committee on the Initial Assessment of Readjustment Needs of Military personnel, Veterans, and their Families, 2010). However, we do know that 10-25% of soldiers' returning from Iraq or Afghanistan are diagnosed with PTSD immediately (Department of Defense Task Force on Mental Health, 2007), and that 14% of soldiers' screenings indicate probable major depression (Schell & Marshall, 2008). We also know that deployment seems to be responsible for the increase in PTSD symptomology, and that more combat exposure is related to higher levels of PTSD symptoms (Vasterling et al., 2010).

What about the children? With more than 2 million military children (Flake, Davis, Johnson, & Middleton, 2009), we have reason to wonder the effect (seen and unseen) of deployment on them. Child maltreatment rates in military families doubled in the year after October 2002 compared to the previous year; for each 1% increase in deployments, the rate of child maltreatment increased between 28-31% (Rentz et al., 2007). Of families who had previously maltreated their children, rates of neglect were twice as high during deployment as when both parents were present (Gibbs, Martin, Kupper, & Johnson, 2007). When looking at a sample of children aged 5-12 who had a parent deployed, Flake and colleagues (2009) found 32% were at high risk for psychosocial issues. When looking at predictors of problems in children, the most powerful predictor was the remaining parent's level of parenting stress.

Child maltreatment rates in military families doubled in the year afer October 2002 compared to the previous year.

This finding is not surprising, since we now know that children's ability to display and regulate their emotions and experiences of stress seems to depend on early caregiving experiences and their relationships with their caregivers (Shore, 1997). In other words, the biology of the brain is affected by our early experiences with our caregivers. As such, as a country, we should be working diligently to buffer our military children by providing supports to military families who are experiencing deployment, who have experienced deployment, and

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who are stressed. After all, many military children will become our future military service members, and we want them to be the best they can be. Ensuring that children become the best adults possible begins early, before pregnancy even occurs. As we saw above, we can work through parents to help increase a child's likelihood of doing well, despite the challenges.

What can we do to help? There is much we can do, whether we believe that the wars are justified or not. An excellent resource is the ZERO TO THREE Military Projects Webpage (http://www.zerotothree.org, click on military projects). We can also get involved in community efforts such as Blue Star Mothers in Utah, the 4H clubs for military children sponsored by Utah State University, and just listen to the experiences of military families and offer our support. We can advocate for funding for research on military families and their children. We can just say thanks for the sacrifices our military members and their families have made.

Get involved in community efforts such as Blue Star Mothers in Utah...

When thinking of young children, there are many things we can do to build resilience:

- Respond to children's needs
- Provide consistent, predictable environments
- Adjust environments to meet children's needs
- Monitor pacing and timing of interactions
- Notice and talk about child's state
- Listen to children and reaffirm their feelings
- Talk to young children in simple terms
- Pick babies up when they cry
- Pay attention to cues given by children and respond appropriately
- Help children have fun!
- Catch them being good!
- Just be there!

Notice that the common factor in each of these suggestions is relationships. We can have meaningful, caring relationships with all children, not just our military children, and increase the mental health of our entire country. Now is a good time to start.

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Desarrolla y Edifica La Capacidad de Recuperación En Los Niños

This article is provided in Spanish and discusses the need to promote resiliency in our children and basic examples on how to do this, as well as encouragement for the parents, teachers, and other caretakers.

Nuestros niños son la esperanza del futuro, los que heredarán las riquezas y las pobrezas que dejemos nosotros los adultos al pasar de los años. Nuestros niños tendrán la responsabilidad de responder a los retos familiares, sociales y políticos del futuro. Ellos también comunicarán a sus hijos los valores de nuestra cultura, y la importancia de promover la paz en la tierra, el respeto por los demás, el amor al prójimo. Como madres, padres, abuelitos, y cuidadores y maestros de estos menores, necesitamos información adecuada y apoyo para aprender a promover la salud física, emocional, psicológica y espiritual en los niños.

