

Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

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Presidential Column:

Infants in Under-Staffed Nurseries: In Wealthy Societies

Introduction by Jody Todd Manly,

USA,

Associate Editor

In childcare settings, there are frequently struggles to balance affordable rates for parents, adequate salaries for providers, equitable resource allocation, and quality service implementation. Parents often face dilemmas balancing work responsibilities and personal goals with family responsibilities and sensitively meeting the needs of their children. With multiple financial and regulatory factors affecting provision of services, needs of young

children may be compromised when management decisions are made. Kai von Klitzing provides a personal reflection that details historical factors in Germany that have resulted in inequities in staffing ratios in childcare settings. Similar challenges exist worldwide, with children caught in the middle. Barriers to accessing high quality care may pose difficult decisions with limited options for families. Providers may find themselves stretched thin when the number of children in their care is too high and insufficient resources are available. Babies and toddlers do not have a voice in these adult decisions, and their emotional needs may be overlooked when cost-cutting measures result in less-than-adequate ratios. When systems do not prioritize children's needs, long-lasting developmental consequences may ensue. How can we, as champions of young children, advocate for systems change that prioritizes children, facilitates relationship development, and provides sensitive caregiving by wrapping a network of support around families?

By
Kai von Klitzing, Germany

Recently, the German Bertelsmann Foundation published a study that investigated how many infants (aged 0–3) on average are looked after by one professional nursery teacher in German nurseries ([Ländermonitoring Frühkindliche Bildungssysteme](#)). This is a relevant topic for several

reasons. The results show how much a wealthy western industrialized country invests in early childcare and whether there are regional differences between the Eastern (until 1990 German Democratic Republic/GDR) and Western (former Federal Republic of Germany/FRG) parts of our country. The two parts of Germany have quite different histories. In the former GDR infants mainly grew up in state nurseries and saw their working parents only in the evenings (in some nurseries they even stayed the whole week) and at the weekend. In contrast, in the FRG the ideal of early education was that children should stay with their mothers until age 3 and then enter preschool or kindergarten.



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These different concepts are still present in the minds of many parents today, although a certain convergence has taken place over the last 30 years. Socially and politically, the two parts of Germany have also developed differently. In the Western part there is greater prosperity compared to the Eastern part; there is more economic power, people earn more money and are wealthier. This causes many inhabitants of the Eastern part of the country to feel they have been short-changed or even neglected. There is still considerable migration from the East to the West, there is more xenophobia in the East, and the right-wing Populist Party is more successful there (latest polls 22%) compared to the West (12%). So I was curious about the Bertelsmann Foundation's results: would the considerable social differences be reflected in the ways that infants are cared for in public nurseries?

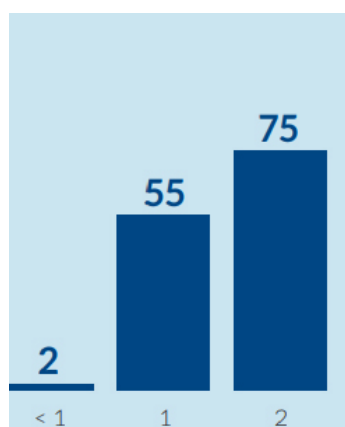
The results showed significant differences. In the largest East German state, Saxony, 2% of children aged < 12 months, 55% of children aged 1–2 years, and 75% of children aged 2–3 years spend more than 25 hours per week on average in a nursery. By comparison, in the West German state of Baden-Württemberg (BW) the numbers are significantly lower: 2% of children aged < 12 months, 24% of children aged 1–2 years, and 50% of children aged 2–3 years.

Furthermore, the majority of children in East Germany (Saxony 71%) spend more than 45 hours per week in the nursery whereas in West Germany (BW 50) only 24% spend more than 45 hours per week there. So quantitatively, in the Eastern part of Germany a large part of the care of infants aged 1–3 still takes place in institutions, whereas in the Western part of Germany mothers still provide most of the care.

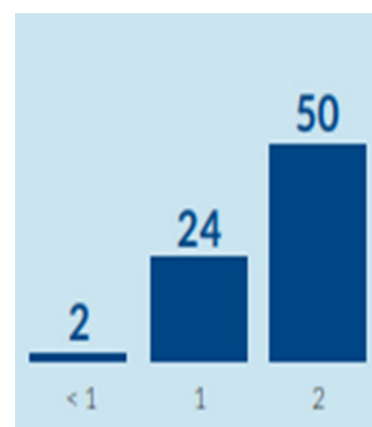
Having this in mind I was surprised when I noticed the average staff member to child ratio: the Bertelsmann Foundation recommends a ratio of 1 professional nursery teacher to 3 infants aged 0–3. In the Western state (BW) the ratio currently is 1:3.2, whereas in the Eastern state (Saxony), the ratio is 1:7.5. That means that in the poorer Eastern region, more children aged 0–3 spend nearly twice as much time in nurseries compared to the richer Western region; at the same time, they receive less than half of the attention and care of their Western counterparts. Furthermore, the researchers drew our attention to the fact that there are always staff members who are not available because of illness, vacation or administrative work, so we may estimate that in the East German state on average one nursery teacher has to care for 8 to 9 children aged 0 to 3.

I must say I was really shocked by these results. Taking care of 8 infants at a time means being able to fulfil only their most basic needs like feeding and cleaning at the most. But there is no time to respond to their emotional needs for affection, attunement, consolation, regulation etc. That means that nationwide, a rich industrialized country like Germany does not provide sufficient care for the youngest members of the society, although it is a fact proven by many scientific studies that emotional neglect in the first three years creates a tremendous risk of later biological and psychiatric suffering over the whole life cycle. The foundations of moral, social, cooperative development have to be laid in the early years (See WAIMH's 2017 position paper: [The worldwide burden of infant mental and emotional disorder: report of the task force of the World Association for Infant Mental Health](#)).

Saxony:



Baden-Württemberg:



From: Ländermonitoring Frühkindliche Bildungssysteme; Bertelsmann Stiftung 2019.

I was also shocked that the inequality of developmental opportunities between the two parts of our country seems to be deeply entrenched this early. After a few days I was even more shocked that the study, which had been reported in the newspapers, caused no public outcry at all. There is a lot of discussion in our media about the fact that adults in East Germany earn around 20% less than their colleagues in West Germany, and that old-age pensions are also lower. But the adult world does not notice that our very young children are at the mercy of this fundamental injustice and inequality!

I was already in a state of anger and sadness when a journalist from our local newspaper called and asked me, as the President of the World Association for Infant Mental Health, to comment on the results from the Bertelsmann Foundation. So, I put all my emotions into my response. The next day, an article appeared under the headline,

**"Does Society Accept Child Maltreatment?"
Professor for Child Psychiatry Criticizes Persistent Inadequate Staffing Ratio in Eastern Nurseries**

"Kai von Klitzing, president of the World Association for Infant Mental Health, criticizes the dramatic shortage of nursery teachers in Saxon nurseries. 'It looks as though society accepts childhood maltreatment.' The professor for child psychiatry is surprised 'that there is no real outcry about this unbelievable failure. Children in the eastern part of Germany seem to have only half the developmental opportunities of their counterparts in the western states.' The medical doctor warns: 'The lack of care can lead to emotional neglect in East German nurseries, which doubles the risk of biological as well as psychiatric illness over the life cycle. The lifelong feeling of having drawn the short straw, which is common in the eastern German states, is already being embedded during the first three years of life.'"

