UAIMH NEWSLETTER

Utah Association for Infant Mental Health

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Special Issue: Domestic Violence

President's Corner

Transformation of a President

Theodora Sophia was born on March 14, 2005 at 6:30 PM, and I am changed forever. Dr. T. Berry Brazelton, the renowned pediatrician, writes about three babies that parents fantasize about before the actual birth. The first is the "ideal" or rewarding baby, the second is the impaired baby, and the third is the mysterious, real baby whose presence is becoming more and more evident in the motions of the fetus. As I look back at my own fantasies about our child during my wife's pregnancy, I realize that I too dreamed and worried about these "three babies."

After Theodora arrived, I distinctly remember lying in our hospital room thinking about this "real baby" that was now here, and how I would adjust as a parent. I also couldn't help but think about the families that I work with each day, and strangely, I was filled with sadness at a time I expected to be so happy. I thought about Brazelton's insight and for the first time, I felt I really understood a portion of the experience of the families I work with. That is, when families come to us for help, they are grieving the loss of that "ideal baby" or "ideal child" they dreamed about for so long.

I felt fortunate to have been surrounded by family and friends during and after Theodora's birth, but I also couldn't help but think about the mothers in my office who tell stories of being completely alone in the delivery room, and alone with their new baby at the hospital. These thoughts brought me great sadness, but they also renewed my commitment to infant mental health, and to the diversity of work we all do with young children and their families. It also reminded me that the work we do is difficult, but profoundly important in such a simple way. While we constantly seek better ways to "help" others, and to find new, "cutting edge" interventions, I am reminded of the old infant mental health credo of "just being with" someone, and the power this contains.

As I close out my year as the president of UAIMH, I carry with me this idea of the power of relationship and "being with," and know that I will use it as the basis for my work every day. Becoming a parent has already profoundly changed my perspective, and allowed me to feel an empathy not felt before.

Finally, I want to take the time to thank the UAIMH board for a fantastic year. I feel like we accomplished all we set out to do and more, and I want to thank them for supporting me in my role as president of the association. I also want to welcome my former colleague and good friend Jessica Singleton to the UAIMH presidency. I know the association is in good hands.

Jessica will bring a new energy and enthusiasm to the role at a time where I am ready to now focus on parenthood. I am often telling others that I don't know anyone who knows more about infant screening and assessment than Jessica, and that is only a fraction of her expertise. Her knowledge about infant mental health will propel the association into the future, and I'm excited to support her in what lies ahead. I would also like to thank you, the committed member reading this newsletter. Without our membership, we would still just be a vision of a few people only two short years ago. It seems timely that my tenure as president is coming to a close just after the birth of my daughter. Daniel Stern writes, "with every birth of a child comes the birth of a parent." So, my daughter and I will now grow together. Wish me luck.

Nick Tsandes, LCSW
Proud father & UAIMH president

News from UAIMH

As Nick Tsandes said, this is a time of change for UAIMH. Nick will be Past-President this coming year, and we will have a new President in Jessica Singleton. More changes are coming up as three members of the UAIMH Board are making room for new board members. And… please don't forget to renew your membership for 2005!

We will continue to offer news about Infant Mental Health and training opportunities in Utah. For the first time, we offer a *Special Issue* – on Domestic Violence and its effects on infants and young children. We hope this information will be helpful for you, our members. If you have ideas about or requests for special topics, training opportunities, etc., please let us know!

Time for New Board Members!

This year marks a change in the UAIMH Board, with three positions opening. Each year, at least three board members leave to make room for new ones. Our bylaws state that three board members serve one year, three serve two years, and three serve three years. Since we used the first year and a half or so to start up the organization, this is the first change-over.

We are sad to see three of our founding members depart the board but deeply thankful for all of their hard work. Their leadership has helped UAIMH grow into a strong organization. Now, three nominees have been proposed to become members of our board: Elizabeth Kuhlman (DCFS), Vonda Jump (EIRI), and Catherine Johnson (Wasatch Mental Health). We believe all three candidates are able to contribute significantly to our work.

Touchpoints™ Mini-Conference

On January 14, 2005, UAIMH held its second mini-conference. This half-day meeting was devoted to Dr. Berry Brazelton's Touchpoints™ program. Aziele Jenson and Kathryn Bell skillfully presented the main points of this early intervention program, using PowerPoint, video, playful examples, and personal stories. Their warm and interactive approach really brought home what this approach is all about: inducing change by engaging in respectful, compassionate relationships.