Nuestros niños están expuestos a situaciones difíciles y traumatizantes, ellos también necesitan apoyo para poder desarrollar las herramientas para recuperarse del trauma y las crisis. Las investigaciones sociales han comprobado que aún los bebés, responden al trauma, y sus funciones físicas y emocionales y la capacidad de desarrollo se ven alteradas cuando sufren miedo, terror, separación de sus seres queridos ó están expuestos a desastres naturales que interrumpen la capacidad de los padres a responder al cuidado del niño. Terremotos, fuegos, cambios de ambiente drásticos, ruidos severos, violencia familiar, y situaciones caóticas afectan a los niños de manera significativa. El abuso familiar, el abuso sexual y las batallas campales en nuestros hogares causan problemas del desarrollo en los bebés, y en nuestros niños. Éstos problemas pueden retardar el dessarrollo físico, emocional y académico en ellos. Por ejemplo, los psicólogos han identificado tres períodos críticos en el desarrollo psicológico y emocional; el primero de tres a seis meses de edad, luego a los tres años y luego en edad escolar, de seis a doce años. Durante estos períodos si un niño ve que el padre le pega a su madre, y ella, sumisa, prepara la cena y calla, entonces se comienza a identificar ésta como una respuesta normal y aceptada. Sabemos que los niños que han observado violencia doméstica, y peleas entre sus padres o cuidadores, comienzan a exhibir problemas físicos y emocionales, los cuales incluyen depresión, ansiedad, deseos de suicidio, dolores físicos frequentes, problemas de aprendizaje, y conducta violenta. Muchos de estos niños luego, en la adolescencia, se inclinan hacia la conducta antisocial, y están a un alto riesgo de abusar el alcohol y las drogas. Estos niños están de cuatro a seis veces más vulnerables a convertirse en perpetradores y hombres violentos, y las niñas a convertirse en víctimas de violencia, pues observaron violencia en su desarrollo temprano. Todos, como adultos responsables en la vida de estos niños, debemos promover la capacidad de recuperación o la elasticidad emocional en estos pequeños para ayudarles a recuperarse de los eventos traumáticos.

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Hace unas semanas atrás se transmitió por la televisión un reportaje periodístico sobre un grupo de jóvemes que estaban estudiando para ser maestros de escuela primaria en la univiersidad en Haití. Ellos estaban contribuyendo a la recuperación emocional de los niños afectados por el gran terremoto. Estos jóvenes estaban dando clases de arte a los niños, y ayudando a éstos a expresar sus impresiones, miedos, y memorias del terremoto en papel, con crayolas y pinceles. Los niños aún muy pequeños algunos, dibujaban y pintanban sus historias de sobrevivencia y de esperanza para un

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futuro. Este proyecto de apoyo comunitario estaba promoviendo la sanidad y salud psicológica en todos. Entonces, se ha demonstrado que para promover esta elasticidad ó habilidad de recuperación psicológica y emocional en nuestros niños *es esencial que por lo menos un adulto responsable desarrolle una relación consistente y de apoyo, con el bebé y el niño de edad temprana.* También es importante *que por lo menos exista un lugar donde el niño de sienta seguro y protegido* (el hogar, un espacio en su casa, o patio, la casa de los tíos, o abuelitos, la escuela, etc.). Finalmente, *es muy importante que el adulto se conecte con recursos comunitarios que fomenten la sanidad y salud física y emocional del niño.*

Puntos Para Recordar:

