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2020 Custody Guardian *ad Litem* Training Manual

8. Overview of Trauma, Substance Abuse and Child Abuse and Neglect in Custody Cases

a. Understanding Trauma and its Impact on Child Clients (Eva J. Klain, ABA Child Law Practice, Vol. 33 No. 9, September 2014)

b. Child Abuse Allegations in the Midst of Divorce and Custody Battles (Mary-Ann R. Burkhart, National Center for Prosecution of Child Abuse)

c. Calm in the Face of the Storm: Strategies on How to Effectively Represent Children in High Conflict Custody and Visitation Cases (Dawn J. Post, The Children's Law Center New York)

d. Attachment and Recovery: Caring for Substance Affected Families (Lynette Tay, Ph.D.; The Connecticut Center for Effective Practice of the Child Health and Development Institute, Inc., September 2005)

e. Signs and Symptoms of Domestic Violence, Substance Abuse, and Child Maltreatment

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TRAUMA IN PRACTICE

Understanding Trauma and its Impact on Child Clients

by Eva J. Klain

Stacey finds her new client Kelly withdrawn and difficult to engage. While reviewing her case file, Stacey realizes that Kelly not only spent years shuffling between foster homes as a result of her mother's neglect, but she also faced violence in her neighborhood and often ran away to avoid bullying at school. When Kelly does respond to Stacey, she is often angry and refuses to believe Stacey will actually advocate for her. Stacey is concerned about Kelly's mental health and suspects there may be other events Kelly is not telling her about.

About 46 million children are affected by violence, crime, abuse, or psychological trauma each year.[1] Many of these children will become involved in the child welfare or juvenile justice systems. Children in foster care like Kelly are more likely to have been exposed to multiple forms of trauma, such as physical or sexual abuse, neglect, family and/or community violence, trafficking or commercial sexual exploitation, bullying, or loss of loved ones. In addition to the abuse or neglect that led to their removal, children in care may experience further stresses after entering the system, including separation from family, friends, and community, as well as uncertain futures.

The trauma children in foster care experience is often complex. If left untreated, it can permanently affect their growth and development and have effects decades later. The Attorney General's National Task Force on Children Exposed to Violence recommends all professionals serving children exposed to violence and psychological trauma learn and provide trauma-informed care and trauma-focused services.[2] Similarly, a recent ABA policy calls for integrating trauma knowledge into daily legal practice and integrating and sustaining trauma awareness and skills in practice and policies.[3] This article will help you understand trauma and its impact on the lives of the children and families you represent, and provide suggestions for integrating that knowledge into your advocacy.

Trauma and its Impact

Approach your cases with an understanding of trauma and polyvictimization.

When representing children and families who have experienced trauma, know the following terms and definitions.

Trauma occurs when a child experiences a traumatic event that results in child traumatic stress.

- **A traumatic event** is one that threatens the life or physical integrity of a child or someone important to that child, such as a parent, grandparent, or sibling, according to the National Child Traumatic Stress Network. Such traumatic events can cause an overwhelming sense of terror or helplessness, and produce intense physical effects such as a pounding heart, rapid breathing, trembling, or dizziness.[4]
- **Child traumatic stress** occurs when a child's inability to cope with overwhelming traumatic situations causes psychological and biological responses.[5] Traumatic stress elicits mental and physical responses that cause problems when they interfere with the ability to function and engage with others.

Trauma may affect the behavior, development, and reactions of children. Children lacking

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the ability to adapt and handle traumatic events may display the following symptoms of childhood traumatic stress:[6]

- Intense and ongoing emotional upset
- Depression
- Anxiety
- Behavioral changes
- Difficulties at school
- Problems maintaining relationships
- Difficulty eating and sleeping
- Aches and pains
- Withdrawal
- Substance abuse, dangerous behaviors, or unhealthy sexual activity among older children

Trauma can also be differentiated by type:

- **Acute trauma** is a short-lived experience tied to a particular place or time.[7] Examples of acute trauma include natural disasters, serious accidents, gang shootings, school violence, or the loss of a loved one.[8] In response to these traumatic events, children may experience feelings of helplessness and distress.[9]
- **Chronic trauma** is prolonged exposure to traumatic situations over a long period. Examples of chronic trauma involve prolonged physical or sexual abuse, exposure to family violence, or war.[10] Child traumatic stress resulting from this type of exposure may include intense feelings of distrust, fear for personal safety, guilt, and shame.[11]
- **Complex trauma** involves exposure to multiple or prolonged forms of trauma and describes "both children's exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure." The events leading to complex trauma are "severe and pervasive," usually beginning early in life. They can disrupt a child's development and the ability to form a secure attachment bond, since they often occur in the context of the child's relationship with a caregiver.[12]

Polyvictimizaton occurs when children experience or witness *six or more* forms of violence or abuse. Research reveals that children exposed to one form of violence are more likely to have had multiple exposures to violence. The 2011 National Survey of Children's Exposure to Violence (NatSCEV II), the second comprehensive national survey to assess the full spectrum of children's direct and indirect exposure to violence, focused on the experiences of youth age 17 years and younger.[13]

NatSCEV II found that 57.7% of its total sample reported experiencing or witnessing at least one form of violent exposure.[14] Almost half (48.4%) of the sample had been exposed to more than one form of victimization, while 15.1% experienced six or more forms and 4.9% had exposure to 10 or more.[15] These high levels of exposure, known as polyvictimization, are particularly worrisome.[16]

Children experiencing polyvictimization are more distressed than other victims in general, but also display more distress than those victims who experience frequent victimization of a single type. Other characteristics of polyvictimization include: cumulative adversity, complex trauma, greater incidence of serious victimization, and exposure to multiple domains of victimization.[17]

Children entering the foster care system are more likely to be victims of complex trauma and polyvictimization. The National Child Traumatic Stress Network (NCTSN) conducted a study of the link between complex trauma and psychosocial outcomes for youth in foster care.[18] Information gathered about children in care who were referred for treatment at NCTSN sites demonstrated the high prevalence of complex trauma exposure for this group.[19] Over 70% of sampled children reported experiencing at least two traumas constituting complex trauma, while 11.7% reported experiencing all five types researched (i.e., sexual abuse, physical abuse, emotional abuse, neglect, and domestic violence).[20]

Recognize the effects trauma may have on children and families.

Some trauma effects you may see in your clients include:

Psychosocial effects. Children who experience multiple forms of trauma tend to have more severe and complicated reactions, which affect their emotional, behavioral, and cognitive functioning.[21] Not all children experience childhood traumatic stress after exposure to trauma; however, children in foster care often have not had the benefit of safe and stable homes that aid in building resiliency. Resiliency, or the child's capacity to cope with future stress, is a critical part of treating children exposed to trauma.[22] Interventions that work towards building healthy relationships between children and caregivers, processing painful memories, and making the child feel safe allow the child to develop strategies and tools for overcoming future trauma.[23]

Health and well-being effects. While adults often think children are too young to be harmed by exposure to trauma and stress, the effects of these experiences on a child's well-being and health can be profound. Starting in 1995 and ongoing today, the Adverse Childhood Experiences (ACE) Study has linked traumatic childhood events, such as abuse and maltreatment, with increased likelihood of risky behavior and disease.[24] The ACE Study shows that children exposed to "four or more adverse childhood experiences were four to 12 times more likely to struggle with depression, suicide attempts, alcoholism, and drug abuse" later

Understanding Trauma		
Term	**Definition**	**Characteristics/Symptoms**
Trauma	A traumatic event that results in traumatic stress.	
Traumatic event	An event that threatens life or physical integrity of child or someone important to child.	• Overwhelming sense of terror or helplessness • Intense physical effects: pounding heart, rapid breathing, trembling, dizziness
Traumatic stress	• Occurs when a child's inability to cope with overwhelming traumatic situations causes psychological and biological responses. • Elicits mental and physical responses that cause problems when they interfere with the ability to function and engage with others.	• Intense and ongoing emotional upset • Depression • Anxiety • Behavioral changes • Difficulties at school • Problems maintaining relationships • Difficulty eating and sleeping • Aches and pains • Withdrawal • Substance abuse, dangerous behaviors, or unhealthy sexual activity among older children
Trauma Types		
Acute trauma	A short-lived experience tied to a certain place or time (e.g. natural disasters, serious accidents, gang shootings, school violence, or loss of a loved one).	• Feelings of helplessness and distress
Chronic trauma	Prolonged exposure to traumatic situations over a long period (e.g., prolonged physical or sexual abuse, exposure to family violence or war).	• Feelings of distrust • Fear for personal safety • Guilt • Shame
Complex trauma	Exposure to multiple or prolonged forms of trauma, usually in context of child's relationship with caregiver. Describes exposure to multiple traumatic events, often of an invasive, interpersonal nature, and long-term impact of that exposure.	• Disrupted child development • Difficulty forming secure attachments
Understanding Polyvictimization		
Polyvictimization	Occurs when child experiences or witnesses six or more forms of violence or abuse.	• Cumulative adversity • Complex trauma • Greater incidence of serious victimization • Exposure to multiple domains of victimization • High distress levels