Many attendees were actively involved in the question and answer activities offered by the presenters. By necessity, this afternoon was only a brief introduction into Touchpoints™ methods. Nevertheless, workshop participants found this introduction very useful for their practice. If you are interested in a full training, see www.hope.usu.edu/Touchpoints, or contact Aziele Jenson (ajenson@cc.usu.edu) or Kathryn Bell (kathrynsbell@aol.com).

Training Opportunities

Various excellent IMH training opportunities are coming up this summer (also see *Mark your Calendars*). There will be a workshop on the **DC 0-3 classification system** at the Mental Health conference in Park City on May 18.

From June 13 to 15, UAIMH board members are teaching an in-depth IMH course as part of the 21st Summer Institute at the College of Social Work, University of Utah, called:

The Parent-Child Relationship:
Developing an advanced skill base in working with very young children and their families

Participants will receive training in observation, assessment, diagnosis, and treatment of very young children and their families. They will leave with increased understanding and skills in working with very young children and their families. Each day promises to provide practical skills for professionals via lecture, video, case examples, and experiential exercises.

The course will be taught by Nick Tsandes, LCSW, Mark S. Innocenti, PhD, Ilse de Koeyer, PhD, Kristina Hindert, MD, Jessica Singleton, PhD, Adrienne Akers, MS, RPT, and Judy Ahrano, MD. For more information, go to www.socwk.utah.edu/pace.

Finally, Dr. Alan Fogel of the University of Utah will offer his second summer course called

Understanding Infants, August 8-12. This weeklong course can be taken for college credit or as a continuing education class. Topics will include infant development in the first three years of life, especially focusing on emotions and social relationships. Alan Fogel uses a unique teaching style, combining short lectures and discussions with experiential exercises that will foster an understanding of what it is like to be an infant. See our previous newsletter for a review!

Secretary's Message

We have had several exciting events over the past few months. The Touchpoints™ workshop in January was well attended and we received a number of new memberships. Several of our members applied for one of two scholarships to attend the February conference, **Bridging the Gap:** *Clinical Application of Attachment Theory and Research*. Congratulations to the drawing winners: Mary LaMont and Amber Davis. Look for their reviews of the conference in this newsletter. Much thanks to all of you who attended the breakfast sponsored by UAIMH at the Bridging conference. We were thrilled to give away three infant mental health books to new and current members. This newsletter features a Book Review on one of these books!

Jessica Singleton, Ph.D.
UAIMH Secretary

Special Issue: Domestic Violence

Yearly, an estimated 10 million U.S. children are exposed to domestic violence (DV) between their parents.[1] The abuse can be psychological (threatening, name-calling), physical, or sexual. Often, all three co-occur. Both men and women can be victims, but abuse of women is more common and usually more persistent and severe.[2] Spousal abuse happens in all layers of the population, but most at risk are families of low SES, especially with substance abuse problems.

Often, children get caught in the middle, whether their parents realize it or not. As they get older, children increasingly try to intervene, protect or comfort their mothers, or seek support from others outside of their family.[3] But even infants, toddlers, and preschoolers can become involved in their parents' conflicts. One study found that 1- to 2.5-years-olds became actively involved in angry adult conflict and often responded with distressed emotions.[3]

How does witnessing DV affect young children (aged 0 to 5 years)? What can we do to intervene if necessary? Three contributors to this *Special Issue* attempt to answer these questions from various angles: personal experience, research, Utah regulations, and a book review. References are provided below.

A Personal Story

by an anonymous mother

As an infant, he screamed and screamed. And at age 4 years, he still has a startle reflex. He notices every little noise and, even when sleeping, his arms flinch covering his face with the faintest sound. He awakes. "What was that, mommy? Call the police. The bad man did it".

I became involved with his father at 15. From the beginning, it wasn't right. But I was young, had low self-esteem, and thought that I could change him. It started with little things. A negative glance, a snide comment, a cruel word. Then it was grabbing, bruising, and physical restraint. It got worse over the years, but I couldn't escape. I tried to leave many times, but I always went back.