I must confess that these were provocative words. It was simply an attempt to summarize the state of scientific

developmental knowledge and to open it up for public debate. It is clear that when one nursery teacher is responsible for 6 to 9 children aged 0 to 3 for several hours, most of the children may not receive adequate support or mirroring that could help them to regulate their own emotional states, to overcome their sadness at being separated from their parents, to manage their anxieties, and to fulfil their need to be loved and cared for. They may be well dressed, fed and clean, but it is possible that they will suffer emotional starvation for several hours every day. The younger they are the more this emotional neglect may overshadow their mood, their self-confidence, and their narcissistic homeostasis. Emotional neglect is probably the most common form of child maltreatment and one of the most important risk factors for many health problems, including cardiac, immunological and emotional diseases, as well substance abuse. Furthermore, early forms of neglect may have a negative effect on cooperative social and moral development, with enormous consequences for the society. For these reasons, I equate poor childcare with the strong words, emotional neglect and child maltreatment.

Three political parties are currently negotiating a coalition for the next government in our state. In addition to activities against climate change, the phasing out of brown coal mining, recruiting more police officers and teachers, improving the state nurseries is one of the hot topics. The politicians seem to agree that they must raise nursery teachers' salaries and the quality of their education, and also significantly increase the staffing ratio. This makes me optimistic, because it shows that scientific efforts and advocacy for infants' needs can lead to political change.

But I also received negative reactions to my statement in the local newspaper. One very good colleague of mine, a mother of 5 children and member of our local parliament, sent me the following email:

"I feel compelled to react to your statement published today in the newspaper. It is a shame that you used a term stemming from criminology in order to draw attention to a problem. And it is not objective or neutral to draw conclusions for the whole of society from a single (but important) issue. Furthermore, it is offensive to devalue the East

Germans. Ultimately you attack women. I personally feel assaulted by your words. I protest against your reproach, that I emotionally neglected my children who all went to nurseries. I agree that the staffing ratio has to be improved. But the situation in the nurseries is the consequence and not the cause of the problems in our society."

Immediately after I received this email, she called me and we had a very good conversation. She argued from a feminist point of view that the tradition in the former communist countries of providing nurseries for all infants from as early as possible enabled mothers to continue working even after they had children, and led to greater equality for women, a situation that was and is superior to the inequality of men and women in many Western countries.

The Swiss newspaper, *Neue Zürcher Zeitung*, recently entitled an article on the situation of parents in Germany: "*On Callous Mothers ('Rabenmütter') and Standout Fathers ('Spitzenväter')*" ([30 Jahre Mauerfall: Was Gleichberechtigung ausmacht](#)). The article went on to analyze the situation in Germany, where the women living in the Eastern parts defend their emancipated position against the traditional and old-fashioned role model in the Western parts of women who were 'chained to house and home and economically dependent on their husbands.' One of the reasons for the more progressive female position in the East is the fact that most children under 3 are cared for in a comprehensive network of nurseries. I think the author's analysis was basically right, but in the whole article there is no mention of the situation of the young children.

The critique from my colleague affected me on a very personal level. We all try to raise our children in the best way possible within the circumstances in which we live. To do that we constantly have to make compromises. For example, if I raise my young child or children as a single parent, want to reach goals in my career or just have a job that provides a living for my family, I have no choice but to place my child or children in the nearest nursery that offers a place for day care. I hope of course that it is a good-quality nursery, but I see every day that there are not enough nursery teachers and that this places a burden on the teachers who are stressed and compromised in their ability to care for all the infants and young children in an

age-appropriate way. I hope then that my child is resilient and can thrive in possibly less than optimal conditions. Sometimes I am also exhausted at the weekend and not as emotionally available for my child as I would like to be. All these limitations and inadequacies may provoke feelings of guilt in me, which is a heavy burden. But I have no choice: there are economic reasons why I cannot stay at home, and even if I could, I would not do it because I am also ambitious and do not want to give up my professional goals. So, when we express concern that our nurseries are short-staffed and that infants do not receive the care that they need we are also criticizing ourselves for neglecting our own children by sending them to the available nurseries. So, our justified claim for quantitative and qualitative improvements in staffing in our nurseries may be accompanied by our own guilt feelings and doubts about our parental qualities.

There is a further dilemma: when we stand up for infants' rights to be raised within "sensitive and responsive caregiving relationships" ([WAIMH Infant Rights Paper](#)) and express our critique that these rights may not be guaranteed in under-resourced and under-staffed nurseries, we may be in conflict with women's rights to participate equally in the social and professional life of our society. Of course this may imply the same problems for fathers, who feel responsible for their children. But in spite of the move towards a new fatherhood, most studies show that in our Western industrialized countries the vast majority of child-rearing work is still done by women. So, it is mostly women who are confronted with the dilemma between adequate care for their young children and maintaining their own professional careers and/or earning enough money for living. Therefore, as my colleague warned me, public critique of unsatisfactory conditions in nurseries can rapidly acquire a flavour of being reactionary and misogynist. (Incidentally, the same reproach can be made when we argue for the fundamental rights of unborn children).

The human rights attorney Bruce Adams argued at the Committee on the Rights of the Child Day of General Discussion, "Implementing Child Rights in Early Development", on 17 September 2004 that many human rights are not absolute rights. For example, with respect to early childhood, there are two sets of interests: the mother's well-being or autonomy, and the infant's well-being. Like all basic rights, the right of the infant to grow up in the context of quantitatively sufficient, sensitive, and responsive caregiving relationships is also context-dependent and requires balancing decisions. This is

what parents do in everyday life. On the one hand, they try to consider the needs of their young children, especially their need for a constant and affectionate parental figure; while on the other, they should not ignore their own wish to participate in adult life, their goals in their professional careers, and their economic situation, as well as their own need for adult intimacy. In the end, their parental practice is the result of compromise between these poles. If they completely lose sight of their children's needs, they are neglectful parents.

To establish nurseries in which infants spend more or less time, are cared for by professional teachers and can have their first experiences with peers is a decision made by society in order to help parents and children to find compromises between the adults' right to self-fulfilment, their economic needs and the infants' right to reliable care. If a wealthy society and/or wealthy parents decide to resource these nurseries so that the staffing ratio makes it possible for nursery teachers to provide reliable care, with respect to each infant's physical and emotional needs, we will have protected the rights of infants and very young children to the care they deserve in the early years.

To acknowledge the state principle of reasonable economic management and the goal of improving women's rights to participation makes sense only if we also acknowledge the other side of the coin: the right of infants to grow up under suitable conditions. We can balance these poles, we can try to find compromises between different rights-holders in a society, but we cannot deny that our youngest members of the society, babies and infants, also have fundamental rights that must be seriously observed and respected.

Therefore, after all these reflections and considerations, I would conclude:

Yes, underfunding of nurseries in wealthy societies is a socially accepted form of child maltreatment!

Perspectives Editors reflective questions

The President of WAIMH, Professor Kai von Klitzing, has presented an historical context to understand the inequity of staffing ratios in early childhood care and education within Germany and foregrounds the infants' experience of this inequity. Kai has raised these issues with courage and passion to give voice to infants' experiences while also being compassionate, thoughtful, and acknowledging of the complex systems of care.

In so doing, his column calls us each, as WAIMH members and allied colleagues of WAIMH, to hold the infants' experience in mind and to use this experience to find ways to voice what babies need in these circumstances. It also calls us connect with each other to further develop our professional sensitivity and responsiveness.

As such, we invite you to join with us and consider the following questions:

What is needed within WAIMH so we can more fully acknowledge and support our early childhood education colleagues?;

What is needed within WAIMH so we can continue to build a strong bridge between the health and education sectors?; and

What useful global models and initiatives for early care and education from organisations such as UNICEF can we identify that lend support to our advocacy efforts with regard to this issue?