1. Enséñale al niño que el ó ella tiene valor, y que ésta seguro y protegido por adultos responsables. Los bebés y los niños de temprana edad responden favorablemente a tu consistente cuidado, tu presencia física tranquila y relajada, y a palabras de afecto y amor.
2. Modela y demuestra conductas de comportamiento saludables.
3. Evita hablar muy fuerte, o gritar, o usar métodos de disciplina violentos. Reglas consistentes y firmes promueven la claridad y el entendimiento de las mismas.
4. No les permitas mirar en la televisión violencia o cosas traumáticas o con mensaje para adultos, evita que usen juegos de video violentos.
5. Enfatiza y practica rutinas predecibles con el bebé y el niño, especialmente después de eventos traumáticos, (por ejemplo, desayunarse en la mesa todos los días, leerle una historia a la misma hora todos los días, decirle ó recordale que es importante para tí, y amado y apreciado, todos los días).
6. Recúerdale al niño que la situación traumática no fue su culpa ó su responsabilidad, y que le ayudarás a aprender a manejar sentimientos de temor, y miedo; que no está solo ó sola.
7. El niño de temprana edad puede expresar sus miedos, y preocupaciones a través del juego, el arte, y también puede aprender ejercicios simples de relajación, como el contar contigo hasta el 10, respirar profundamente, y también puede aprender ejercicios sencillos de calistenia o yoga, para aprender a sentirse en control de su cuerpo y su espacio físico.
8. Enseña la autoestima, recuerda comunicarle al niño que él es importante para tí, y apreciado, especial, que él tiene habilidades, destrezas, y que él sí puede recuperarse y puede aprender cosas nuevas.
9. Como madre, padre, maestro ó cuidador, nunca te sientas solo, recuerda que hay recursos y profesionales que están a tu disposición, a veces tan cerca como marcar un número telefónico.
10. Cuida de tí misma o de tí mismo, para que puedas promover en tus hijos, y en cualquier pequeño que te toque cuidar, el bienestar y la salud física, emocional y psicológica.

Artículo preparado por : Nellie M. Arrieta, LCSW, terapéuta, educadora y amiga de padres y cuidadores, Marzo 28, 2010. (Referencias: No Violencia a la Mujer, Diario Libre, República Dominicana, 23/11/06; The Educational Needs of Children Living with Violence, by Susan E. Craig, 1992; SafeStart Training Manual, Department of Children, Youth and Their Families, San Francisco, CA, 2001).

Resiliency Is the Ability to Use Ones Strength to Deal with Life's Challenges and Obstacles

Resiliency as a dynamic and moving force is offered as a promise of overcoming the odds for many families and children. Resiliency captures the purpose of our website dedicated to the premise of hope and optimism of rebounding in a forward way, stretching and flexing in response to the pressures and strains of life. We would suggest this life force is inherent in all living things imposing its effects from genetics, development, history, family culture, context and environment and expressing its effects recursively back unto these

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same dimensions in such ways which reconstitutes them and makes them anew. Health outcomes such as physical, mental and social wellbeing is interposed with resiliency processes. The following multiple pathways to these endings propose energies and resources which can be modified and built upon using systems of relationships and communication, telling of ones life stories while renewing values, beliefs, cultural and nature connections, and meanings making us stronger to both survive and even thrive. Read more at http://www.health.utah.gov/able.

Resiliency: What We Have Learned by Bonnie Benard—is a beautiful contemporary book, distilling what works in order to make a difference using a strength based approach from the historic seminal work of Werner and Smith of the Children of Kawai—a longitudinal study of more than 700 people across four decades. These results determined what would constitute interventions for resiliency in children such as restoring connection with a sense of belonging, instilling high expectations with a belief in the child while promoting opportunities and making a contribution to the community. You will enjoy a sample of her book with selected chapters http://www.wested.org/online_pubs/resiliency/resiliency.40pg.pdf

Louis Allen, MD

Child Maltreatment Policy and Attachment Theory

There is a plethora of policies that have been created to help prevent and treat child abuse/neglect, yet child maltreatment still exists in all forms. When a victim of child maltreatment is in the media because of horrific abuse/neglect, the response is to blame the perpetrator, the parents and/or child protective services. Blame may assuage the public, but it further harms the victims. Child maltreatment hurts everyone in a society—whether we are the victims, the perpetrator, or the public at large. The fact that child maltreatment exists, despite current policies for prevention, supports the need for a systemic policy review and revision. When a child dies of abuse/neglect, this fact becomes glaringly vivid. The majority of maltreated children, however, survive to adulthood, and sadly, many continue the cycle of abuse/neglect with their own progeny.