Sources: The National Child Traumatic Stress Network, www.nctsn.org; Finkelhor, D., H.A. Turner, A. Shattuck, & S.L. Hamby. "Violence, Crime, and Abuse Exposure in a National Sample of Children and Youth: An Update." *JAMA Pediatrics,* 2013, 1-8.

in life.[25]

Societal costs. Without intervention, children whose behavioral and emotional development are impacted by trauma are more vulnerable to negative outcomes such as dropping out of school, substance abuse, delinquency, and lower job attainment as adults.[26] In addition to the physical, mental, and developmental effects of trauma on child well-being and health, trauma also represents a huge financial cost for society. Children suffering from trauma will likely have a loss of productivity over their lifespans; and public systems, such as child welfare, social services, law enforcement, juvenile justice, and education, may also carry the burden of these costs.[27]

Consider a child's chronological and developmental age.
A child's reaction to trauma may differ depending on her resiliency and age:

Very young children. Preschool-age and young children will likely feel great fear in response to trauma. Young children have not developed the ability to know where they can find security and thus their fear extends past the circumstances of the traumatic event.[28] Caregivers may notice a loss of language and a regression in toileting skills, as well as repeated night terrors.[29] Beyond these behavioral responses, children who experience trauma during their infant and toddler years are apt to suffer limitations in brain growth.[30] Specifically, exposure to child abuse and neglect can negatively affect the parts of the brain regulating learning and self-control.[31]

School-age children. Brain development of school-age children can also be affected by childhood traumatic stress. For example, research links exposure to domestic violence with lower IQ scores for youth.[32] School-age children often become preoccupied with the traumatic experience, and may feel guilt or shame about their role in the event.[33] They may complain about stomachaches or headaches.[34] Caregivers may observe a change in behavior such as abrupt development of a new fear, inability to sleep well, signs of aggression, or impulsivity.[35]

Adolescents. Symptoms of childhood traumatic stress may be most difficult to detect in adolescents, who are often considered an emotionally volatile group regardless of trauma exposure. However, adolescents may experience a preoccupation with the traumatic event and internalize their fear, guilt, or shame.[36] Adolescents often worry about being abnormal or weak, and allow the trauma to isolate them from others.[37] They may have thoughts of revenge. These symptoms and others, such as sleep disturbance, can be masked by late night studying or staying up with friends.[38]

Form trauma-informed systems and approaches in your community.
Trauma-informed systems are structured with an understanding of the causes and effects of traumatic experiences, along with practices that support recovery. This approach gives children a sense of control and hope, and requires involvement by those working with the child, including caseworkers, lawyers, judges, providers, birth parents, and caregivers (foster parents and kinship caregivers). It also promotes awareness of secondary trauma among professionals working with traumatized children (also known as vicarious trauma or

Attorneys and Secondary Trauma

Any trauma-informed system of care should include awareness of secondary trauma and provide ways to address its impact on individuals working within the system. Secondary trauma is the cumulative effect on physical, emotional, and psychological health resulting from constant exposure to traumatic stories or events when working with others in a helping capacity. Secondary trauma is also often referred to as vicarious trauma or compassion fatigue. It is important for child-serving professionals to be aware of secondary trauma and develop personal and professional strategies to effectively address it.

Signs of secondary trauma may include disturbed sleep, withdrawal, tension, or intrusive thoughts. Other symptoms may include feelings of hopelessness, an inability to concentrate, anger or cynicism, or chronic exhaustion and other physical ailments. Secondary trauma can impact a person's ability to listen to or engage effectively with clients, or make thoughtful decisions, which can have negative effects on child clients who themselves are coping with the effects of trauma.

Some ways to address secondary trauma in a positive way and engage in self-care include:

- Provide training to all stakeholders on secondary trauma and self-care.
- Interact with co-workers through informal gatherings.
- Establish a peer support group to create ongoing dialogue within the office.
- Maintain a healthy lifestyle, including exercise and good nutrition.
- Establish life-work balance, which may include flextime scheduling or balanced caseloads
- Spend time with family and friends outside the professional setting.
- Consult a mental health professional or Employee Assistance Program (EAP).

Source: National Center for Child Traumatic Stress Secondary Stress Committee. S*econdary Traumatic Stress: A Fact Sheet for Child-Serving Professionals.* Los Angeles, CA, and Durham, NC: NCTSN, 2011. Available at www.nctsn.org/sites/default/files/assets/pdfs/secondary_traumatic_tress.pdf.

compassion fatigue) and helps them develop positive strategies to address its impact (see sidebar on Secondary Trauma and Self Care).

Serving children through a trauma-informed lens requires awareness of trauma and its effects, appropriate trauma screenings and assessments, and trauma-specific treatments. Collaborative efforts require implementing a trauma-informed approach that is not limited to one agency or court. To be effective, all child-serving systems must work together across systems to seamlessly deliver services. A trauma-informed system is more than just treatment. It is a comprehensive approach to engaging and serving children and youth that focuses on their capacity for resilience.

Resources on Trauma and Polyvictimization

The **National Child Traumatic Stress Network (NCTSN)** maintains a comprehensive website (www.nctsn.org) with numerous resources to help professionals, parents, and others, including a dedicated section on child welfare practice.

The **ABA Center on Children and the Law**, through a federally funded Office for Victims of Crime Action Partnership for National Membership, Professional Affiliation, and Community Service Organizations Responding to Polyvictimization, is addressing the need for trauma-informed legal advocacy for court-involved children and youth experiencing trauma (www.americanbar.org/groups/child_law/what_we_do/projects/child-and-adolescent-health/polyvictimization.html).

The **Office for Victims of Crime, U.S. Department of Justice**, provides resources on trauma and polyvictimization for multiples audiences (http://ojp.gov/ovc/pubs/ThroughOurEyes/introduction.html).

The **National Council of Juvenile and Family Court Judges (NCJFCJ)** maintains a website on trauma-informed court systems (www.ncjfcj.org/our-work/trauma-informed-system-care) and works collaboratively with other organizations to promote trauma awareness in juvenile and dependency courts.

Trauma-focused approaches

Several court and legal practice models incorporate a trauma-focused delivery system. Each successful model recognizes that involving all stakeholders – caseworkers, administrators, service providers, judges, attorneys, parents, and caregivers – in developing and implementing a trauma-informed system results in increased awareness, a greater capacity to overcome obstacles, and a broader range of resources. Specific training on trauma-informed legal practices involving youth, families, and caregivers can help you effectively advocate for the services your clients need. Ultimately, a more effective system allows more children in care to receive the support necessary to overcome the effects of childhood traumatic stress and thrive at home or in their placements.

Stark County Family Court in Ohio is a nationally recognized model of a trauma-informed family and juvenile court. The court, led by Judge Michael Howard, has increased systemwide awareness of trauma and built capacity for trauma-specific services for children and caregivers. National experts were brought in to educate court, child-serving, and mental health staff on child trauma.[39] A countywide Traumatized Child Task Force was formed to determine a plan for screening, assessing, and providing identified children with services.[40] Trauma-specific screenings are offered through the juvenile court, and any staff suspecting trauma can refer a child for screening.[41] The importance of trauma awareness is emphasized among all child-serving personnel, as well as families and caregivers.