As editors we invite you to share your responses with us. We also especially invite early care and education colleagues and specialist consultants in the early care and education sector to be part of a special interest group to explore this issue on a global scale as a way to uphold the infants experience, be a voice for infants and their families, and to provide a WAIMH supported network for colleagues in this sector.

If you are interested in being part of this initiative, please contact the editors.

WAIMH Executive Director Corner

By Kaija Puura, Tampere, Finland,
WAIMH Executive Director

It is now November, which in Finland means mostly gray skies, rain and days that keep getting shorter and shorter. During this dark time of the year it is nice to think about the upcoming 17th WAIMH World Congress in Brisbane taking place from 7th-11th June, 2020. The Local Organizing Committee (LOC) chaired by Elisabeth Hoehn and Libby Morton, and the Scientific Program Committee (SPC) chaired by David Oppenheim have both been working hard, and together with the Professional Congress Organizer have managed to get over 900 submissions for the Congress. These submissions include new research findings and, as has been our unique feature, also lots of examples of clinical programs and interventions from all around the world.

In addition to the submissions, the Brisbane Congress will have a large number of international experts presenting their research and clinical work. Prior to the official Congress program, the local Australian Affiliate will have a pre-congress event running for the whole day, and a group of our Affiliates from different parts of the world will be organizing a half-day pre-congress event. We warmly invite you to attend these pre-congress events as well.

The four plenary speakers, who have already been introduced to you on the Congress website and in the social media postings, come from different countries, and the topics they will be covering are varied and interesting. In Brisbane our traditional Master Classes are for the first time included in the Congress participation fee, and I can tell you that the Master Class speakers all represent the best in their individual fields. And as a novelty at WAIMH Congresses, the Scientific Program will also include three State of the Art lectures with distinguished researchers and clinicians as speakers.

As many of you may know, preparing a WAIMH World Congress is a long process with a lot of stages. Now, with the Congress about half a year away, both the submission and review of the abstracts are completed. The next step is the meeting of the Scientific Program Committee here in Tampere at the beginning of December, where the Committee members will go

through all the abstracts one more time in order to make the final acceptance. During the four-day meeting the Committee, together with the WAIMH Office staff, will create the Congress Program from the accepted submissions - I can tell you from experience that it is hard work! You can visit the Congress website at the end of December to see what the final program will look like. This time you don't have to print anything from the website in order to have the program with you in June as we will have it in an electronic app that you can install on your smartphone or tablet.

We will also keep you posted in social media on how things are proceeding with WAIMH Brisbane 2020. The registration pages are already open, and when you register you will also be able to donate to our Sponsor a Delegate program. The Sponsor a Delegate program has been a WAIMH tradition since the Cape Town Congress, and with it we want to help colleagues from low income countries to participate in the Congress.

Brisbane and Australia offer many opportunities to combine the Congress with leisure. The Congress website at www.waimh2020.org gives you many ideas on what to do if you have some time for a holiday as well.

The WAIMH Office will have its stand at the Brisbane Congress, with Minna, Sari, Reija and myself present. Come and say hello to us!



WAIMH Executive Director, Professor Kaija Puura.



From the Editors

By

Maree Foley, Switzerland,
Deborah J Weatherston, USA
Patricia O'Rourke, Australia
Jody Todd Manly, USA
Salisha Maharaj, South Africa
and Minna Sorsa, Finland

This Fall (2019) edition of WAIMH *Perspectives in Infant Mental Health* includes reviewed and accepted papers since the Winter/Summer (2019) edition. Each paper calls attention to and consideration of what WAIMH members and allied infant mental health colleagues around the world are thinking, doing, and writing about.

For newcomers to WAIMH, *The Signal* was the former name of *Perspectives in Infant Mental Health*. Furthermore, Emily Fenichel, named *The Signal* after an international contest. At the time Emily was Associate Director of Zero to Three and was also the Editor of the Zero to Three Journal from 1992 – 2006. Currently, issues can be accessed online, with past issues dating back to 2007 currently available by following this link: <https://perspectives.waimh.org/perspectives-archive/>. In addition, past articles are also available online in text format, which in turn can be shared: <https://perspectives.waimh.org/>

Editorial Board News

Over the past few years, much has changed with regards to the publication including shifting to an online publication, digitalizing recent and past editions, as well as the production of shorter social media-oriented posts. As such, the Editors of *Perspectives in Infant Mental Health*, with the WAIMH Board, Executive Director, and the Editorial Board, have been engaged in a reflective review process concerning the structure of the Perspectives Editorial staff and the Editorial Board.

As a result, the following decisions have been made:

1. To work with a larger editorial staff team in contrast to the current small editorial staff team and large Editorial Board;
2. To disband the Editorial Board structure and focus on a globally representative editorial team;
3. To invite the WAIMH Board member who held the communications portfolio to join the *Perspectives in Infant Mental Health* Editorial team as an Associate Editor;
4. To continue with the existing roles: Editor in Chief; Associate Editor; and Production Editor; and
5. To add two new editorial roles: WAIMH Board Associate Editor; and WAIMH *Perspectives in Infant Mental Health* Intern.

We very much want to thank the past Editorial Board members for their service and commitment to this publication. We also greatly appreciate the ongoing support that many have offered to the work of the publication.

As of October 2019, we began work as a new editorial team and this Fall issue represents the collaboration of a newly formed *Perspectives in Infant Mental Health* Editorial team:

- Maree Foley (Switzerland) Editor-in-Chief
- Deborah J. Weatherston (USA) Associate Editor
- Patricia O'Rourke (Australia) Associate Editor
- Jody Todd Manly (USA) WAIMH Board Member Associate Editor
- Salisha Maharaj (South Africa) WAIMH Perspectives Intern
- Minna Sorsa (Finland) Production Editor

Introducing the WAIMH Perspectives in Infant Mental Health Editorial Team

Editor-in-Chief: Maree A Foley, PhD



Maree Foley Ph.D. is a Child, Family, and Organisational Consultant in Geneva, Switzerland. Maree started her career in the late 1980's as a Social Worker. From the mid 1990's Maree practiced as a registered child psychotherapist, in

the public, private and civil society sectors in New Zealand. She also has researched in the area of attachment theory and work-place relationships and practiced as an organisational consultant. She is currently engaged with research concerning infant mental health and global public health. She is the past President of the Infant Mental Health Association of Aotearoa New Zealand (IMHAANZ). From 2010-2018 she was an Executive board member of the World Association for Infant Mental Health (WAIMH). From 2019, as Editor-in-Chief of WAIMH Perspectives in Infant Mental Health, Maree is a general WAIMH Board member.

Associate Editor: Deborah J. Weatherston, PhD, IMH-E®, Infant Mental Health Consultant



Deborah Weatherston, Ph.D. co-developed and directed the Graduate Certificate Program in Infant Mental Health at the Merrill-Palmer Institute of Wayne State

University in Detroit, Michigan from 1988-2002. She was Executive Director of the

Michigan Association for Infant Mental Health from 2002 - 2016 where she helped to develop the MI-AIMH Competency Guidelines and the MI-AIMH Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health®, now licensed for use by 30 state infant mental health associations, Ireland and West Australia. In 2016 she became Executive Director of the Alliance for the Advancement of Infant Mental Health® and retired in 2018 to emeritus status. Of additional interest, she was a ZERO TO THREE Leadership Fellow, a Board Member of the World Association for Infant Mental Health (2010-2014), Editor of WAIMH Perspectives in Infant Mental Health (2012-2019) and is a Consulting Editor for the Infant Mental Health Journal. She has written extensively about infant mental health practice and, most recently, about reflective supervision as a cornerstone for effective work with infants, very young children and families.