When I became pregnant, I was so scared. The relationship was straining me, I was so ill from the pregnancy, and I had nothing. I looked at many options, because I knew that in my heart a child deserves better than abuse. In the end, I chose to take care of my baby. The first step was to leave the abusive father. I did leave for most of the pregnancy, because more than once he had injured me while pregnant. If my child were to have any chance, he needed to be held to full term. It was these injuries during pregnancy that really made me look at reality.

Unfortunately, some of my family felt that it was not okay to be a single mom and told me the

father should be in my child's life. So when my son was born, I contacted the father and gave it my all once again. It went okay for a month. Then, his car broke down, and I again got hurt. My son started crying and he tried to go after the baby. I stopped him. But I became highly aware that my son was now in great danger, too.

After that incident, my baby cried night and day, although I had broken off all contact with the father. The doctor said this was caused by the domestic violence and warned me that going back to the father might endanger my child's development. She said that boys witnessing domestic violence are more likely to become abusive, while girls are more likely to be victims. There is also an increased risk of alcohol and drug use to escape the emotional pain. I vowed never to go back, for my baby's sake.

But even now, the domestic violence still haunts us. Throughout the 4 years of my son's life, his father has often broken the protective order. My son is afraid to sleep and calls his dad "the bad man" (not knowing this is his dad). He is highly alert, hears every noise, and startles over very little. We had a hard time establishing a secure attachment relationship.

A therapist working with young children is helping my son with his fears – he helped us a lot more then I expected. I am tremendously grateful to the therapist and the facility he works at. We are still in therapy (individually and together) and things have drastically changed. My son has experienced a lot in his little life, but we are lucky we got out while he was still very young. Most of the trauma experienced can be dealt with and I have no doubt he will continue to grow up healthy and safe.

Most women stay in a domestic violence relationship "for the children." This is a paradox. I believe that the children are hurt the most. When a friend advised me to contact the YWCA during my pregnancy, I started filing police reports, when threatened, injured, or followed by the father. Still, I did not seek refuge at the YWCA until after my baby was born, after the abuser had threatened my newborn baby.

I can still remember the advocate's face when she welcomed my crying infant and me into her office at the YWCA. The very first thing she gave me was a blanket to warm my son. I cried and was very hurt. She was the first person in my life that let me, without telling me "it's okay" or "shut up or I'll give you something to really cry about." I felt like she cared. Even with court and trials and police and protective order breakages, I am better off out of the relationship than in and my son is too. He has a chance at life without abuse. A chance I never had. For more information contact the YWCA and (801) 355-2804 or go to their web sight at WWW. YWCA.com

Research & Information

The impact of domestic violence

Elizabeth Kuhlman, MS, DCFS

"If he ever touches my kids, I am leaving!" So many of us who have felt trapped in an abusive situation have said this. There are all kinds of reasons that compel us to stay with an abusive partner, fear that he will hurt us worse if we leave and economic dependence being both all too common and all too realistic. We know in our hearts that witnessing abuse is not good for our children, but we hope that we can absorb all the pain ourselves, that at least we are protecting our children from serious harm.

But this is a delusion. Every time he hurts us in the presence of our children, he hurts them too. Children feel betrayed by the abusive partner, grow up unable to trust, feel responsible and guilty that they were not able to prevent the violence.

Babies are particularly and tragically harmed by living in the midst of family violence. We may think they are too young to understand. We may think they are asleep so they don't know what is going on. We may think that as long as they are not physically harmed, they will be OK. But none of this is true.

Recent research on the human brain has demonstrated again and again that violent, chaotic environments have a negative impact on early neurological development. In his book *Neurons to Neighborhoods,* a compendium of

research about early development, Pediatric Neurologist Jack Shonkoff calls such environments "neurotoxic." When infants are born, their brains are still growing. Everything that happens in the first years of life contributes to the developing structure of the brain. The interaction between the environment in which the baby lives and the genetic predispositions she is born with literally shape the brain.

Babies who live in the midst of family violence are all too often exposed to situations in which they are frightened and alarmed. The baby's protective reaction to such situations is either fight, flight, or shutdown. When such experiences occur frequently, the part of the brain governing these reactions becomes overdeveloped at the expense of the parts that govern social, cognitive, and language skills.