Legal Services for Children (LSC) – San Francisco helps lawyers understand how trauma sensitivity can inform their daily practice. LSC proposes a model of child representation that integrates trauma awareness into every aspect of legal practice, focusing on relationships, advocacy, and coordination of care. In the first phase of its work, LSC has developed practice recommendations addressing how lawyers can build attorney-client relationships that are sensitive to youth who have experienced trauma and can increase their engagement with their legal case. Moving forward, LSC will incorporate best practices for incorporating trauma knowledge to strengthen legal advocacy. Best practices will enhance lawyers' understandings of their clients' motivations, behaviors, and needs, and promote a collaborative, holistic response to clients in crisis, including referrals to trauma-specific services and/or participating in multidisciplinary teams.[42]

Trauma-informed advocacy tools

Tools such as Identifying Polyvictimization and Trauma Among Court-Involved Children and Youth: A Checklist and Resource Guide for Attorneys and Other Court-Appointed Advocates[43] can also help you incorporate trauma awareness into your practice. These tools help you recognize the impact exposure to violence and trauma has on child development and well-being, respond to child traumatic stress through legal representation that reflects such recognition, and collaborate with other professionals to support the recovery and resiliency of the child and family. The checklist is not intended as a screening instrument but as a tool to help identify different types of traumatic experiences and symptoms of trauma in your child clients, and services to address their needs. For more information see: http://www.safestartcenter.org/pdf/Resource-Guide_Polyvictim.pdf.

Conclusion

Children in foster care are especially vulnerable to the effects of childhood traumatic stress. Your advocacy on behalf of clients should recognize

the impact of trauma, respond in a way that reflects that awareness, and aid children's recovery and ability to draw on their capacity for resiliency to overcome the negative effects of trauma. Such trauma-informed representation improves outcomes for children and their families, a key part of a trauma-informed court system.

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Update - Volume 13, Number 10, 2000

Child Abuse Allegations in the Midst of Divorce and Custody Battles: Convenience, Coincidence or Conspiracy?

By Mary-Ann R. Burkhart[1]

Child abuse allegations are difficult to prove. The difficulties lie with the inherent secretive nature of the offense. Most often, the only witnesses to the crime are the child and the abuser. Additional difficulties arise with elements of proof, oftentimes due to a lack of physical or scientific evidence.

Reaching the truth seems especially problematic when the allegation arises in the context of a contested divorce or custody dispute. The adversarial setting muddies the facts, and potentially causes individuals to wonder whether the accuser (often the mother) is trying to protect the child or to sully the reputation of an ex-spouse and gain full custody. Ensuing publicity may shift the focus from the child and foster the perception that false allegations are common weapons in divorce or custody situations. The perception may even stretch to the belief that *all* allegations made in the midst of divorce or custody proceedings are false.

Such perceptions are uniformed and unsubstantiated by the studies. For example, a study was conducted in 1986 in which over 9,000 families, appearing in eight domestic relations courts, were evaluated for sexual abuse allegations. The study found that less than 2 percent of the cases involved an allegation of sexual abuse.[2]

Handling those child abuse allegations that occur in the midst of acrimonious divorce or custody cases often presents a special challenge for child abuse professionals. Although the surrounding circumstances cannot be ignored, it is important to remember that the focal point should be the allegation of abuse. Interpreting the credibility of the allegation, understanding the child's behavioral and physical symptoms, and taking advantage of available investigative tools will pave the way to a smoother prosecution. Initially, however, understanding why the allegations would arise in the context of a custody dispute is vital for successful argument before a jury.

Why Allegations Might Arise in the context of Custody Disputes

Speculation as to why a mother or child would fabricate a story of child sexual abuse includes an hysterical or crazy mother raising allegations in order to hurt the father, or an angry, bitter mother who will stop at nothing to avenge the wrongs of her failed marriage. From those perspectives, she is viewed as a bad mother for exploiting her child to prevail in the adversarial proceeding.

Little attention has been paid, however, to the reasons why actual abuse would be exposed at that time.

Oftentimes the separation of the parents creates opportunities for disclosure. First, the dynamics of interfamilial sexual abuse are such that the non-abusive parent typically refuses to face the fact of abuse while the family is together. Once the separation occurs, however, that parent has reason to become aware and to stop selectively perceiving what has been going on.

Second, a sexually abused child is often intimidated into silence by threats, including the abuser's warning that no one will believe her. The child may feel freer to disclose once the abuser, and hence the threats, are gone. The child may also feel at that time that the non-abusive parent will now be receptive to disclosure and she will be believed.

Another reason why children might feel freer to disclose after the breakup of a family is the feelings of responsibility often felt by children who are sexually abused. Children often feel obliged to endure their role in the family dynamics due to a heightened sense of responsibility to keep the family together. This pressure dissipates once the family splits.

Feelings of loyalty may also come into play. Specifically, although the child is harmed by the sexual abuse, he may still feel torn by loyalty toward his abuser. The child is likely to desire affection from the parent and comply with the abuse. However, the separation of the parents is conducive to disclosure because the original scenario of abuse is disrupted. When the child is apart from the abuser, his emotional conflict is less looming.[3]

The Need for a Thorough Assessment and Investigation

The key to any successful child sexual abuse prosecution is a thorough assessment of the child's statement and a thorough multi-disciplinary team investigation. Since the crime of sexual abuse is a private one, and the child is the only eyewitness, proof may turn on the child's testimony.

Determining whether a report of sexual abuse is valid is a process of evaluating available information and evidence. Although corroborating evidence can be found in many cases of child abuse[4], the child's statements and testimony are typically the most significant evidence.

Interpreting the Credibility of the Allegation

As with all state witnesses and pieces of evidence, there needs to be a determination made of the credibility of the child's statements. Following are some suggestions for guidelines in making such a determination.

Detail: The nature and amount of information given by the child could be extremely convincing. A young child who has been sexually abused will often demonstrate an accurate knowledge of sexual anatomy and functioning beyond the norm for her age and background. Additionally, sensory detail information (e.g., taste, odor or feel of semen) will eliminate the suggestion that the child has received sexual information from sources other than the actual sex act. Finally, the use of highly personalized details will lend credence to her statement (e.g., how the act felt). A child's inability to provide any such detail may indicate a lack of abuse. Before jumping to that conclusion, however, be sure that the child is not suffering from fear, embarrassment, or a lack of ability to understand the interviewer.

Words Used: The words used by the child should be age appropriate. For instance, a five-year-old's description of sexual abuse such as "My daddy peed on my tummy" is graphic and appropriate for her age. In contrast, the same five year old saying "My daddy sexually assaulted me" would raise suspicions of coaching. Make sure you know terms normally used by the child to describe anatomy. Some children are taught proper names such as penis, vagina and anus at an early age. If your child uses language such as "sexually assaulted", "molest", or other such terms, be sure to review prior statements of the child, as later statements may include such legalistic terms that the child hears from others.

Child's Manner and Emotional Response: Emotional responses such as crying and shaking are more difficult for children to manufacture and may be an indication of reliability. If a child displays an unusual emotion, however, do not assume the child is not credible. In one, case, a child giggled throughout the interview. This puzzling behavior became understandable when investigators learned that giggling was how the child displayed anxiety. Indeed, the suspect who confessed to the crime noted the girl giggled throughout the rape.

Content of Statement: Does the child's allegation make sense? Is she telling you something that is physically impossible? elicit the details you can and then use common sense. The following factors can be indicative of credibility:

Description of multiple events over time, particularly where the suspected offender is known to and has a relationship with the child;

Description of a progression of sexual activity conducted over a period of time rather than in a single incident, especially if occurring within the child's family;

Elements of secrecy indicating an express or implied understanding between the offender and the child that she was not to tell; and

Elements of coercion indicting a misuse of the power and authority of the adult suspect.

Existence of a Motive to Fabricate: Your evaluation should also take into consideration what motives, if any, the child might have to fabricate. Keep in mind that when children lie, it is normally to avoid trouble rather than create it, and disclosure of abuse typically has many negative consequences. Take special note of any expressions of affection the child has for the abuser. A child who expresses affection toward the abuser or concern for his fate is providing evidence of her lack of motive to lie.

To Whom Did the Child Disclose? Especially in the case of acrimonious divorce or custody matters, this factor could be among the most important. Did the child disclose to a third party such as her therapist, a trusted teacher or friend? By disclosing to someone outside the home, the likelihood that the allegation is fabricated is substantially diminished. If, however, disclosure was made solely to the child's mother, and the child, and the child is extremely hesitant to discuss the disclosure with anyone else, the allegation should be more carefully scrutinized.

Meeting and Defeating the Untrue "Conspiracy" Defense

In spite of the foregoing facts, the goal of defense counsel is to have the jury believe that child abuse allegations that arise in the midst of divorce or custody proceedings are rampant and primarily false. The studies show both of those perceptions to be untrue. Explaining to the jury exactly why the allegations arose during this volatile time period may help aid in the jury's understanding as to the timing of the disclosure. It is during this time period, once the perpetrator has left the home, that the child feels safe enough to disclose any abuse taking place in the home.