Associate Editor: Patricia O'Rourke, PhD



Patricia O'Rourke, Ph.D. is a child psychotherapist and psychodramatist and works in the public and private sectors in Australia and

New Zealand. She has a special interest in preventative work with infants and their families, child protection, reflective supervision and group work. Since 2011 she has coordinated the Infant Therapeutic Reunification Service at the Women's and Children's Hospital, Adelaide, South Australia. This service makes timely decisions for maltreated and neglected infants and, where possible, works therapeutically to reunify infants with their parents. Currently Patricia provides reflective supervision individually and in groups to workers in both the infant mental health and early education systems. She believes there is an urgent need to translate what is learned in research into everyday clinical practice. As part of her PhD research with mothers and newborns, Patricia has created a clinical tool for midwives which is currently undergoing further validation and development.

WAIMH Board Member Associate Editor: Jody Todd Manly, PhD



Jody Todd Manly, Ph.D. is a clinical psychologist who is currently the Clinical Director at the Mt. Hope Family Center and a Sr. Research

Associate in the Psychology Department of the University of Rochester in Rochester, New York. Mt. Hope Family Center is a member of the National Child Traumatic Stress Network, where Dr. Manly works with U.S. trauma experts on provision of evidence-based trauma treatments. She was honored to be appointed as Executive-at-Large for the World Association for Infant Mental Health (WAIMH) and continues to be inspired by the dedicated people around the world who are working on behalf of young children and their families. She is on the leadership team for the TRANSFORM National Center on Child Abuse and Neglect, and Co-PI of a TRANSFORM treatment evaluation study designed to prevent child maltreatment. In conjunction with Dante Cicchetti and Douglas Barnett, Dr. Manly developed a maltreatment classification system that is used by research laboratories around the world to operationally define dimensions of child maltreatment. Dr. Manly has published in the areas of linkages among attachment, trauma, child maltreatment, depression, domestic and community violence, and poverty with a broad age range of children from infancy through adolescence, from a lifespan developmental approach. In partnership with Alicia Lieberman and colleagues at the University of California in San Francisco, Dr. Manly and her colleagues at Mt. Hope Family Center have evaluated Child-Parent Psychotherapy (CPP), a trauma treatment program for children 0-5 and their caregivers, and have supported the dissemination and training in this effective intervention model. She has more than thirty-five years of experience in providing clinical services to children who have experienced trauma and their families, and in conducting research with children exposed to violence and maltreatment.

WAIMH Perspectives Intern: Salisha Maharaj, MA Clin Psych



Salisha Maharaj (MA Clin. Psych) completed her Master's Degree in Clinical Psychology at Wits University in 2008. She worked in the Child and Family Unit at Rahima Moosa Mother

and Child Hospital in Johannesburg for 8 years before moving to Cape Town in 2017. She is currently positioned as the Senior Clinical Psychologist at Tygerberg Hospital Child and Family Unit and Lecturer at Stellenbosch University's Department of Psychiatry. Salisha is the Secretary of the Western Cape Association of Infant Mental Health, an affiliate to the World Association of Infant Mental Health. She also co-facilitates an Infant Mental Health clinic at Tygerberg Hospital where a specialized service is offered to vulnerable infants and their families.

Production Editor: Minna Sorsa, PhD



Minna Sorsa, Ph.D. and Senior Administrator is working at the Central office of the World Association for Infant Mental Health. She has previously worked in international

research collaboration on dual diagnosis. She is currently continuing her own Postdoctoral research on help-seeking of vulnerable women in MiStory consortium. She has an interest in qualitative research methodology and complex life situations. Minna is a trained Psychiatric Nurse and has served in local and regional political commissions of trust since 2004.

As the WAIMH Perspectives editorial team, we thank each person for their interesting and thoughtful contributions. We welcome submissions from the field that challenge the way we think about infants, families, culture, and community, and offer fresh perspectives on policy, research, and practice. As always, we invite comments in response to what is published in WAIMH Perspectives in Infant Mental Health.

Asking about Adverse Childhood Experiences (ACEs) in Prenatal and Pediatric Primary Care: A Narrative Review and Critique

Whitney Ereyi-Osas, Nicole Racine PhD,
Sheri Madigan PhD

Department of Psychology, University of
Calgary, Calgary, AB, Canada

Alberta Children's Hospital Research
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Summary

The negative consequences of adverse childhood experiences (ACEs) on the physical and mental health of infants and young children has been well-established. In order to reduce the potential effects of these stressful events, inquiring about ACEs in pregnant women, infants, and young children has been identified as an important avenue for prevention. As such, there has been an impetus to use questionnaires asking about ACEs in both the prenatal and pediatric primary care settings. Although the assessment and identification of childhood adversity may be a first step in mitigating poor health outcomes associated with exposure to ACEs, concerns about the potential for discomfort in being asked to report ACEs, lack of trauma-informed training available to healthcare providers, low availability of resources for individuals with high ACEs, and feasibility of asking such questions, have been raised with regard to obtaining ACE histories in primary care settings. The overarching goal of this narrative review was to summarize the existing literature on ACEs history taking in the healthcare setting for pregnant women and children under the age of 6 years. The current review had three main research objectives: 1) to summarize research on parent perspectives on the use of an ACEs-related questionnaire in the prenatal and primary care setting, 2) to summarize research on

the perspectives of healthcare providers using an ACEs-related questionnaire with patients in pregnancy and under the age of 6, and 3) to identify gaps in the current literature and provide recommendations for future research.

Introduction

Over the last two decades, there has been a fundamental shift in the understanding of the origins of health and disease across the lifespan: adverse childhood experiences (ACEs) can initiate a cascade of events that may lead to negative consequences for an individual's physical and mental health. Adverse childhood experiences (ACEs) include stressful or traumatic events such as abuse, neglect, and household dysfunction, that occur before the age of 18. The initial ACE study found that exposure to adversity is common with 65% of adults having experienced at least one ACE in childhood and 12% of adults experiencing 4 or more ACEs. They also found a dose-response association between ACEs and health difficulties: as ACEs increase, so too does the consequential effect on health (Felitti et al., 1998).

Although the medical field was revolutionized by this conceptualization of determinants of health and disease in adulthood, research in the fields of infant mental health and developmental psychopathology have long demonstrated the detrimental effect of early adversity (Cicchetti & Toth, 2015; Rutter, 1977). Specifically, exposure to adversity in early childhood has been linked to alterations in the developing brain that have consequences across domains of cognitive, behavioural, social, and emotional functioning (Shonkoff et al., 2012). More recently, the intergenerational transmission of adversity has been demonstrated, whereby parents with high levels of childhood adversity are more likely to have children who also experience adversity (Madigan et al., 2019), as well as developmental difficulties, child mental health disorders, and poor physical health (Choi et al., 2017; Folger et al., 2018; Madigan, Wade, Plamondon, Maguire, & Jenkins, 2017; Racine, Plamondon,

Madigan, McDonald, & Tough, 2018). This transmission is hypothesized to occur via biological embedding as well as through environment experiences and exposures (Buss et al., 2017; Racine, Plamondon, et al., 2018). Given that pregnancy and early childhood are sensitive periods for experiencing adversity and its intergenerational transmission, identifying ACEs during these periods has been highlighted as a potential step in preventing the cascade of developmental issues characterized by high ACE scores (Garner et al., 2012; Hudziak, 2018).