In Utah, child protective services' main goal is to prevent recurrence of abuse and but does not address multigenerational patterns. According to the Utah Child Protective Service Report of 1996 (p. 27), in Utah alone, there were 15,254 total referrals to their offices in 1996, with 5,409 of those cases substantiated. In Utah, child maltreatment referrals are classified as valid or invalid. A valid report is one where the evidence found after an investigation indicates child maltreatment has occurred, and is thus substantiated (personal communication, J. Tingey, 2006). Of those cases substantiated, there were 8,306 child victims. Human Services Division of Child and Family Services Report of 2007 (p. 8), states that in Utah alone, 20,340 referrals were made to CPS, with 8,386 of those cases substantiated. Of those cases being substantiated, there were 12,284 known victims. In 2008, Child Protective Services in Utah investigated 19,878 cases; of those 8,284 were substantiated. Because Child Protective Services is family-based, there were many family cases with more than one victim. A total of 12,571 victims were substantiated. Of the total maltreated, 53% were female, and 47% were male. Forty-two percent of the victims were aged 0-5 (Child Protective Services, 2008) National figures for 2008 show 80% of fatalities were less than 4 years old (U.S. Dept Health and Human Services, 2009).

The fact that child maltreatment exists... supports the need for a systemic policy review and revision.

Child maltreatment does not just affect the children involved. Other family members are victimized and traumatized by witnessing child maltreatment and the results of it. Even the perpetrators are traumatized by their own actions and their victim's fear and tears. Many perpetrators of child maltreatment were at one time maltreated children and have adamantly proclaimed they would never hurt their children like they were hurt. It is likely that there are far more victims than those reported. As humans, primary relationships are essential

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to our survival and the nature of those relationships is critical to our mental health. When people witness their own child or other children being hurt, they too may feel hurt, insecure, and unsafe. Child maltreatment is a pattern of behavior that can be passed down generation to generation. This happens not out of desire to hurt, but rather out of trauma. The majority of child maltreatment cases involve parent offenders. In 2008, adult offenders between 18-30 years old comprised 44% of all offenders (Child Protective Services*,* 2008).

Child maltreatment has been shown to produce neurological effects in the brain of the victims. Infants and toddlers who experience child maltreatment may suffer devastating consequences to their development. Child maltreatment affects a person's memory and cognition (Christianson, 1992; Howe, 2000; Reissberg & Hertel, 2004; Toth & Cicchetti, 1998). Child maltreatment has a deleterious impact through elevation of stress hormones in the body. Stress hormones alter the victim's brain maturation and neuropsychological outcome. Child maltreatment is associated with many adult psychiatric disorders (Harvard Medical Health Letter, 2005).

There are children who grow up being maltreated and yet sustain relative mental health. A child with resilience can gain positive adaptation to survive the abuse. However, in a longitudinal study, only 61% of children who demonstrated resilience during elementary and intermediate school continued to sustain it during adolescence (Herrenkohl, Herrenkohl, & Egolf, 1994). Resiliency is characterized by individual psychological characteristics that allow children to cope effectively with stress, including "belief in one's own self-efficacy, the ability to deal with change, and a repertoire of social problem-solving skills" (Rutter 1985). Infants develop resilience through primary relationships as they adjust and adapt to their world. Falling does not stop them from walking and babbling does not stop them from learning to talk. On the other hand, adults who do not develop resilience early become fearful of change. Change brings discomfort, fear, anger or a loss of control. An adult may not accept or adapt favorably to change because of anxiety and negative energies related to the situation or poor resilience (Resilient Children, 2005).

Child maltreatment is associated with many adult psychiatric disorders.

Our current system for preventing and rehabilitating victims of child maltreatment is failing our children, our families, and our society. Child maltreatment receives widespread public attention in our society when a shocking tragedy occurs. However, it is rarely discussed or challenged before a child dies or is seriously hurt. There are severe consequences for maltreated children and their perpetrators that may be harsh and counterproductive. Child safety and emotional wellbeing is necessary for the emotional health of succeeding generations of any society. On the other hand, pulling an injured and devastated child from their primary family and placing him or her with strangers in a group home, a foster home, or a proctor home may be less supportive for many victims. A child's home/ family environment provides a sense of security and belonging, even where maltreatment exists.