By the time they are three years old, some children exposed to domestic violence lack the ability to self-regulate -- to calm themselves down and control their impulses. Some lack a strong bond to one or more caregiver(s). Some are withdrawn and lack the ability to engage with other children or new adults in their lives. These symptoms, unfortunately, are not "merely environmental". They are neurological, that is, they reflect actual differences in brain development when compared to children who are raised in safe, consistent, nurturing environments.

Protective Factors

This news may seem exceedingly bleak. Are these children lost at the age of three? Fortunately, the brain continues to develop and adapt throughout life. Protective factors, such as one person who is consistent and nurturing (the non-abusive parent, another adult family member, a child care provider, or early interventionist), can stabilize the development of the brain and override the neurotoxic impact of early experiences of violence.

Definitions of Child Abuse and Neglect in Utah

For parents living with domestic violence, help is available. Physical assault is a crime. If you or someone you know is in a violent crisis situation, call 911. **In Utah, state law defines domestic violence in the presence of a child as child abuse**. To clarify all that counts as child abuse in Utah, definitions from *Utah Code §62A-4a-101* follow.

In the state of Utah, child abuse is defined as "actual or threatened nonaccidental physical or mental harm; negligent treatment; sexual exploitation; or any sexual abuse" to a minor child (under 18 years of age). Research shows that, depending on the sample, partner abuse and direct child abuse overlap in 25-75% of the families.[2,4] Thus, children witnessing domestic violence are at heightened risk of being the target of physical or psychological abuse – either by their fathers or their (abused) mothers.[4]

"Neglect" means "abandonment of a child; subjecting a child to mistreatment or abuse; lack of proper parental care by reason of the fault or habits of the parent, guardian, or custodian; failure or refusal of a parent, guardian or custodian to provide proper or necessary subsistence, education, or medical care, including surgery or psychiatric services when required or any other care necessary for [the child's] health, safety, morals, or well being…"

A finding of child abuse or neglect can be either "supported" or "substantiated." An allegation of maltreatment is supported when the Division of Child and Family Services has concluded, based on evidence at the completion of an investigation, that there is reasonable basis to conclude that abuse or neglect occurred. "Substantiation" of abuse or neglect is a judicial finding based on a preponderance of the evidence that abuse or neglect has occurred. Investigation may also result in the allegation being unsupported or without merit.

Child abuse, including a child's exposure to domestic violence, must be reported to the Division of Child and Family Services (DCFS) at 800-678-9399. This number leads to a recording that lists the phone number to call in the county where the incident occurs. Every Regional DCFS office employs a domestic violence specialist who will assist with investigation of any situation in which a child is exposed to family violence.

Resources in Utah

There are domestic violence shelters and

advocacy programs throughout the state. For information about these, you can call 1-800-897-5465. DCFS also employs a statewide domestic violence specialist. Her name is Dawn Hollingsworth and her phone number is 801-538-4273. She can help you find the services you need.

Young Children Witnessing Domestic Violence: A Research Review

Ilse de Koeyer, PhD, University of Utah

Starting at preschool age, children witnessing DV are at risk for a variety of problems. They may experience externalizing (aggression, antisocial) and internalizing (fearful, inhibited, depressed) behaviors, symptoms of trauma (PTSD), social competence problems, and lower academic functioning.[3] They may also have greater trouble developing empathy, lower verbal abilities, and be more likely to endorse violence as a means of solving conflict than are non-witnesses.[4, 5] As adults, they are at increased risk for feelings of depression, low self-esteem, symptoms of trauma, social adjustment problems, and using violence with their own spouse and/or children – continuing the circle of violence.

Young Children

Surprisingly few research studies focus on young children,[5] although about 40 to 49% of families experiencing DV in five major U.S. cities include children aged 0 to 5 years.[2] Young children are likely to be extremely vulnerable to DV exposure. As outlined above, their nervous systems are at a sensitive stage of development and increasing evidence shows that early relational experiences shape neuronal pathways in the brain. In addition, infants do not yet have the cognitive coping strategies that can help them make sense of violent events between their parents.

Young children's repeated exposure to DV may be as traumatizing as direct child abuse. A study by Scheeringa and Zeanah (1995)[1] found that children under 4 years of age who witnessed threats to caregivers showed more Post-Traumatic Stress Disorder (PTSD) hyperarousal symptoms and more new fears and aggression than children who did not experience DV. The personal story depicted in this Newsletter provides a good illustration of PTSD-like symptoms in an infant who experienced DV even before he was born.