If disclosure was made to someone outside the home, the defense argument of "conspiracy" would fall severely short, for it would require that not only the mother and child be co-conspirators, but the trusted teacher, therapist or neighbor as well. The defense becomes more unlikely with the entrance of each neutral third-party.

To contend that a young child involved a teacher or other neutral party in a conspiracy of false accusation is so untenable as to border on the absurd. Under this scenario, the child would have to realize that the teacher, being a mandated reporter, would be required under law to report the allegation to the Division of Social Services, or a like agency. The child, further, would have to disclose with the knowledge that the Division of Social Services, after responding to the allegation, would also be required to disclose the allegation to law enforcement, who would conduct a joint investigation and then turn the

case over to the prosecutor's office. Such a level of sophistication is highly unlikely in a young child.

Conclusion

An Allegation of child abuse arising out of a divorce or custody situation should be taken seriously and investigated thoroughly. It is wrong to assume that such an allegation is untrue or can't be proven. Although an allegation arising during a custody situation may create unique problems of proof, these children are no less deserving of protection.

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[2] AFCC/RESEARCH UNIT, ALLEGATIONS OF SEXUAL ABUSE AND CUSTODY AND VISITATION CASES: AN EMPIRICAL STUDY, REPORT FOR NATIONAL CENTER ON CHILD ABUSE AND NEGLECT (1988); Nancy Thoennes & Patricia Tjaden, *The Extent, Nature, and Validity of Sexual Abuse Allegations in Custody/Visitation Disputes,* 14 CHILD ABUSE & NEGLECT 151 (1990).

[3] For further discussion on this issue, see *Allegations of Child Sexual Abuse in Custody Disputes: Getting to the Truth of the Matter,* by Meredith Sherman Fahn, FAMILY LAW QUARTERLY, Volume XXV, Number 2, Summer 1991.

[4]Victor Vieth, *When a Child Stands Alone: The Search for Corroborating Evidence*, UPDATE, VOL. 12, NUMBER 6, 1999.

Calm in the Face of the Storm: Strategies on How to Effectively Represent Children in High Conflict Custody and Visitation Cases

By Dawn J. Post[1]

Jewel's[2] parents recently separated and showed all the signs of comfortably settling into a long family court battle designed to maximize the hurt they could cause the other parent. Jewel was very aware during the interview that I conducted with her that her parents were fighting over her and expressed considerable sadness over the conflict. When asked specifically, how does this make you feel, 5-year-old Jewel's response surprised me in the depth of feeling and insight she conveyed in one simple sentence: "I feel like a mood ring – all blue and grey". As an attorney for the child, what is my role and responsibilities on behalf of this young client? How can I effectively represent her and what strategies can I employ in order to defuse the conflict and reach a resolution which provides her the time and affection, free from conflict, she craved from both of her parents?

The Children's Law Center New York

At the Children's Law Center New York (CLCNY) we provide representation to children in custody/visitation, guardianship, domestic violence and related child protective cases in New York City Family Courts and Integrated Domestic Violence Parts in Supreme Courts. Our mission is to give a child a strong and effective voice in a legal proceeding that has a critical

[1] Dawn J. Post is the Co-Borough Director of the Brooklyn, New York office of the Children's Law Center (CLC), a non-profit law firm providing representation to over 10,000 children per year in the busiest Family Court system in the United States in guardianship, custody, visitation, orders of protection and related child protective cases. Prior to her current position, she was an Assistant Attorney-in-Charge of the Legal Aid Society's Juvenile Right's Practice in the Brooklyn office, providing representation to children in child protective and delinquency cases. Dawn is an expert in children's rights, advocacy and litigation, and the central theme of her work is that children and adolescents are entitled to have a voice and representation in legal proceedings that have a significant impact on their lives. To that end, she promotes cultural competence to address the underlying issues of poverty and social exclusion based upon race and socio-economic status in the legal and foster care systems in the United States. Dawn provides various trainings on family law matters in New York City focusing on trial skills, the role of the attorney for the child, custody and visitation, and child protection. Nationally, she has led panels and discussions about providing voice to children in high conflict custody and visitation cases and addressing broken adoptions. Internationally, she has lectured on the role and responsibilities of the attorney for the child. Dawn works to find new and innovative ways to improve the lives of the children in the legal system and is effective at reflecting upon and examining the issues and policies which impact children and families from various angles and from a global perspective.

[2] The names of the CLCNY clients have been changed in order to protect their anonymity.

impact on his or her life. Our core values are to provide high quality representation and to provide children with supportive, informed and passionate advocates who give voice to their unique needs. The cases to which CLCNY is assigned are varied and complex. The cases have a direct and substantial impact upon the lives of children, including: where and with whom they will live; whether or not they will visit a parent, grandparent, or sibling; and who will be their legal guardian. In more than half the cases, there are allegations of domestic violence between the parties, often involving the children. CLCNY attorneys and social workers interview the children, the parties if permission is granted, and other interested adults and collaterals such as paramours, therapists, teachers, and doctors, and obtain all pertinent records. Our client values are:

Communicate our client's voice

High quality representation

Integrate legal representation with social work

Listen to our clients

Develop the client's sense of participation

The Role of the Attorney for the Child and High Conflict Cases

In New York, the Attorney for the Child (AFC), formerly known as Law Guardian, takes a client-directed approach in advocating the client's position in all proceedings before the court. Under rule 7.2 of the New York Rules of Court, [3] the AFC must zealously advocate the child's

[3] N.Y. CT. RULES, § 7.2 (McKinney 2011). New York Court Rules defines the function of the attorney for the child as follows:

> (a) As used in this part, "attorney for the child" means a law guardian appointed by the family court pursuant to section 249 of the Family Court Act . . . (c) In juvenile delinquency and person in need of supervision proceedings, where the child is the respondent, the attorney for the child must zealously defend the child. (d) In other types of proceedings, where the child is the subject, the attorney for the child must zealously advocate the child's position. (1) In ascertaining the child's position, the attorney for the child must consult with and advise the child to the extent of and in a manner consistent with the child's capacities, and have a thorough knowledge of the child's circumstances. (2) If the child is capable of knowing, voluntary and considered judgment, the attorney for the child should be directed by the wishes of the child, even if the attorney for the child believes that what the child wants is not in the child's best interests. The attorney should

position unless the child "lacks the capacity for knowing, voluntary and considered judgment" or if "following the child's wishes is likely to result in a substantial risk of imminent, serious harm to the child." [4]

"High-conflict" custody cases are marked by a lack of trust between the parents, a high level of anger and a willingness to engage in repetitive litigation."[5] However, high-conflict custody cases can originate or be compounded by more than the parents locked in a custody dispute, but also by the mental health professionals and attorneys (haven't you found attorneys to be as alienating as their clients) and the court system "in which procedures, delays or errors cause unfairness, frustration or facilitate the continuation of the conflict." [6] This is why the role of the AFC is essential - to be the calm in the face of the storm – such as in Jewel's case in which the AFC's voice was literally the voice of reason and provided her feelings and preferences to the very people who should readily hear them. It is not uncommon for children to express during interviews:

"I just want to be normal"

"I love them both and just want them to get along"

"I don't want to be a part of this"

> explain fully the options available to the child, and may recommend to the child a course of action that in the attorney's view would best promote the child's interests.

Id.

[4] Id. at § 7.2(3). The rules further explain:

> When the attorney for the child is convinced either that the child lacks the capacity for knowing, voluntary and considered judgment, or that following the child's wishes is likely to result in a substantial risk of imminent, serious harm to the child, the attorney for the child would be justified in advocating a position that is contrary to the child's wishes. In these circumstances, the attorney for the child must inform the court of the child's articulated wishes if the child wants the attorney to do so, notwithstanding the attorney's position.

Id.

[5] *Child Custody Proceedings Reform, High-Conflict Custody Cases: Reforming the System for Children Conference Report and Action Plan.* Conference sponsored by the American Bar Association Family Law Section and The Johnson Foundation Wingspread Conference Center, Racine, Wisconsin, September 8-10, 2000.