In response to this research evidence, prenatal and pediatric clinics across North America and abroad have started to implement routine ACE history-taking to identify both children and their parents who may be at risk of poor health outcomes. Despite the adoption of ACEs history taking as a preventative measure, concerns related to this widespread implementation exist, most notably in relation to potential distress or discomfort for families, the lack of evidence-based treatments specifically tailored for families with high ACE scores, and the availability of resources and trauma training (Finkelhor, 2018; McLennan et al., 2019). Furthermore, there remains a lack of consensus on what adverse experiences should be included as items within the questionnaire (Lacey & Minnis, 2019). Lastly, little is known about whether asking parents about their child's ACEs as well as their own leads to any tangible benefits or adverse events such as distress and discomfort. A summary of the perspectives of parents and healthcare providers in studies that have implemented ACE history taking is needed to inform practice and future research directions.

To our knowledge, there is no overview of how ACEs questionnaires are used in the prenatal and pediatric setting, and how feasible and acceptable this practice is to families and care providers. Therefore, the purpose of this narrative review was to understand the implications of asking about ACEs within these primary care settings. The three main objectives that guided this review were as follows: 1) to summarize research on parent perspectives on the use of the ACEs questionnaire in the prenatal and primary care setting, 2) to

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summarize research on the perspectives of healthcare providers using the ACEs questionnaire with patients in pregnancy and under the age of 6, and 3) to identify gaps in the current literature and provide recommendations for future research. The synthesis of information surrounding ACE history taking will provide tangible recommendations to practitioners who use the ACEs questionnaire, and inform clinical practice guidelines related to identifying child and parent ACEs in primary care.

Methods

A narrative review, as defined by Bryman (2012), served as the methodological guiding tool for this review. A narrative review was selected as outcomes were not consistently reported across studies and could not be easily extracted or analysed through a meta-analysis. A systematic approach to the literature search was conducted to allow for a comprehensive search and to increase the validity of findings (Bryman, 2012; Haddaway, Woodcock, Macura, & Collins, 2015).

To identify relevant articles, searches were conducted in January-February 2019 in the databases MEDLINE, PsycINFO, and CINAHL with no restrictions or filters enabled in the search. The search strategy was developed in collaboration with a Health Sciences librarian and included a combination of MeSH headings and search terms. ACEs were searched as *Adverse childhood** and combined with terms related to "healthcare setting" and "screening". A cited reference search was also conducted of key articles that were previously identified.

A total of 1,447 studies were initially identified, and primary studies were included if they: 1) asked parents about two or more categories of ACEs as defined by Felitti et al. (1998); and 2) reported on one of the following outcomes: provider outcomes, parent/child outcomes, and feasibility. Studies were excluded if they were conference abstracts and review articles, and if the topic was unrelated (i.e., not in a pediatric or prenatal setting). Furthermore, studies were only included if parents were asked about their own ACEs or the ACEs of a child who was under the age of 6. After abstract reviews and full-text article review of 77 studies, 9 articles were deemed to meet inclusion criteria for the narrative review (see Figure 1 for a detailed flow diagram of the review process).

Table 1. Studies discussing use of ACEs history taking in the healthcare setting.

Author	Sample	Type of questionnaire	Healthcare setting	Study description
Conn et al. (2018)	15 parents of pediatric patients completed interviews at a pediatric clinic.	ACES Questionnaire	Pediatric Clinics	Parents completed ACEs questionnaire and was asked about their opinions regarding the process.
Eismann et al. (2019)	16 providers (from both primary care and pediatric care) and 1,057 parents of pediatric patients.	Safe Environment for Every Child (SEEK)	Pediatric and Primary Clinics	SEEK was implemented across three clinics. Training was provided to providers before implementation and social worker was available on hand. Providers were interviewed afterwards.
Feigelman et al. (2011)	95 pediatricians and 429 pediatric parents.	Safe Environment for Every Kid (SEEK) Questionnaire	Pediatric Clinic	In a randomized control trial, pediatric practices were assigned to either the intervention group (use of SEEK questionnaire) or a control group. Parents reported perspectives after trial through a questionnaire.
Flanagan et al. (2018)	26 providers (physicians and nurses) interviewed from two prenatal medical centres. 355 women completed ACEs questionnaire.	11-item Behavioural Risk Factor Surveillance System Questionnaire	Maternity Clinic	ACE history taking was implemented after a 2-hour training session with providers. Patients were given questionnaires and clinicians reviewed questionnaires with patients.
Gillespie and Folger (2017)	975 parents of pediatric patients. 27 pediatricians and 1 nurse practitioner.	10-item ACE questionnaire and 14-item ACE questionnaire. Item level and aggregate level response.	Pediatric Clinic	975 parents completed ACE questionnaires and reported on comfort afterwards. 27 healthcare providers reported on comfort with using the questionnaire.

Author	Sample	Type of questionnaire	Healthcare setting	Study description
Koita et al. (2018)	28 caregivers from an urban pediatric facility and 16 providers (a mixture of physicians, nurses, and other health professionals)	16-item BARC Pediatric Adversity and Trauma Questionnaire	Pediatric clinic	Caregivers recruited through convenience sampling and administered questionnaire by providers. Questionnaire was modified iteratively.
Nguyen et al., 2019	600 women in a diverse urban pregnant cohort.	10-item ACE Survey	Women's health clinic	Caregivers were recruited through a convenience sample and were asked by research team members to complete the anonymous 10-item ACE survey.
Selvaraj et al. (2019)	2569 families from a pediatric care centre.	13-item Addressing Social Key Questions for Health Questionnaire (ASK Tool).	Pediatric clinic	ASK Tool was created to collect both parent and child ACE history, and information on unmet social needs. Caregivers from a pediatric clinic were asked to complete the ASK tool.
Wickramasinghe et al. (2019)	16 providers (paediatricians and allied health specialists) and 356 pediatric patients.	14-item (modified) ACE questionnaire	Pediatric clinic	16 providers (mixture of pediatricians and allied-health specialists) trialed the ACE checklist in their practice and completed phone-interviews or email surveys afterwards about use.

provider outcomes included healthcare provider comfort, perceived benefits of history-taking practices, concerns, resource use and availability, and trauma-informed training. Healthcare providers also provided information on the feasibility of ACE history-taking such as the time required and the type of questionnaire used. Descriptive data were reported when provided by the study authors.

Parent Perspectives

Parent Comfort.

Six studies provide information on parent comfort with being asked about their child's ACEs or their own ACE history (Conn et al., 2018; Eismann, Theuerling, Maguire, Hente, & Shapiro, 2019; Feigelman, Dubowitz, Lane, Grube, & Kim, 2011; Flanagan et al., 2018; Koita et al., 2018; Nguyen et al., 2019; Selvaraj et al., 2019). One study reported that "only a small handful of caregivers" refused to complete the questionnaire or discuss results, although an exact percentage was not provided (Eismann et al., 2019), while another study reported that 5% of parents (35 out of 660) declined to complete the ACEs questionnaire when asked (Nguyen et al., 2019). Two other studies reported that the majority of patients (85-86%) wanted ACE history taking to continue (Flanagan et al., 2018; Selvaraj et al., 2019). In contrast, Koita et al. (2018) reported that 50% of parents who were asked about their children's ACEs experienced discomfort, as items generated emotional responses of parents' past experiences as children. However, patients still reported gratitude about being asked about adversity, and recognized the importance of being asked (Koita et al., 2018).