DV during pregnancy

Stress during and after pregnancy can bring abuse to previously abuse-free relationships, or make existing abuse worse.[2] Almost 50% of previously abusive males have abused their female partners during pregnancy.[1] Rates of partner violence during pregnancy range from 1% (in a sample from a private clinic) to 40% (in women seeking pregnancy termination). On average, it occurs in as many as 20% of pregnant women.[5] Issues that increase the risk of abuse during this time include jealousy of the fetus, increased financial stress, the pregnancy being unwanted, and loss of self-respect in the expectant mother. At particular risk are teenagers, substance-abusing women, and women of low income and education (SES). These risk factors often co-occur.[2]

Battering of expectant mothers obviously carries direct physical health risks, for example a four times increased risk of giving birth to a low birth-weight baby or a baby with birth defects.[1] Other complications include prenatal hemorrhaging and growth restriction, premature birth, and even death of the fetus in severe cases.[2]

Maternal stress, anxiety, and depression

More and more research studies show that prenatal depression, anxiety, and stress in the mother – which can easily arise in DV situations – increase the likelihood of self-regulation problems in the child.[6] Babies of stressed, depressed, and/or anxious mothers are often more unpredictable in their sleeping and eating patterns, show more sad affect, and cry more. These behaviors evoke stress in the parents and can increase the risk of further spousal abuse, abuse of the infant's siblings,[2] or even direct abuse of the infant.

Perceptions of the newborn baby

Two recent studies showed that prenatal

abuse can negatively affect early mother-infant bonding and maternal perceptions of her newborn.[5,7] Huth-Bocks and colleagues (2004) interviewed 206 mothers in their third trimester; 91 had experienced mild to moderate violence. Abused mothers-to-be were more likely to doubt their efficacy as a mother and to have negative or insecure perceptions of their unborn babies. They were likely to be classified as *Disengaged* (emotionally distanced, not recognizing the infant's individuality) or as *Distorted* (not recognizing their own impact on the infant and being overwhelmed or preoccupied).

One of the mothers classified as Disengaged strongly identified her unborn infant with her abusive partner. When asked to describe her relationship to her baby, this mother said, "Hmmm, the baby's hyper, he's really hyper. Very active, he moves a lot. Kicks me in the ribs, beats me up." When asked about her sense of what the baby may be like, she replied, "Oooh, bad. Bad, like his father. Really bad (*laughs*)." (p. 89). Another mother, coded as Distorted, described her unborn baby as extremely nervous, shaking, and anxious, much like herself.

Luckily, one third of the abused women were classified as *Balanced*, characterized by a recognition of the infant's uniqueness, openness to change, and psychological involvement with the infant and the relationship. Despite the trauma, these women were able to talk coherently about their new baby, see themselves as competent caregivers, and feel joy about the baby. This suggests that some women are able to form a positive relationship with their infants, serving as a protective factor for the baby.

Attachment security

The development of a secure attachment relationship is a major developmental task in infancy. However, strained relationships within the family increase the likelihood of developing insecure attachment relationships.[1]

The development of secure relationships may be threatened in various ways. As described above, many prenatally abused mothers view their infants negatively and rigidly. This may set them and their babies up for more negative mother-infant interactions in the first year of life and, subsequently, more insecure attachment relationships. Prenatal representations of the infant predict the quality of parent-infant attachment when the infant is one year old.[11] Further, both parents are likely to be less emotionally available and responsive when they themselves experience so much stress.

Frightening behaviors in mothers

Mothers who are abused frequently show signs of trauma, including intrusive thoughts, symptoms of dissociation, and hyperarousal or hypervigilance.[2] Being so caught up in her own trauma not only makes a mother less available for her infant, but at the same time it may cause her to be frightening and unpredictable to her baby. Thus, the mother becomes the source of both security and fear, and this increases chances of developing a disorganized attachment relationship. In disorganized attachment, an infant has no working strategy to find security and is likely to continue to experience dysregulation (e.g., externalizing problems, peer relationship problems).

Gender differences?