[6] *Id.*

"I don't want to have to choose"

"Just make this go away"

However, adults frequently become consumed by the litigation and misguided motivations to hurt the other parent, and they either ignore or are incapable of recognizing how their child is feeling and how they are negatively impacted by the constant legal battles, hostile family environment, and acts of verbal and physical aggression. For Jewel my initial role during the settlement and conferencing phases of the case was simple: to share her profound sense of loss and sadness and convince her parents that the better option was to resolve their issues outside of court. In fact, a critical role I believe of the AFC is to be mediator and negotiator throughout the life of a case.

Of course, despite the AFC's best efforts, a large number of cases reach trial because parents are unable to obtain any insight into their own behaviors or attitudes. Observationally such parents are so locked into their belief systems that they will disagree with any contrary conclusions of an assessor or therapist and are immune to therapy, education, or persuasion. They view their own actions as being in the child's best interest and will never acknowledge or accept responsibility for their actions or change. They appear self-absorbed and blind to the effects on the child, on the other parent, as well as extended family. Children in these cases are often raised in family court, even after a determination is made on the original case. Often supplemental petition after petition is filed, until the child reaches the age of majority. In fact, I recently closed supplemental Y in the case of Myra, who has been the subject of intense litigation for 13 out of the last 16 years of her life.

It is our experience at CLCNY that high conflict cases that reach trial generally have one of the following issues at play: religion, mental illness, inter-familial conflict, relocation, or allegations of parental interference and alienation. I will expand on a few of these issues.

Religion can be a central issue at trial when one parent becomes less religious than the other, one parent leaves the religion or is cast out. Religious difference can be used to limit the parenting time of the non-custodial parent, exacerbate conflict over related educational and medical decision making, and may include the religious community and leader or competing

sects. One extreme example of this involved 8-year-old Shlomo whose father, his relatives, and the religious community of which they were a part made it clear that they would not obey the court's orders directing them to refrain from discussing this litigation with Shlomo when those orders come into conflict with their belief that they have an obligation to urge Shlomo to reject the mother's way of life, to press him to participate fully in the orthodox community, and to convince him that the only way he can remain a faithful Jew is to live with the paternal family in Brooklyn. Shlomo felt the pressure so keenly that he has considered harming himself and described himself as hitting his head against a table or a wall in frustration, and feeling as if he had been knocked down by a battering ram. Moreover, Shlomo likened his situation to that of a rope in a tug-of-war, had said that he felt as if he was tangled in two soccer nets, and as if he had a "whole bunch of wild animals going on top of [him]." In this case the attorney for the father also intensified the conflict as he was unable to separate his role as a Rabbi and spiritual advisor from that as an attorney representing a client in a secular court boldly stating that the pressure being brought to bear on the 8-year-old child, including from the spiritual advisors, was justified:

> Everyone up and down the line has done the correct thing. This child must be prevented from the deviant behavior on the part of [the mother]. … The obligation of Jewish education is something incumbent upon a father of a child, not the mother of a child. … It's [the mother] who's decided to drive the wedge. … The Rabbis are doing exactly what Rabbis are supposed to do. They are supposed to do everything in their power to make sure that every Jewish child attends a Yeshiva and observes the laws of the Torah as they were given so indeed they're doing exactly what the Rabbis are supposed to do. They would be remiss if they were to do anything but, and … [i]t's incumbent upon them to do everything in their power, whatever it takes, to make that happen.

Inter-familial conflict due to the death of a parent and financial incentives frequently drive high conflict cases. Some of the most complex cases that I have personally worked on have involved the death of one parent allegedly at the hands of the other parent, frequently in front of the children. For example, in the case of Danielle, age 7, the father allegedly strangled the mother in the bedroom that the parents shared with her. The father then fled, leaving the mother's body in the bottom bunk of a bunk bed, while Danielle apparently remained asleep in the top bunk. In such cases, the maternal and paternal families quickly squared off staking their claim on the child. Frequently, the child's relationship with the other family is minimized and the children's feelings, during a time when they should have the love and support from everyone,

are lost or ignored. In such traumatic cases, children's overriding desire is generally for a stable home and to maintain relationships with all members of the maternal and paternal families. However, a decision often needs to be made quickly about where and who the child should live with during the pendency of the litigation. In such cases, the role of the AFC in gathering a comprehensive perspective on the needs and wants of the child as well as how each family can and are willing to meet those needs is crucial. Using mediation and negotiation is central in order to preserve and encourage relationships while focusing on the needs and the best interest of the children.

Allegations of parental interference and alienation are common in high conflict cases. The phenomenon of parental alienation syndrome is controversial, overused and misunderstood and demands greater study than this article will allow for. However, in reality, "[v]ery few children, between 1% and 5% of alienation cases, become fully 'enmeshed' with the alienating parent, where a child has incorporated as his or her own, the extremely hostile feelings of the alienating parent for the target parent. Once this happens, it is impossible to encourage or even force the child to be with the target parent; and no amount of evidence disproving the stated reasons for the hatred will serve to abate it."[7] For practitioners, alienating strategies to be watchful of include:

• Badmouthing • Limiting Contact • Interfering with Communications • Interfering with Symbolic Communication • Telling Child Targeted Parent Does not Love them • Forcing Child to Choose • Creating Impression Targeted Parent is Dangerous	• Confiding in Child • Asking Child to Spy • Asking Child to Keep Secrets • Referring to Targeted Parent by First Name • Referring to SM or SF as Mom or Dad • Withholding medical, social or academic information • Changing Child's Name • Cultivating Dependency[8]

[7] Ward & Harvey, Family Wars: *The Alienation of Children*, NH Bar Journal, Vo., 34, No. , March 1993, quoting Clawar & Rivlin, *Children Held Hostage: Dealing with Programmed and Brainwashed Children*, American Bar Association (1991), p. 142.

[8] Dr. Amy J. L. Baker, Adult Children of Parental Alienation Syndrome: Breaking the Ties That Bind (2007)

One of the most emotionally draining cases that I worked on in which some of the above strategies were employed involved Alex, age 8, who was dying of cancer. Her mother sought to suspend the father's visitation rights even while in the confines of the hospital as she could not bear to share her daughter with anyone else. During a time when this child should have been experiencing love and support from everyone in her family, she became consumed with changing her last name to that of her mother's. Tragically, Alex died during the pendency of the case.

In custody and visitation cases, it is often very difficult to determine when to substitute judgment, particularly when allegations are made that the child is being heavily influenced or brainwashed. At CLCNY, when alienation allegations are made, particularly for an older child, we believe that it is necessary to have a finding by a neutral and qualified mental health professional that the child cannot make a knowing, voluntary and considered decision, and seek to have to the following questions resolved before substituting judgment: Was my client's decision conscious, intentional and deliberate? Was my client's decision by their free choice? Was my client's decision made with care keeping in mind possible consequences? In addition, we may ask ourselves the following:

- How serious are the acts attributed?
- How entrenched is the child in their position?
- Do observations of interactions comport with what the child is saying?
- Does the client know all the facts?
- Are there facts my client should know – but I can't or shouldn't be the one to tell them?

Solutions

In my experience, having practiced both as a child protective and custody/visitation attorney, I have found that the emotional abuse that children suffer in high conflict custody/visitation cases to be far more intentional, insidious and wide spread than in cases in which parents have been charged with abuse or neglect. For example, no matter how severe the abuse or neglect allegations, I had only a handful of children who stated that they did not wish to see a respondent parent. In stark contrast, the number of children who want to limit or suspend

contact with a parent is a large percentage of many AFC's caseloads in custody and visitation cases. It is no surprise that children of high conflict parents are three times more likely to develop psychological distress than children of low conflict parents and are also more likely to suffer from behavioral problems as they are growing up.[9] These cases, which account for the largest number in family court, demand greater attention and expertise.

Custody and visitation cases can take years. For the AFC, it is critical to identify high conflict cases early on and accelerate the process for a forensic evaluation and trial. Legal and therapeutic interventions should be geared toward fostering full reconciliation in the shortest possible time and to keep moving forward, not backwards, in parental contact, rather than take a wait and see approach. In fact, a case recently closed at CLCNY which had been pending since 2004. Justice delayed is truly justice denied.

In addition to early identification and acceleration, it is important for the AFC to possess as much information as possible from collaterals as well as the parties. As stated previously, one of the most important roles that the AFC is to gather a lot of information in order to play a facilitative role and to help mediate and negotiate on behalf of our client. Information is important to be able to assess dynamics as well as aid resolutions. In the process, AFCs use the role to educate the parents and attorneys about how the conflict is impacting children.