Of the four studies that asked about parental ACEs, there were mixed findings regarding parent comfort with reporting on their own ACEs (Conn et al., 2018; Flanagan et al., 2018; Gillespie & Folger, 2017; Selvaraj et al., 2019). Two studies found that parents were more comfortable reporting on their children's ACEs than their own (Conn et al., 2018; Selvaraj et al., 2019). However, two other studies reported that the majority of parents (e.g., 62.6% in Gillespie & Folger, 2017) were comfortable with being asked about their own ACEs (Flanagan et al., 2018; Gillespie & Folger, 2017), were grateful to have been asked about adversity (Gillespie & Folger, 2017), and gave little resistance to providers (Gillespie & Folger, 2017). One study found that parent comfort with being asked about ACEs was moderated by patient ACE scores, with a greater majority of parents with low ACE scores (76.3%) reporting

Results

Study Characteristics

Of the 9 studies that met inclusion criteria, one study examined healthcare provider perspectives of ACE history taking, three studies provided parent perspectives, and the remaining 5 studies provided perspectives from both healthcare providers and parents. The majority of the studies provided outcomes on ACE history taking in pediatric care facilities (n=6), while the others provided perspectives in either a prenatal care setting (n=1), a primary care setting (n=1), or a mixture of both primary and pediatric care (n=1). With regards to the types of ACE history

obtained, 4 studies obtained a parental report of their child's ACEs, 3 studies obtained a report of parental ACEs only, and 2 studies obtained both child and parent ACEs. The majority of studies were conducted in the USA (n=8), while 1 was conducted in Australia. A description of the study characteristics can be found in Table 1.

Outcomes of obtaining an ACE history were identified from the included studies and were divided into two main categories: parent perspectives and healthcare provider perspectives. A summary of the results can be found in Table 2. Parent outcomes included parent comfort and perceived benefits of providing an ACE history. Healthcare

being comfortable with answering questions about ACEs, compared to parents with high ACE scores (34.9%) (Flanagan et al., 2018).

Although not a direct measure of parent comfort, one study reported that parent completion of ACE questionnaires differed by location within the facility, and timepoint when the ACEs history was obtained (Nguyen et al., 2019). The aforementioned study reported that 9.3% more parents completed ACEs questionnaires when asked in an examination room, in comparison to an outpatient waiting room. Furthermore, the study also reported that parents asked in the prenatal period may have been more comfortable answering questions regarding their ACE history in an outpatient setting, in comparison to parents in the postpartum period who were asked in an inpatient setting. Whether the time period or location impacted the comfort in reporting is unknown.

Perceived Benefits.

Of the five studies that asked about parental ACEs, one study reported that obtaining an ACE history contributed to mothers feeling better understood by healthcare providers (Flanagan et al., 2018), and in another, improved satisfaction by parents was reported (Feigelman et al., 2011). Two studies reported that ACE history taking resulted in patients viewing their care provider as a resource (Conn et al., 2018; Selvaraj et al., 2019). Two studies also reported that patients recognized the importance of ACE history taking as it made them want to learn more about ACEs, resilience, and parenting (Conn et al., 2018; Gillespie & Folger, 2017).

Healthcare Provider Perspectives

Healthcare Provider Comfort.

All four studies that reported on healthcare provider comfort asking about ACEs found that the majority of healthcare providers were comfortable asking about and discussing ACEs with patients (Eismann et al., 2019; Flanagan et al., 2018; Koita et al., 2018). One study reported that provider comfort increased with practice (Flanagan et al., 2018), while two others reported provider comfort increased with training (Eismann et al., 2019; Feigelman et al., 2011). Overall, the majority of healthcare providers were comfortable with asking about ACEs.

Perceived Benefits.

Five studies reported on healthcare provider perceived benefits to ACE history taking (Eismann et al., 2019; Feigelman et al., 2011; Flanagan et al., 2018; Gillespie & Folger, 2017; Wickramasinghe, Raman, Garg, Jain, & Hurwitz, 2019). Providers found that asking about ACEs led to more understanding and trusting relationships with patients, and new conversations that allowed providers to support patients in new ways (Eismann et al., 2019; Gillespie & Folger, 2017). Providers saw patient ACEs history as valuable (Gillespie & Folger, 2017; Wickramasinghe et al., 2019) and wanted to continue the practice of asking about them (Feigelman et al., 2011; Flanagan et al., 2018; Wickramasinghe et al., 2019).

History-Taking Practices.

Four studies reported on current history taking practices for asking parents about child ACEs (Eismann et al., 2019; Feigelman et al., 2011; Gillespie & Folger, 2017; Wickramasinghe et al., 2019). Three studies (Eismann et al., 2019; Gillespie & Folger, 2017; Koita et al., 2018) that undertook history taking with underprivileged populations asked about additional factors outside the original ACEs questionnaire such as food insecurity (Eismann et al., 2019) or neighbourhood violence (Eismann et al., 2019; Gillespie & Folger, 2017; Koita et al., 2018). One study reported high rates of ACE history taking (all 8 providers in the practice) because of the high instances of trauma in the population (Wickramasinghe et al., 2019). Overall, few providers asked about household dysfunction such as exposure to caregiver mental illness, caregiver substance use, or exposure to domestic violence, and providers were more likely to ask about ACEs if they worked with high-risk populations or had prior knowledge about the effect of ACEs on health.

Healthcare Provider Concerns.

Four studies reported on healthcare provider concerns about ACE history taking (Eismann et al., 2019; Flanagan et al., 2018; Gillespie & Folger, 2017; Koita et al., 2018). Overall, the three major provider concerns about asking about ACEs were resource availability, lack of trauma training, and the increased time asking about ACEs would add to patient visits.

Three studies reported that providers were concerned that there were limited resources available to support patients with elevated ACEs (Eismann et al., 2019; Gillespie & Folger, 2017; Koita et al., 2018). Providers from Eismann et al. (2019) also reported being concerned about not

knowing enough about resources in the community to assist caregivers. Providers from Flanagan et al. (2018) suggested that resources should be in place prior to implementing routinely asking about ACEs. Three studies identified a lack of knowledge on how to deal with trauma as a major concern, particularly with not knowing how to respond to patients with high ACE scores (Eismann et al., 2019; Flanagan et al., 2018; Gillespie & Folger, 2017). Gillespie and Folger (2017) reported that providers were particularly concerned about triggering an emotional response when asking about parental ACEs. Providers from Eismann et al. (2019) were concerned about offending parents when asking about their child's exposure to parental mental health, substance abuse, or domestic violence.

Three studies reported concerns about the extra time asking about ACEs would add to patient visits (Eismann et al., 2019; Gillespie & Folger, 2017; Koita et al., 2018). Providers from Eismann et al. (2019) reported that they thought asking about ACEs was worth the extra time, but already had pre-existing time pressures to consider. Gillespie and Folger (2017) reported an initial concern about timing prior to when they started asking about ACEs, and this remained a concern in the post-study interview.

Resource Use and Availability.