Interestingly, a recent study (David & Lyons-Ruth, 2005)[8] suggests that there may be gender differences in how infants approach frightening mothers. Eighteen-month-old boys tended to show the classic "fight or flight" response when their mothers said or did something frightening (such as, making sudden, attack-like moves, or wearing a frightened expression): they fought being held and tried to run away or hide. Girls, on the other hand, showed more of a "tend and befriend" pattern: they tended to approach their mothers, even when they were frightening. The more frightening the mother was, the more often the toddlers appeared fearful and hesitant, sometimes even freezing as they approached.

This study did not specifically study DV families. but it is relevant for gaining insight into potential mother-child interactional patterns that might occur when mothers become overwhelmed with the trauma associated with DV.

Marital conflict and infant dysregulation

A recent study conducted at BYU also suggests infant dysregulation problems in families with higher marital conflict, even though this was a low-risk sample.[9] Chris Porter and his colleagues studied 56 first-time mothers and their 6-month-old babies. Marital quality was assessed by a self-report questionnaire. Even in this sample, higher marital conflict was related to lower scores on the Bayley Mental Development scales, lower emotion regulation scores, and lower vagal tone in the infants. Higher vagal tone reflects a better capacity to regulate through the parasympathetic nervous system (i.e., better at "calming down"). Thus, this study found some indications that mild to moderate marital distress is related to lower emotional and physiological regulation in young infants.

Assessment and Intervention

Rossmann and colleagues (2004)[1] recommend to always use multiple informants when assessing potential problems from witnessing DV in young children, such as interviewing the parent, observing the infant/toddler directly, and conducting standardized developmental tests. They suggest: 1. taking a short history; 2. use a developmental screening device; and 3. conduct at least the parental interview for PTSD symptoms (by Zeanah and colleagues) as part of the initial screening. With preschoolers, a similar approach is suggested, but play observations can also be added. See also the *Book Review* below.

Resilience

Not much is known about resilience in young children. A remarkable number of older children has been found to be quite resilient, especially if removed from the violent situation. One study found that about half of 229 children living in a shelter showed no problems at all or only mild distress.[3] Older children may be protected by their cognitive capacities. In one study, for example, 8- to 11-year-old DV witnesses were likely to develop internalizing problems (e.g., nightmares, panic attacks, feeling lonely), but *only* if they blamed themselves for the conflict. Children who knew the arguments had nothing to do with them were not more likely to develop problems than their peers.

Conclusion

In conclusion, witnessing DV is often dysregulating and even traumatizing for young children. It is likely that some are more resilient than others, depending on factors such as temperament, the severity of the situation, staying in the violent situation or not, and developing some positive relationships. However, the potential effects of witnessing violence within the family are severe, including symptoms of PTSD. It is crucial for service providers to be aware of these risks, to screen for symptoms of trauma and dysregulation, and to offer suitable intervention. Children need protection and love, not threat!

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Book Review

"DON'T HIT MY MOMMY!"

A Manual for Child-Parent Psychotherapy With Young Witnesses of Family Violence

By Alicia F. Lieberman and Patricia Van Horn

> *"My daddy makes my mommy cry and my mommy makes me cry, and that's how it works."*
> Sandra, 3 years old

And thus the 'cycle of violence' goes on. As a therapist, parent, and children's advocate I have continually searched for means and ways to stop this cycle. *"Don't Hit My Mommy,"* by Lieberman and Van Horn is an excellent source of information and treatment guidelines to address the behavioral and mental health problems in infants, toddlers and preschoolers whose most intimate relationships are disrupted by the experience of violence. Its purpose is to provide practitioners from a variety of disciplines with an understanding of the impact of violence and with concrete intervention strategies to address the consequences of such an experience for young children.

Lieberman and Van Horn describe their book as a 'manual' divided into four sections. Section I describes the theoretical premises that guide their treatment model, providing an overview of child-parent psychotherapy, and explains how this form of treatment is used with infants, toddlers, and preschool children who have witnessed or experienced potentially traumatizing levels of violence. Section II specifies the main domains of interventions that are uniquely essential to child-parent psychotherapy and gives detailed descriptions of therapeutic strategies. Section III describes the procedures recommended when the intervention needs to include case management, particularly contacts with the legal system and Child Protective Services. Section IV provides a list of items that are essential but not unique to child-parent psychotherapy as well as a list of items that are incompatible with their treatment model.