We need more options to help families heal without being torn apart. Prevention needs to be addressed separately from treatment. In the past twenty years, there have been increased efforts to develop and examine the efficacy of evidence-based interventions for child maltreatment (Chadwick Center for Children and Families, 2004; Toth & Cicchetti, 1993). In experimental labs, rats have been utilized to help researchers find empirically based evidence for treatment of child maltreatment. In one lab, with an attachment orientation, using attachment theory and its clinical applications has been shown to improve security and quality of attachment of maltreated rats (Cicchetti, Rogosch, & Toth, 2006).

Attachment theory provides a useful framework for understanding formative and functional aspects of human relationships and is applicable to child maltreatment research. Attachment theory suggests that the experience of child maltreatment can affect a child's internal working model of primary relationship, which then impacts quality of future relationships (Bowlby, 1969/1982; Finizi et al., 2001; Lamb et al., 1985).

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Attachment theory provides the basis for our understanding of the formation and quality of interpersonal relationships. There are two basic types of attachment. One type is a “secure attachment”. In a secure attachment, a child uses his/her caregiver as a secure base. These children have a balance between independent exploration and safety/security with their caregivers. (Bowlby, 1969/1982) The other category of attachment is an “insecure attachment”. There are several styles of insecure attachments. They are the “anxious-avoidant” (anxious-resistant) attachment, the “anxious-ambivalent” attachment, and the “anxious-disorganized” (disoriented) attachment. Anxiously attached children may seem fearful and insecure. These children may not explore their world or take risks to explore their environment and may not enjoy or trust parental contact or depend on parental cues.

Children with an anxious-avoidant attachment style ignore or avoid parental contact and do not demonstrate a preference between their parent and strangers. A child in this category also often displays more anger and engages in more conflict with his/her parents. A child who has an anxious-ambivalent style often seeks contact with their parents and then avoids or tantrums when contact occurs. These children will sometimes seek attention and then are resistant to their parents’ response (Ainsworth et al., 1978). A child with a disorganized/disoriented style is apprehensive and anxious. When the child and parents unite after separation, the child may appear dazed and unresponsive (Main, Kaplan, & Cassidy, 1985)

Many children and adults have attachment problems, yet are not clearly diagnosable as having an “attachment disorder.” Currently, Reactive Attachment Disorder (RAD) is the only category of attachment disorder diagnosis listed in the DSM-IV-TR. Most people with attachment issues do not have RAD. A child with a disorganized attachment style does not have the ability to organize and may not know how to cope with stress (Main & Hesse, 1990). Children who have a disorganized attachment style are likely to have poor developmental outcomes, ineffective stress management skills and the risk of externalizing problem behavior in adulthood (Boris et al, 1997; Carlson, 1998; Hesse & Van Ijendoorn, 1998). Some research has indicated that children who are maltreated have an 80% chance of developing a disorganized attachment (Barnett et al., 1997; Beeghly & Cicchetti, 1994; Cicchetti & Barnette, 1991). This attachment style is the only one that may develop into reactive attachment disorder.

With this knowledge, it is obvious that blaming and punishing perpetrators is not appropriate and may impede treatment or prevention. What may help is screening families for attachment quality at the very first CPS assessment. Even if cases are unsubstantiated, the recognition of attachment issues before the child maltreatment occurs may be a lifesaver. To intervene with treatment before a child is hurt badly enough to require removal from their home and family may prevent future maltreatment and could decrease long-term expense for our child protective system.

It is important to be aware that “an insecure attachment does not destine a child (or family) to failure. Change can occur. However, the longer a child (family) follows a specific pattern, the more difficult it is to alter that path” (Appleyard & Berlin, 2007). Identifying an attachment style in young children can be assessed relatively simply and inexpensively. Attachment-based research identifies young children with attachment disorders using the Strange Situation Inventory (SSI; Ainsworth, Blehar, Waters, & Wall 1978). Adolescents and adults can be identified with the Adult Attachment Inventory (AAI). These two measures have yielded empirical results with clinical applications (Oppenhiem & Goldsmith, 2007).