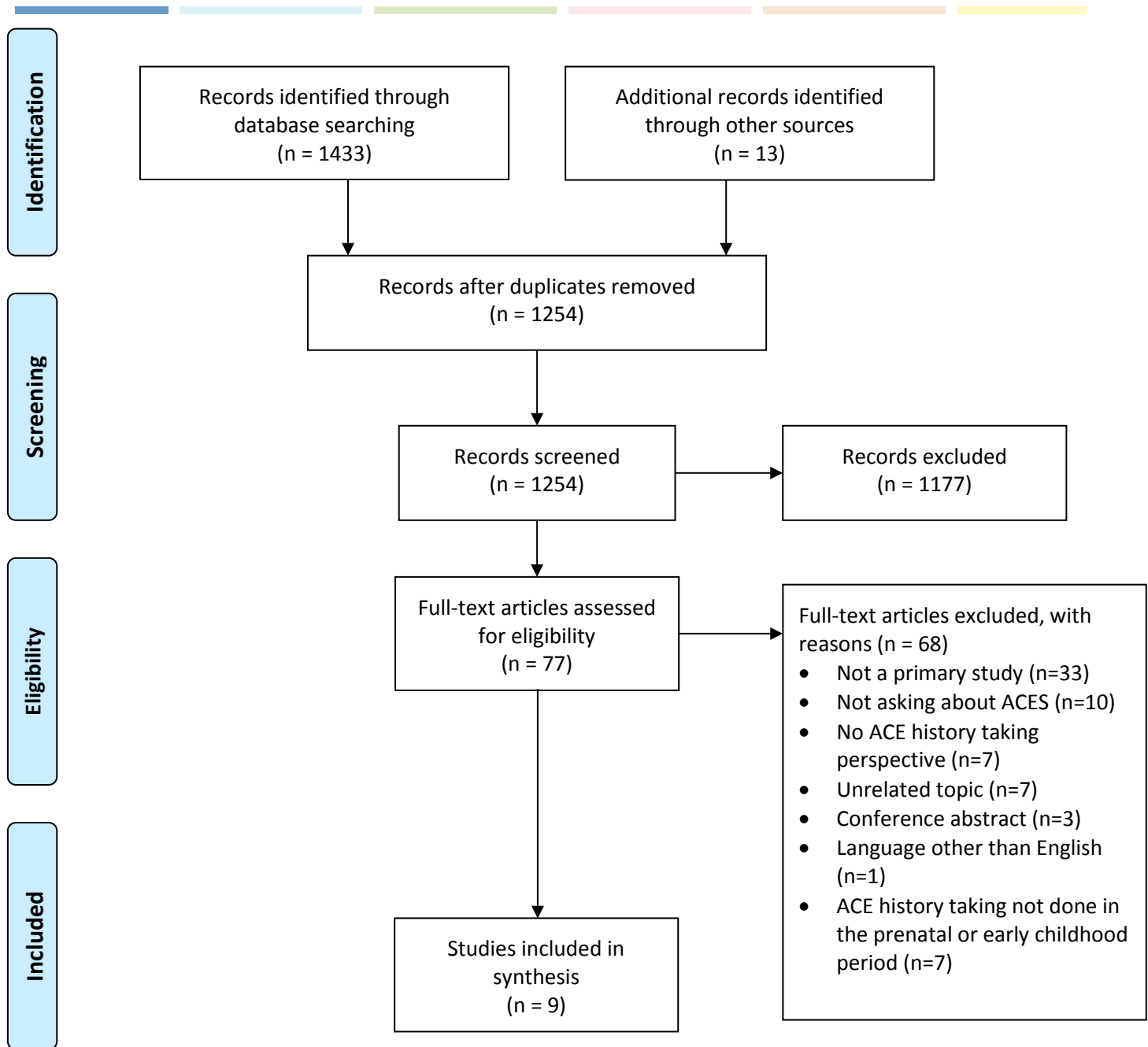
Five studies reported on resources available in the primary care setting. Four of these five studies reported that social workers or counselling services were available within the medical practices, which were either provided by the study authors or were existing beforehand (Eismann et al., 2019; Feigelman et al., 2011; Flanagan et al., 2018; Selvaraj et al., 2019). All four studies reported using their available resources when needed. One study that had social workers and community health workers on site reported that having these personnel onsite as resources was helpful (Eismann et al., 2019). Resources were not provided or available in one study as they were not reported to be needed (Gillespie & Folger, 2017). Overall, most practices had an integration of social services in preparation for ACE history taking and resources were typically used for children's ACEs rather than parent ACEs.

Trauma-Informed Training.

Three studies reported that providers received training before they started asking about ACEs (Eismann et al., 2019; Feigelman et al., 2011; Flanagan et al., 2018). Training ranged from 2-8 hours (mean=6 hours), and training procedures

Table 2. Summary of results.

CATEGORY	OUTCOME	SUMMARY
Parent Perspectives	Patient Comfort (n=9)	<ul style="list-style-type: none"> Majority of patients were comfortable with ACE history taking Individuals with higher ACE scores were less comfortable with ACE history taking ACE history taking piqued patients' interests about parenting, ACES, and resilience Two studies reported that parents were more comfortable with being asked about children's ACES rather than their own Two studies (one in prenatal, another in pediatric) found parents to be more comfortable reporting own ACE history than their children's More comfort in completing ACE questionnaire in private examination room v. waiting room More comfortable completing ACE questionnaire in prenatal period vs. postpartum period
Health Care Provider Perspectives	Current Practices (n=4)	<ul style="list-style-type: none"> Low ACE history taking rates for any ACE (ranged from 19%-43%) Physicians were more likely to ask about ACEs if they worked with high-risk populations or had prior knowledge about the impact of ACEs
	HCP Concerns (n=4)	<ul style="list-style-type: none"> Lack of resources available, lack of knowledge on resources Concern with how to deal with trauma Concern about extra time added
	Resource Use and Availability (n=5)	<ul style="list-style-type: none"> Social services or counselling widely available in clinics, either through study implementation or previously available Integration of social services is feasible Resources were more widely used in pediatric clinics and seen as beneficial
	Trauma-Informed Training (n=3)	<ul style="list-style-type: none"> Training procedures included an introduction to trauma-informed care, information on community resources, and the impacts of ACEs Training increased comfortability of ACE history taking and use of questionnaires
	HCP Comfort and Benefits (n=4)	<ul style="list-style-type: none"> Majority of physicians comfortable with asking about ACEs ACE history taking improved relationship with patients and physicians wanted ACE history taking to continue
Feasibility	Timing (n=3)	<ul style="list-style-type: none"> Questionnaires ranging from 10-15 items added 1-5 minutes to visits with patients Time increased for patients with higher ACE scores
	Type of Questionnaire	<ul style="list-style-type: none"> Different ACE questionnaires used One study paired questionnaire with resilience questionnaire Aggregate level response was found to better identify ACEs



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med* 6(7): e1000097. doi:10.1371/journal.pmed1000097

Figure 1. PRISMA flow diagram of review process.

included an introduction to trauma-informed care, information on resources in the community, and the health effects of ACEs (Eismann et al., 2019; Feigelman et al., 2011; Flanagan et al., 2018). Two studies reported that training increased provider comfort with asking about ACEs and confidence in their ability to help patients (Eismann et al., 2019; Feigelman et al., 2011; Flanagan et al., 2018). One study found that after receiving training, physicians were more inclined to ask their patients about ACEs (Feigelman et al., 2011). In sum, more training

was associated with higher comfort of healthcare providers and increased likelihood of asking about ACEs.

Timing.

Three studies reported on the time it took to ask about ACEs (Eismann et al., 2019; Gillespie & Folger, 2017; Wickramasinghe et al., 2019). All studies used different tools to ask about ACEs, each with varied questions of varying lengths. For the two studies that asked about child ACEs, the 15-item Safe Environment for Every Child

(SEEK) was used in one, and in the other the 14-item ACE questionnaire was used (Wickramasinghe et al., 2019). The third study asked about ACEs in parents, and used both the 10-item and the 14-item ACE questionnaire (Gillespie & Folger, 2017). However, all three studies found that asking about ACEs only added 1-5 minutes to the visit with each parent. One study that did not report timing did however report that interviews with high ACE patients were longer than interviews with low ACE patients (Flanagan et al.,

2018). Providers from Eismann et al. (2019) reported that they thought the extra time added to the visit due to ACE interviews were worth it.

Questionnaire Type.