First and foremost in the treatment of traumatic responses is the establishment of a safe environment both for children and adults in real life and in the therapeutic setting. Another prerequisite to the recovery process is recognition of the traumatic impact of violence. Parents tend to underestimate their children's witnessing and understanding of violence.

Child-parent psychotherapy is a relationship-based form of intervention that focuses on the child-parent interaction and on each partner's perception of the other. Goals include increasing the parent's and child's age-appropriate capacity to be emotionally attuned to each other's needs and motivation. Specifics as to assessment and treatment are laid out, with an underlying tenant that psychotherapy should consider development as a process that encompasses the entire life span. Child-parent psychotherapy focuses on developmental issues as these pertain both to the child and to the parent.

The authors present six modalities, which are integrated and flexibly deployed according to the families' needs. In this sense, child-parent psychotherapy is truly cross-disciplinary, combining elements of social work, mental health interventions, teaching and advocacy. Ports of entry for the various intervention strategies must be geared to the child's developmental stage. In general, the less verbal the child is, the more effective it is to intervene using direct action.

Whenever possible, the clinician will support the parent taking action. However, when safety demands it, the clinician may first take action and then discuss that action with the parent and child.

The book not only describes interventions that are unique and essential aspects to child-parent psychotherapy with young children, but it also provides many case examples of various situations and children of various ages. This is an effort to highlight general intervention principles that will need to be individualized for the thousands of individual circumstances that emerge in the course of treatment. The authors also emphasize the basic principle of emotional support, warmth, and empathy as essential adjuncts to any therapeutic intervention. I found this format to be extremely helpful as well as interesting.

These are some of the major highlights, which I gleaned from the book. As a final thought, I want to re-emphasize that the manual should only be used in situations where a baseline of physical safety for the victim of domestic violence (or other traumatic situations) and the child is already well established. Ensuring physical safety is the single most important step in intervention and its highest priority. I highly recommend this book to anyone working with young children.

Kathleen Smart, LCSW

Conference Reviews

Bridging the Gap 2005: Clinical Application of Attachment Theory and Research
Presented by the Children's Center

Review 1

My interest in this subject area took active form when some years ago I was asked to teach parents and foster parents about ADD and ADHD and the psychotropic medications prescribed. I was cautioned not to discuss alternative approaches and/or ideas to these "problems." This mandate frustrated me because I had already started processing some ideas/opinions regarding behavioral difficulties in children. I was very concerned that I may be missing an important opportunity for discussing effective strategies to help promote prevention and/or protection of healthy children and families. However, this experience triggered more serious study plus closer observation of relationships, especially interactions between parent and infant/child.

I was grateful when I was introduced to UAIMH and the learning opportunities provided through membership in this organization. After winning one of UAIMH's scholarships, I was pleased to attend the Sixth Annual "Bridging the Gap" Conference held in Salt Lake City, Utah on February 10-11. The conference consisted of four expert lectures presenting very interesting research/case studies with breakout sessions for discussion and application.

The information presented had a profound effect on me and further defined the value of my own role working with at-risk families through our nurse home visiting program, in recognizing the importance of early support and the powerful benefits of improved assessment skills/tools in identifying a need for appropriate counsel and/or referrals.

Although others may have gained different insights, the following are bits of wisdom that had an impact on me: (paraphrased notes)

- the importance of maternal "licking and grooming" in development
- children who are insecurely attached have impaired coping skills, higher cortisol levels, less eye contact, etc.
- maternal depression affects child development leading to hyperactivity at 4-6 years, attachment disorders, insecurity, delays, lack of behavior regulation, etc.
- it's very difficult to pay attention to the outside world if the inside world is unsatisfied
- depressed mothers perceive their interaction with infant/child more negatively
- holding and being with upset child leads to a regulated child and adult
- the most effective mother is more accepting of emotional state of infant and not threatened
- the state of mind of mother predicts the attachment of child

- "we don't see things as they are, we see them as we are"
- use time-in NOT time-out.....improve relationship with child
- if a community values its children, it must cherish its parents

and much, much more - Excellent conference!