Some cases may appear to be high conflict but are in fact not particularly when there has been a traumatic separation. In these cases, parents may not be prepared, skilled or knowledgeable enough to handle a child's feelings towards the rejected parents while at the same time dealing with their own emotional trauma. Ultimately, these parents will be open to education, changing their behaviors for the benefit of the child, and engaging in therapy, and will be receptive to any feedback you may provide.

Furthermore, it is important is to make sure that orders are thorough, clear and unambiguous and set out clear expectations. The order must provide for mechanisms for enforcing the orders and allow for rapid intervention if the court orders are not complied with.

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[9] Bala, N. and Bailey, N. (2004). Enforcement of access and alienation of children: Conflict reduction strategies and legal responses. *Canadian Family Law Quarterly*, 23, 1–61.

Temporary orders must be as carefully crafted as final orders. Even using language as seemingly straightforward as "M" and "F" in order to designate parenting time can be problematic as in the case of Ariana, age 4, whose mother convinced a police officer, who had been called by the father to help enforce the visitation order, that "M" and "F" stood for male and female, not mother and father as it is commonly used and understood in family court. With respect to final orders, "[t]he goal of the family law system should be to give the parties the tools to restructure their lives after the immediate case."[10] Accordingly, all issues related to custody and visitation should be addressed in order to limit or prevent future litigation which could prove harmful to the child.[11]

Finally, representing children in custody and visitation cases can be significantly different than representing children in child welfare proceedings. It has been stated that child protective cases are tragedies while custody/visitation cases are dramas. Yet, even in the drama of custody and visitation litigation, a child's voice still needs to be heard and their stories told. It is up to the child's attorney to be the calm in the face of the storm and provide that voice.

[10] *Id.*

[11] Appendix Kings County Custody and Visitation orders drafted by Supervising Judge Paula Hepner.

dc's CHILDREN'S LAW CENTER family. health. education.

A Note from CLC Social Worker, Ryan Kool, LICSW, MGSW:

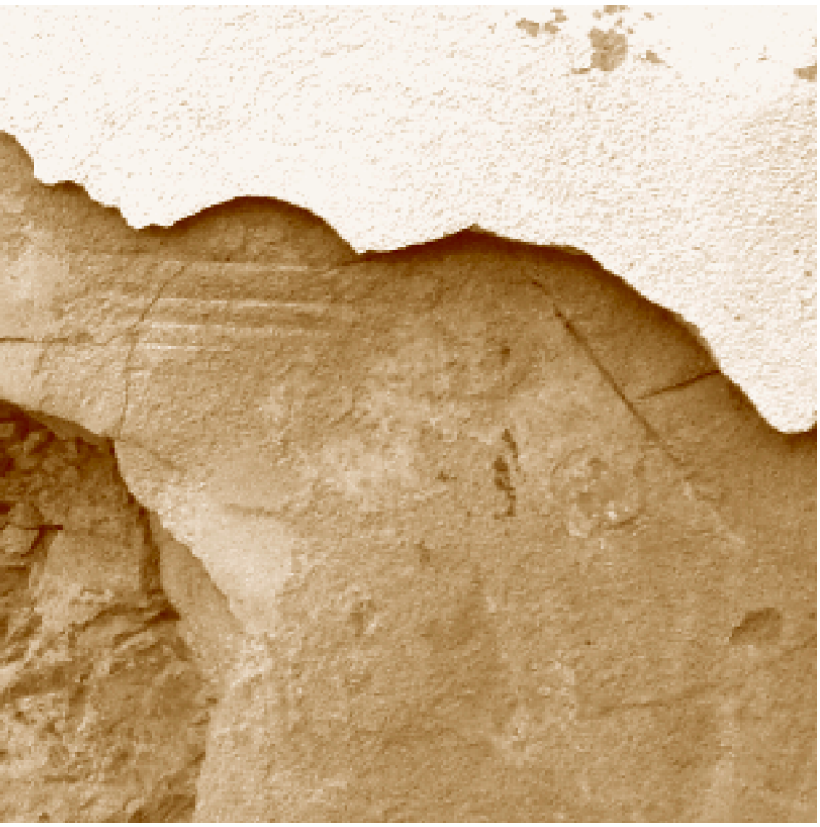
This article was chosen for inclusion into CLC's pro bono manual because it provides an overview of the problems that can occur when a child's primary caregiver abuses substances. These problems include obvious safety risks, but also include clinical concerns about the strength of a child's attachment to their primary caregiver. Poor attachment patterns have lifelong effects on children, and this dynamic is explored in the article.

One important note is that the article relies heavily on the phrase 'mother,' as opposed to 'caregiver.' Mothers naturally serve as primary attachment figures for their children. Importantly, male attachment figures and caregivers from outside of the nuclear family can form equally strong attachments with children as can biological mothers.

The report was prepared by the Child Health and Development Institute for the Connecticut Department of Children and Families. The full text of the report is available at: https://www.chdi.org/index.php/publications/reports/other/attachment-recovery-caring-substance-affected-families

April 2015

ATTACHMENT & RECOVERY:
CARING FOR SUBSTANCE AFFECTED FAMILIES



Prepared by:
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ATTACHMENT & RECOVERY:
CARING FOR SUBSTANCE AFFECTED FAMILIES

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NATIONAL ABANDONED INFANTS ASSISTANCE RESOURCE CENTER

The Connecticut Center for Effective Practice is a project directed by Robert P. Franks, Ph.D., under the auspices of the Child Health & Development Institute of Connecticut. The Center was developed in partnership between the State of Connecticut Department of Children and Families, the State of Connecticut Court Support Services Division, the Yale University Child Study Center and the University of Connecticut Health Center. This report was completed thanks to funding provided by the State of Connecticut Department of Children and Families.

www.chdi.org

INTRODUCTION

The number of children and families affected by substance abuse in the United States is growing. There are direct and indirect implications for these children and their families, ranging from physiological issues, such as fetal exposure to drugs, to social and emotional concerns, such as separation of children from their parents and disruptions in mother-child bonds, as well as situational challenges, such as poverty and lack of housing. In order to address the needs of this population various programs have been initiated and developed over time to provide mental health, social support, medical and substance abuse treatment options to these families. Overall, these endeavors have achieved mixed results, and some types of programs and some types of treatment approaches appear to work better than others. Over the past two decades or more, there has also been a significant growth in our understanding of the characteristics of families affected by substance abuse, the common challenges that they tend to face, and the rubric of individual, family and societal factors that can impede treatment. All of this has served to further inform intervention efforts and has resulted in several innovative programs and projects geared towards meeting the needs of this population. This paper will provide a general overview of key issues that families affected by substance abuse are facing today, a description of the intervention programs that show promise of effectiveness, the core ingredients of these programs, and the lessons that we can take away from these efforts.

More specifically, the impact of substance abuse on the lives of children and families is a central focus of this paper. The topic areas highlighted in the subsequent sections were chosen to reflect this focus. As a result of substance abuse within the family, there are potential disruptions to crucial attachment relationships and bonds that can occur, which in turn, can affect infant and child development in negative ways. Other topics that will be discussed include issues that are salient for substance abuse affected families, and may also present as obstacles to the formation of positive attachment relationships if they are not adequately addressed when intervening with these families. For example, infants and children from substance abuse affected families are often faced with multiple out-of-home placements in order to ensure that they are in a safe home environment. The section on transitions discusses how multiple placements and changes in caregivers can affect the development of attachment bonds for these children and steps that can be taken to minimize any negative effects that may result from disruptions in the child-caregiver relationship. Other sections of this paper highlight complex issues that are important to address in order to support parents in their substance use recovery efforts, keeping in mind that their health and overall level of functioning will impact their ability to care for their children, as well as to be physically and emotionally available to them. These range from the practical, yet fundamental, consideration of permanent housing for substance abuse affected families to more clinical concerns of addressing the complex treatment challenges that come with intervening with substance abusers who have co-occurring mental health problems.