An insecure attachment does not destine a child (or family) to failure.

Attachment theory provides the basis for evaluating the attachment quality of relationship that has been formed with the parent. The SSI reveals the quality of a child’s attachment by demonstrating how children relate to their parents in different standardized situations in a consistent physical setting: (a) being with a parent alone, (b) introduction of a stranger into the situation,

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(c) being left alone with the introduced stranger, (d) subsequent reunion with parent, (e) being left completely alone, (f) stranger reenters and attempts to engage with child, and then (g) parent reenters and stranger leaves. Children with a secure attachment react very differently from children who are insecurely attached (Ainsworth, Blehar, Waters, & Wall, 1978). Three aspects of the child's behavior are observed during the Strange Situation: (a) the amount and safety of exploration (e.g., playing with new toys or destructiveness in play), (b) the child's engagement and reactions to the parent departing and returning, and (c) the child's response to the stranger.

AAI asks adults to provide five adjectives that describe each parent and an illustrative example of each adjective. The interviewer then asks five questions describing the adult's childhood caregivers: (a) how they responded to them when s/he was upset? (b) whether caregivers threatened them, (c) whether they felt rejected, (d) explanation for caregiver's behavior, and (e) effects of these childhood experiences on her/his personality. The responses of the AAI are evaluated on two dimensions: (a) coherence—a clear and convincing description, is truthful and complete, and is presented in an orderly manner; and (b) ability to reflect on the motives of others (George, Kaplan, & Main, 1985). Four types of adult attachment have been identified through the AAI: (a) secure/autonomous, (b) dismissing, (c) preoccupied, and (d) uninvolved/disorganized. Studies also suggest that a child's attachment style can be predicted by the parent's attachment style (George et al., 1985).

Securely attached/autonomous adults/adolescents are able to appropriately respond to their children. They make sense of their own childhood experiences and are able to understand the motives of others. The securely attached adult fosters a secure child attachment. Adults with a dismissing adult attachment strategy use incoherent contradictory adjectives in describing their own caregivers. This type of adult attachment is correlated with avoidant attachment in their children. Adults with a preoccupied attachment strategy supply incoherent and vague references on the AAI. They are preoccupied with past relationship experiences and may appear angry.

Sometimes children must be removed from their home to be protected from their family.

Familial boundaries are blurred or lacking. This type of adult attachment in a parent correlates with an ambivalently attached child. An unresolved/disorganized adult attachment is seen on the AAI as incoherence that lacks logic, consistency, or truth. An example would be an adult using language inferring that a deceased parent is still living (Wilson, 2008). There is a large gap of resources and instruments to identify an adult's attachment style and to support adult attachment security using effective interventions. More research in this area is needed. However, identifying attachment styles of each family member can provide the basis for a more specific and effective family centered intervention, assisting in future prevention.

Child-Parent Psychotherapy (CPP) has been shown to be effective in treating attachment issues (Trauma-Informed Interventions, 2008). The child/children attend therapy with their parent. This intervention combines cognitive behavioral therapy, (talk therapy, shifting cognition and changing behaviors) with play therapy. Child-led play helps a child process trauma and cognitively shift from helplessness to self-control. The therapist working with the family can also facilitate the family in creating a crisis plan to hold the parents accountable and keep the children safe. CPP has been supported by findings from several randomized trials demonstrating increasing attachment security of maltreated children and their mothers (Lieberman & Van Horn, 2005). Helping parents heal from their own childhood trauma supports their child's healing process and may stop the perpetration of child maltreatment in future generations.

Sometimes children must be removed from their home to be protected from their family. A child's safety and life is inextricably bound with their caregivers. Assessing for insecure attachments and risk factors for abuse and neglect and then seeking out appropriate evidence-based treatment may prevent recidivism of child maltreatment and its generational perpetuation.

(continued...)

Decreasing the frequency of child abuse/neglect is a moral imperative with clear benefits to society (Lundhal, Nimer, & Parsons, 2006). Preventing child maltreatment should be the goal.