Amber D. Davis, Public Health Nurse

Review 2

This year's Bridging the Gap Conference was both impressive and informative. Highly published researchers in the area of attachment were featured along with successful treatment programs for the promotion of secure mother-infant attachment. All presentations both increased knowledge of the area of attachment research and provided applicable strategies toward the promotion of secure attachment for those working with parents and young children.

Dr. Charles Zeanah, whose latest research has included the use of foster families for children who were placed in orphanages in Bucharest, Romania, presented his research as well as the helpful practices of social workers involved in the program. They visited the family every 10-14 days, and interventions for behavior and development were provided if needed. They used a "parallel process" in which the relationship between the social worker and the foster parent was the model for the parent-child relationship. A support group for foster parents was also provided.

Dr. Miriam Steele presented her research about adult attachment representation and adoption. Her work suggests that early adoptions are more successful than later ones, and that a secure attachment representation for the parent makes later adoptions more positive. Some attachment facilitating behaviors for these parents are the overemphasis of responses to a child's muted cues, the use of the child's name and the reference to joint experiences.

Dr. Roseanne Clark's research involves work with maternal depression. She emphasizes the importance of support for these mothers and uses the group format for intervention. Mothers bring their babies to groups which facilitates changes in mood and behavior.

The Circle of Security Project presentation provides an example of a treatment program which works. Their work focuses on videotaping each mother and child, and mothers' discussion groups as they view the videos.

A group Question & Answer period ended the Bridging the Gap Conference for this year. I look forward to trying some of the strategies learned and for the conference next year!

Mary LaMont, MS, School Psychologist

Committees

University Training Committee

The University Training Committee is still alive, progressing slowly but surely. So far, we have mainly focused on clarifying IMH training needs in Utah. We are also working on an overview of existing IMH programs and trainings (some excellent options are announced in this Newsletter). Our next Newsletter will be a Special Issue devoted to training!

Mark Your Calendars

- **DC 0-3 Workshop** by Donna Weston at the **Mental Health Conference**, May 18, 2005, Yarrow Hotel, Park City, Utah. See www.ubhn.org/mh%20conf.htm
- **Quality Infant/Toddler Caregiving Workshop** in Syracuse, NY, June 6-10. This national workshop is designed to help people seeking an understanding of infant development and practical training in infant/toddler caregiving. Email QIC@uc.syr.edu or call (315) 443-9378.
- **The Parent-Child Relationship: Developing an advanced skill base in working with very young children and their families**, at the 21st Summer Institute, College of Social Work, University of Utah, **June 13-15**, 9:00am – 1:00pm. For more information, see the article in this newsletter, or www.socwk.utah.edu/pace
- **Understanding Infants - University of Utah Class by Dr. Alan Fogel, August 15 -19, 2005 (NOTE CHANGED DATE!)**, 8:00am-5:00pm.

This course is perfect for all those working with infants and for parents as well. The class can be taken for credit (Psych 1220) or non-credit (Psych 222, call 581-6461). For more information, email Alan Fogel at alan.fogel@psych.utah.edu

- **Insightfulness Assessment (IA) coding workshop**, September 2005, Drs. David Oppenheim and Nina Koren-Karie. The workshop will take place in Salt Lake City, and will involve 5 full days of study with a small group of participants. Our work during the workshop will involve understanding the theoretical underpinnings of the Insightfulness Assessment, familiarizing participants with the IA procedure, and, primarily, learning how to code IA transcripts. Contact oppenhei@psy.haifa.ac.il or nkoren@psy.haifa.ac.il for more information.
- In September, UAIMH will present its **next Mini-Conference**. Details and date to be announced!

UAIMH Activities

Website: Don't forget to visit the UAIMH web page at www.hope.usu.edu/uaimh. We are continually updating the content so there is always information on a conference or new information on the "Tool Kits" to view. You can also **renew your membership for 2005 online.** If you hear of any upcoming event that you would like to post please send an email to janetwade@utah.gov.

For information about the **World Association for Infant Mental Health (WAIMH)**, log on towww.waimh.org**.**

To become a **member of UAIMH,** log on to www.hope.usu.edu or contact Janet Wade at janetwade@utah.gov

The next UAIMH Newsletter will be a Special Issue on **Training in IMH**. The deadline will be July 1, 2005. Please contact ilse.dekoeijer@psych.utah.edu or (801) 581-2233 if you would like to contribute!