SECTION 2:

ATTACHMENT THEORY AND IMPLICATIONS FOR CHILDREN FROM SUBSTANCE ABUSE AFFECTED FAMILIES

The infant-mother relationship is recognized as pivotal to a child's emerging personality. Greenspan (1997), Schore (1994), and Siegel (1999) have written convincingly about the ways that the early caregiving relationship influences the child's developing cognitive ability, shapes her capacity to modulate affect, teaches her to empathize with the feelings of others, and even determines the shape and functioning of her brain. The attachment and caregiving systems are at the heart of this crucial first relationship. However, for women and children affected by substance abuse, there are significant risk factors that leave the mother-child attachment relationship vulnerable to difficulties. Not only are there direct effects of the drugs used on parent behavior and health, there are also other risk factors associated with drug abuse, including children's prenatal exposure to drugs and parents' past experiences of trauma, that can affect the attachment bond between mother and child.

ATTACHMENT THEORY

Bowlby (1969; 1973; 1980) described the attachment and caregiving systems in biological and evolutionary terms stating that, across species, the attachment system was as important to species survival as were feeding and reproduction. At the heart of the attachment and caregiving systems is the protection of a younger, weaker member of the species by a stronger one. The infant's repertoire of attachment behaviors are matched by a reciprocal set of caregiving behaviors in the mother. As the mother responds to the infant's bids for protection and security, a strong affectional bond develops between the two, which becomes the template for the infant's subsequent relationships.

Attachment behaviors change as the child develops. A young infant who is tired, frightened, hungry, or lonely will show signaling and proximity seeking behaviors designed to bring his caregiver to him and keep her close. The infant may cry, reach out, or cling to his mother. Later when he is more mobile, he may actively approach her, follow her, or climb into her lap. A toddler may use his mother as a secure base, leaving her briefly to explore his world, and then reestablishing a sense of security by making contact with her by catching her eye, calling out to her and hearing her voice, or physically returning to her (Lieberman, 1993). By the time a child is four years old, she is typically less distressed by lack of proximity from her mother, particularly if they have negotiated or agreed upon a shared plan regarding the separation and reunion before the mother leaves (Marvin & Greenberg, 1982). These older children have less need for physical proximity with their mothers, and are better able to maintain a sense of felt security by relying upon their mental image of their mothers and upon the com-forting presence of friends and other adults.

Bowlby (1969; 1982) referred to attachment bonds as a specific type of a larger class of bonds that he and Ainsworth (1989) described as "affectional" bonds. Ainsworth (1989) established five criteria for affectional bonds between individuals, and a sixth criteria for attachment bonds. First, an affectional bond is persistent, not transitory. Second, it involves a particular person who is not interchangeable with anyone else. Third, it involves a relationship that is emotionally significant. Fourth, an individual wishes to maintain proximity or contact with the person with whom he or she has an affectional tie. Fifth, he feels sadness or distress at involuntary separation from the person. A true attachment bond, however, has an additional criterion: the person seeks security and comfort in the relationship.

It is important to note that an infant does not have only one attachment relationship. Bowlby (1969; 1982) posited that babies routinely form multiple attachment relationships, arranged hierarchically, although they most likely have a single preferred attachment figure to whom they will turn in times of distress if she is available. As the infant develops, however, he will form multiple attachment bonds and an even greater number of affectional bonds. And the need for attachment bonds does not end with infancy. Across the lifespan, we all experience times when we feel weak, ill, or vulnerable and turn to a loved person for support and comfort. This turning to a preferred attachment figure is the echo of our infant attachments, and our expectations of what will happen when we turn to another when we are in distress are also built in infancy.

Keeping these fundamental tenets of attachment theory in mind, it becomes evident that for infants and young children from substance abuse affected families, there are numerous situational and environmental factors that can jeopardize a child's formation of secure emotional bonds and disrupt their attachment to a preferred caregiver.

PATTERNS OF ATTACHMENT

The quality of the child's attachment to his mother is determined by the way the mother responds to her child's bids for attention, help, and protection. As Ainsworth (1989) pointed out, the defining characteristic of an attachment bond is that it is marked by one person seeking a sense of security from the other. If the seeker (child) is successful, and a sense of security is attained, the attachment bond will be a secure one. If the child does not achieve a sense of security in the relationship, then the bond is insecure. Ainsworth and her colleagues (1978) established the most widely used research method for assessing quality of attachment: a laboratory procedure known as the Strange Situation which involves two brief separations from mother in which the infant is left with a stranger. The infant's behavior on reunion following these separations forms the basis for classifying her quality of attachment.

Ainsworth (1978) described three basic patterns of attachment: securely attached, avoidant, and resistant. Babies described as securely attached actively seek out contact with their mothers. They may or may not protest when she leaves the laboratory, but when she returns they approach her and maintain contact. If distressed, they are more easily comforted by their mothers than by the stranger, demonstrating a clear preference for their mothers. They show very little tendency to resist contact with their mothers and may, on reunion, resist being released by her. Babies who are classified as avoidant in the Strange Situation demonstrate a clear avoidance of contact with the mother. They may turn away from her or refuse eye contact with her. They may ignore her when she returns after the separation. Some avoidant babies seem to prefer the stranger and appear to be more readily comforted by the stranger when they are distressed. The third group, resistant babies, may initially seek contact with their mothers on reunion, but then push her away or turn away from her. They demonstrate no particular preference for the stranger, but on the contrary appear angry toward both their mother and the stranger.

A fourth pattern of attachment behavior was later described by Main and Solomon (1990), known as disorganized/disoriented behavior. These babies seem to have no clear strategy for responding to their care-givers. They may at times avoid or resist her approaches to them. They may also seem confused or frightened by her, or freeze or still their movements when she approaches them. Main and Hesse (1990) hypothesized that disorganized infant attachment behavior arises when the infant perceives the attachment figure herself as frightening. Studies have demonstrated a higher incidence of disorganized/disoriented attachment patterns in infants whose mothers report high levels of intimate partner violence (Steiner, Zeanah, Stuber, Ash, & Angell, 1994) and in infants who were maltreated (Lyons-Ruth, Connell, Zoll, & Stahl, J., 1987). The babies of mothers who abuse alcohol have also been shown to have higher incidence of disorganized/disoriented attachment behavior (Lyons-Ruth, Easterbrooks, & Cibelli, 1997). In general, infants and young children of mothers affected by substance abuse tend to be more at risk for developing attachment behaviors that are problematic, as described above.

THE ROLE OF ATTACHMENT IN EMOTIONAL AND SOCIAL DEVELOPMENT

Bowlby (1969; 1982) believed that it is by experiencing her caregiver's responses to her bids for help and protection that an infant or young child develops cognitive/emotional templates of herself and what she can expect from her relationships with other people. These templates are referred to as internal working models. An infant whose mother responds quickly and sensitively to her cries comes to see herself as worthy of attention and help. She comes to anticipate that other people in her life will respond to her positively when she needs something. She gains a sense of efficacy and agency: a belief that she can make things happen. On the other hand, a infant whose mother does not respond to her bids constructs an internal working model of herself as unworthy and other people as unresponsive

or, perhaps, as dangerous. The avoidant, resistant, and disorganized styles of attachment described above are in response to inconsistent or insensitive caregiver responses to an infant's bids. For an infant with a mother who is struggling with substance addiction and abuse, it is more likely that maternal responses to their child will be less consistent and less responsive, thereby impeding the development of healthy internal working models.

The literature suggests that the internal working models of attachment that are formed in infancy and early childhood form the templates for a variety of interpersonal relationships throughout one's life. Preschool children with secure attachment histories have been shown to be more self-confident and less dependent with their teachers than insecurely attached children (Erickson, Sroufe, & Egeland, 1985). The same children, at age ten, were less dependent on summer-camp counselors than were children with insecure attachment histories. It has also been found that securely attached six year olds were more competent in play and conflict resolution with peers than were insecurely attached children. Other researchers have found that these increased competencies extended into later childhood (Grossmann & Grossmann, 1991) and adolescence. Further, some research findings suggest that insecurely attached babies tend to develop behavioral problems during childhood. For example, it has been reported that insecurely attached boys were more aggressive than securely attached ones at four and six years of age, respectively; and Turner (1991) found that insecurely attached girls were more dependent and less assertive than securely attached girls. More recent studies have also noted that other factors besides inconsistent or insensitive maternal caregiving contribute to attachment insecurity. For instance, it has been suggested that it is more the fit between a child's temperament and a variety of environmental factors, including caregiver variables, such as child maltreatment, maternal depression and maternal substance abuse, as well as situational variables, such as level of family stress, which influences the development of insecure attachments (Greenberg, 1999). Hence, children who develop attachment difficulties due to parental use of substances or other reasons may have long term difficulties which can affect their adjustment, functioning and personality development later in life.