Addendum

At this year's *Bridging the Gap* conference (February 1, 2010) in Salt Lake City, Utah, Miriam Steele, Ph.D. (Department of Psychology, New School for Social Research, New York) shared that in her research she found that 80% of maltreated infants have a disorganized attachment. When a parent has an autonomous style, their child will likely have a secure attachment style. When a parent has a dismissing attachment style, their child will likely have an avoidant style. A preoccupied parental attachment style yields a resistant style with their child. An unresolved past loss or trauma (including child maltreatment) experienced by the parent, is likely to create a disorganized attachment style in their children. In addition, familial abuse cycles (for example-grandmother abused mother, mother abused daughter, daughter abuses granddaughter) can be stopped when a disordered intergenerational pattern of attachment is ended. Dr. Steele utilized both the Strange Situation and the AAI in her clinical research ("Attachment Representations and Affect Regulation for Clinical Work"). Another researcher, Neil W. Boris, M.D., shared his findings on attachment and trauma. He also spoke about intergenerational patterns of attachment. His focus was on the parent/child relationship and interventions to limit the impact of a caregiver's trauma on the parent-child relationship. Intergenerational attachment is a newer concept and a relatively new area for research. This is an exciting new prospect in the area of child maltreatment. It is personally and professionally validating to learn that prominent research is addressing this issue, as many of us in the field have recognized the need and the potential.

Familial abuse cycles can be stopped when a disordered intergenerational pattern of attachment is ended.

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News From Around the State

The Children's Center, Salt Lake City, Utah
Safety Net Program for Families with Young Children

About The Children's Center

The Children's Center provides comprehensive mental health care to enhance the emotional well being of infants, toddlers, preschoolers and their families. Over the course of our 48-year history, we have become a prominent mental health facility for very young children in Utah. Our services are in high demand as we receive 30-40 new referrals every week. The vast majority of the families we treat are low-income. We provide service to over 1,800 children and families in the last year.

Overview of Trauma Program

In September 2009, the Children's Center was awarded a three year federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). This allows us to become part of the National Child Traumatic Stress Initiative, and will effectively help us to become a nationally known Trauma Center for families with very young children. Our program is called the *Safety Net Program for Families with Young Children.*

The *Safety Net Program for Families with Young Children* will transform access to care and the availability and delivery of trauma services for infants, toddlers, preschoolers and early elementary aged children. Using Trauma Focused-CBT, Child Parent Psychotherapy, and Family Resource Facilitated Wraparound services; we will expand services to growing populations of minority and refugee children and families with children of deployed military personnel. Over the three year program, 325 children and their families will receive treatment. Through this program, we will work to enhance community awareness regarding the presence and effects of trauma on young children. Specifically, we will focus on increasing awareness among multicultural groups and military families.

Children and Families Who will Receive Services

- Ages birth to eight years
- Complex Trauma
- Sexual and physical abuse and/or neglect
- Witness to severe domestic violence
- Death of a primary caregiver
- Refugee children
- Children of military personnel suffering from loss or the return of impaired caregiver

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Collaborative Mental Health/Early Intervention Program

In September, **Wasatch Mental Health** kindly opened their doors to house the new **Provo Early Intervention Program** (PEIP). The seed for this collaboration was planted by UAIMH as both Catherine Johnson, Director of Children's services at Wasatch Mental Health and Janet Wade, Director of Services for Easter Seals PEIP, served on the first UAIMH board. A benefit from being housed with the mental health agency is the access to consultation, staff training, and a smooth referral for those families receiving early intervention services who may need more specific mental health resources.

Upcoming Conferences

- Generations 2010, April 19-20, Salt Palace Convention Center, 100 So. West Temple, Salt Lake City
- Common Problems in Pediatrics, June 7-9, 2010, Behavior and Psychiatry Topics, June 8, Westminster College, 1250E 1700S, Salt Lake City
- World Association for Infant Mental Health (WAIMH), June 29 - July 3, 2010, Leipzig, Germany (http://www.waimh-leipzig2010.org)
- Critical Issues Facing Children and Adolescents, October 19-20, 2010, Salt Lake City.