ATTACHMENT PROBLEMS IN YOUNG CHILDREN FROM SUBSTANCE ABUSE AFFECTED FAMILIES

Even though some studies indicate that insecure attachment styles can lead to emotional and behavioral difficulties, it is important to keep in mind that insecure attachment styles are not mental disorders. They are strategies for protection seeking on the part of the infant or young child that occur in the normative population. When the child's attempt to engage with a caregiver are frequently rejected or ignored, for example, it becomes adaptive for a young child to not expect, rely upon, or continually seek such interactions. Lieberman and Zeanah (1995) propose three separate categories of attachment disorders that tend to warrant more clinical concern: (1) disorders of non-attachment, (2) disordered attachments, and (3) disrupted attachment disorder: bereavement/ grief reaction. Of particular significance for infants and young children affected by substance abuse are the disorders of non-attachment, which closely parallel the description of reactive attachment disorder as it appears in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV, TR; APA, 1994). These disorders most frequently appear in children who have not had the opportunity to attach to a single caregiver, and they are of two major types, the first involving emotional withdrawal and the second, emotional promiscuity or indiscriminate behavior.

Example of non-attachment with indiscriminate behavior (Source, 1999): Susan was 15 months old when she came to live with her paternal aunt and grandmother. Until then, she had been in the care of her mother who was addicted to crack cocaine and had lived with her in a variety of crack houses and, sometimes, on the street. Her mother also had left Susan sporadically with relatives, sometimes telling them that she would be back in several hours and then not returning to retrieve her daughter for days or weeks. When Susan's mother learned of her own hiv status, she left Susan with her aunt and grandmother, saying that she could no longer care for her. Susan was physically weak, dirty and malnourished, unable even to sit up. A physical exam disclosed that she had been raped. When she was first seen in the clinic, Susan had been with her grandmother and aunt for three

months. She had regained her physical strength and was able to stand and walk, but emotionally she was still having difficulties. She clung to both her aunt and her grandmother, screaming if they left the room and waking up in terror several times each night to make sure that they were still there. She hugged strangers in line at the bank, and when her uncles came to visit, she crawled into their laps, embraced them, and tried to remove her clothing. She approached the therapist in the very first session, clung to her knees, and sat on her lap. At the end of the hour, she sobbed when the therapist got up to leave, and could not be comforted even by her grandmother. It took many months of sensitive care for Susan to begin to develop a preference for her grandmother and to reliably turn to her for comfort.

Research on the interactions of substance abusing mothers with their infants suggests significant risk for difficulties in the mother-child relationship. In a study of infants placed with substance-abusing mothers following birth, seven percent died prior to one month of age and four percent were reported for abuse or neglect prior to six months of age (Tyler, Howard, Espinosa, & Doakes, 1997). Observations of cocaine-using mothers found they spent significantly more time disengaged from their newborns than a comparison group (Gottwald & Thurman, 1994). When compared to a control group, polydrug-using mothers are observed to be less attentive to, and less interactive with, their infants regardless of the infant's willingness to interact (Mayes, et al., 1997). Further, it is important to take into account the multitude of economic, psychological and environmental factors, including poverty, lack of permanent housing, mental illness, child abuse and inadequate parenting skills, which can have a significant impact on the home environment and parent-child relationship in substance abuse affected families. All these issues have significant treatment implications when addressing attachment problems with this population since solely focusing on maternal sobriety may not be sufficient for fostering a secure, nurturing and responsive environment.

Maternal separation from infants, which often occurs in families affected by substance abuse, may compound preexisting mother-infant interaction problems. Mothers who are separated from their infants are less likely to be familiar with the child's attachment signals. Thus, when reunification does occur, interaction difficulties are further compounded by the infant's grief over loss of an attachment figure and the mother's lack of familiarity with the infant's needs. Mothers separated from their infants may also have less understanding of, and less tolerance for, their infant's individual needs, which may inadvertently lead to an increased risk of child maltreatment (Wobie, Eyler, Conlan, Clarke, & Behnke, 1997).

According to attachment theory, the quality of care provided in the kinship or foster placement will determine the type of attachment relationship the child and caregiver develop. Although there is little empirical data available on the quality of care provided in kinship and foster placements and the establishment of healthy attachment relationships with substitute caregivers, kinship placement has been found to be safer for infants than placement with an actively substance-abusing mother (Tyler et al., 1997). There is, however, a range of care provided in kinship placements with some kinship placements failing to provide the sensitive, responsive care needed for the development of a secure attachment. Hence, number and type of placements are a significant concern when considering intervention programs and efforts for this population of children. The complex attachment challenges that can arise for infants and young children who are separated from their mothers and have to experience multiple caregiver transitions are further discussed in the next section, which addresses the issue of multiple placements for infants and young children.

Table 1.
Potential Attachment Difficulties in Children from Substance Abuse Affected Families

- Emotional withdrawal in infants whose bids for interaction are consistently unmet
- Emotional promiscuity / indiscriminate behavior – infants becoming overly attached quickly to new and multiple adult figures in order get nurturing needs met
- Mother-child relationship problems – mothers feeling disengaged from their infants; infants being less interactive with their mothers; mothers being less tuned in to their infants signals
- Maternal separation from infants and young children
- Less understanding and tolerance for infants' needs and behaviors on the part of the mothers
- Disruptions in attachment relationships due to multiple placements
- Kinship placements may not always provide an optimal nurturing environment for infants

"FOR WOMEN AND CHILDREN AFFECTED BY SUBSTANCE ABUSE, THERE ARE SIGNIFICANT RISK FACTORS THAT LEAVE THE MOTHER/CHILD ATTACHMENT RELATIONSHIP VULNERABLE TO DIFFICULTIES."

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Quick Reference: Common Signs and Symptoms of Domestic Violence, Substance Abuse, and Child Maltreatment

SIGN: A manifestation of a condition that can be objectively observed by a clinician.

SYMPTOM: A manifestation of a condition that is apparent to the person suffering from the condition, but may not be objectively apparent to a clinician.

PHYSICAL ABUSE

SIGNS	SYMPTOMS
• Reported injury by a parent or caregiver • Unexplained bruises, burns, bites, broken bones, other injuries	• Repeated accidents • Fear • Anxiety • Aggression • Social Withdrawal

SEXUAL ABUSE

SIGNS	SYMPTOMS
• Bedwetting • Pain, bleeding, infections in the genital or rectum • Recurrent vomiting or stomachaches • Pre-teen or early teen pregnancy	• Hypervigilance / fear • Inappropriate sexual knowledge and/or belief • Self-mutilation / suicidal threats • Sleep disturbances • Running away

Adapted from Child Welfare Information Gateway (https://www.childwelfare.gov/) and Kaiser Permanente (http://share.kaiserpermanente.org/)

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NEGLECT

SIGNS	SYMPTOMS
• Dirty appearance • Inappropriate dress • Listlessness or tiredness • Developmental delays • Need for dental, optometric, or medical treatment	• Hunger • Stealing food • Missed school • Lack of supervision • Inability to stay awake • Drug or alcohol abuse

EMOTIONAL ABUSE

SIGNS	SYMPTOMS
• Physical delays • Emotional delays • Attachment difficulties	• Extremes in behavior • Inappropriately adult behavior • Inappropriately infantile behavior

Effects of Domestic Violence in Children

CHILDREN 5 YEARS OLD AND YOUNGER

• Regression	• Difficulty sleeping
• Withdrawal from touch	• Disrupted attachment
• Clinginess	• Higher risk of physical injury
• Violence in play	• Increased crying
• Eating problems	• Nightmares

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CHILDREN 6 – 11 YEARS OLD

- Absences from school
- Academic difficulty
- Behavioral difficulty
- Abrupt changes in mood
- Sadness
- Worry
- Self-blame
- Somatic complaints
- Any of the behaviors seen in children 5 and younger

ADOLESCENTS 12 – 17 YEARS OLD

- Substance abuse
- High-risk sexual behaviors
- School truancy
- Staying out past curfew
- Early sexual activity
- Any of the behaviors listed for other age groups

Indicators of Possible Substance Abuse by Caregivers

- Reports from children or other adults
- Paraphernalia
- Observed changes in mood or behavior
- Financial stress
- Difficulties with work
- Difficulties with relationships
- Criminal behavior

Adapted from Child Welfare Information Gateway (https://www.childwelfare.gov/) and Kaiser Permanente (http://share.kaiserpermanente.org/)