Studies varied in the way they asked about ACEs. In addition to the 15-item SEEK questionnaire (Eismann et al., 2019), the 10-item ACE questionnaire (Gillespie & Folger, 2017) and the 14-item ACE questionnaire (Gillespie & Folger, 2017; Wickramasinghe et al., 2019), one study used the 11-item Behavioural Risk Factor Surveillance System Questionnaire (Flanagan et al., 2018) to screen for ACEs, and two studies (Koita et al., 2018; Selvaraj et al., 2019) created their own tool to identify ACEs by combining aspects from the original ACE questionnaire (Felitti et al., 1998) and other social factors. Furthermore, studies differed in the way they used their questionnaire. For instance, one study paired identified ACEs along with resilience factors, which providers found beneficial (Flanagan et al., 2018). Another study trialled both an item-level response questionnaire and an aggregate-level response questionnaire, and found that an aggregate-level response led to higher ACE identification (Gillespie & Folger, 2017).

Discussion

With the goal of mitigating the effect of ACEs on infant and maternal mental health and well-being there has been a rapid implementation of ACE history taking in prenatal and pediatric primary care settings. However, there are concerns that this practice may be premature due to the lack of evaluation of potential harms, the lack of targeted interventions for individuals with high ACEs, and challenges with regards to what ACE items should be asked about (Finkelhor, 2018; McLennan et al., 2019). Thus, we conducted a narrative review to summarize the existing literature on parent and healthcare provider perspectives on ACE history-taking within the primary care setting as well as identify implications for clinical practice and directions for future research. Three important findings emerged from the current review: 1) a large proportion of parents (up to 50%) experienced discomfort from being asked about ACEs, particularly parents with high ACEs, 2) trauma-informed training and adopting a trauma-informed approach is needed prior to implementing an ACE history-taking strategy within a clinic or organization (Racine, Killam, & Madigan, 2019), and 3) the availability of resources for patients and families who are asked about ACEs and need additional support is critical. Clinical

implications of these findings for the practice of infant mental health as well as areas where more work and evidence are needed are discussed below.

Across the reviewed studies there was variability in the level of comfort parents experienced when reporting on ACEs in the primary care setting. While some parents reported feeling comfortable providing a report, other studies demonstrated that half of parents experienced discomfort when reporting on their family history of adversity (Koita et al., 2018). Furthermore, comfort for providing a report was influenced by the parent's ACE score and the location the questionnaire was given, as parents generally felt more comfortable reporting on their child's ACEs than their own, and were more likely to report their ACEs history in a private examination room in comparison to clinic waiting rooms. These findings suggest that healthcare providers should be mindful of the potential discomfort parents may experience when reporting on their histories of child adversity and use trauma-informed approaches that minimize re-traumatization (SAMHSA, 2014). For example, ensuring a safe and private clinic environment, as well as ensuring staff are aware of the wide impact of trauma are needed. There are also several strategies that could be used within primary care practice that could help reduce parent discomfort and distress. For example, using an aggregate-level ACEs score rather than asking about specific adversity experiences may help reduce discomfort and increase privacy (Gillespie & Folger, 2017). Finally, health organizations and clinics should consider whether asking about ACEs is appropriate in their setting and whether the information is needed or has the potential to improve the outcomes of infants and young children in their practice. For example, will obtaining this information change the approach to care or have the potential to improve outcomes? The potential benefits of ACEs history taking in clinical practice should be weighed against the potential harms, such as parent discomfort.

Healthcare providers identified that trauma-informed training was integral to knowing how to ask and respond when obtaining an ACE history. Across studies in the current review, healthcare providers varied in the training they received on ACEs, however, a consistent concern that was identified was how to respond to patients with high ACE scores. Training in trauma-informed approaches to patient-care was found to improve healthcare provider comfort in asking about ACE. Thus, trauma-informed training should be required by all staff to successfully

meet the needs of complex families. Components of a trauma-informed training program should provide information on the impacts of ACEs on health, instructions on how to sensitively respond to individuals who have experienced trauma, and guidance on how to use and incorporate community resources (SAMHSA, 2014). Future research is needed to evaluate how using trauma-informed training approaches may be associated with parent-child health outcomes.

A third important finding identified by the current review is the importance of having resources available for patients to access if they are identified as needing support following an ACE history taking. Studies in our review demonstrated that the presence of mental health personnel, such as social workers, was not only feasible but also already present in several studies. Healthcare providers generally reported that these additional resources were helpful for addressing ACEs. Pediatricians interviewed in a study conducted by Bright, Thompson, Esernio-Jenssen, Alford, and Shenkman (2015) suggested that the use of a multidisciplinary team integrated with community supports such as social workers, teachers, and psychologists was beneficial when asking about past histories of trauma. For organizations where these resources are not readily available, the development of community partnerships can help to fill these service gaps and connect families with the resources they need such as treatment programs, food vouchers, and housing aid (Hall, Porter, Longhi, Becker-Green, & Dreyfus, 2012; Jichlinski, 2017; Plax, Donnelly, Federico, Brock, & Kaczorowski, 2016). Future research needs to identify which resources are beneficial for families with high ACE scores as well as guidance for healthcare professionals on how to acquire and develop community partnerships to meet their patients' needs.

There remain several important future directions to consider with regards to ACE-history taking. First, there was no standardized measure for obtaining an ACEs history across studies. As can be seen in the current review, studies used different questionnaires of different lengths, resulting in a variation in the length of time added to the interview, and the items asked. Currently, there remains no consensus on which adverse childhood experiences are most important to ask about in primary care (Finkelhor, 2018; McLennan et al., 2019). While all studies in this review generally asked about abuse, neglect, or household dysfunction as specified by the original ACE study (Felitti et al., 1998), some studies also asked about factors outside the scope of ACEs

such as food insecurity (Eismann et al., 2019; Koita et al., 2018), neighbourhood violence (Eismann et al., 2019; Gillespie & Folger, 2017; Koita et al., 2018), or refugee trauma (Wickramasinghe et al., 2019). These factors have been argued to produce similar effects on long-term health, which suggest that a rigorous evaluation of which childhood adversities should be asked about is needed (Finkelhor, 2018; Finkelhor, Shattuck, Turner, & Hamby, 2013; Lee, Larkin, & Esaki, 2017; Purewal et al., 2016). Indeed, the types of questions that are relevant may vary and differ across clinical populations. However, as noted by Lacey and Minnis (2019), there remains a lack of evidence-based justification as to why even the original 10 ACEs ought to be included in an ACEs questionnaire, let alone other adversities as well. Thus, future research should identify which ACEs are most pertinent to infant mental health outcomes, and how they can be applied across a variety of populations.

A second, future direction is to identify the potential benefits of considering past and current resilience factors that may be present in the lives of infants and young children. One study found that the use of a resilience questionnaire in pregnancy in addition to asking about adversity was beneficial (Flanagan et al., 2018) as identification of resilience factors helped providers better understand patients' current coping abilities and availability of support resources. Furthermore, research has demonstrated that resilience factors, such as social support, can attenuate the association between ACEs and relationship difficulties (Madigan, Wade, Plamondon, & Jenkins, 2016), as well as ACEs and difficulties in pregnancy (Narayan, Rivera, Bernstein, Harris, & Lieberman, 2018; Racine, Madigan, et al., 2018). For instance, Madigan et al. (2016) found that the associations between ACEs and marital conflict in the postnatal period was moderated by neighborhood social support: higher ACEs was not associated with marital conflict when neighborhood social support was identified as being high. In addition, a study conducted by Narayan et al. (2018) found that the identification of resilience factors, or benevolent childhood experiences, accounted for the reduced impact of high ACE scores on prenatal health. Thus, social support can act as an important buffer of the effect of ACEs on maternal health and functioning. As such, an understanding of the supports and coping skills that are present for families may be important indicators of overall health and functioning.

A third future direction is to identify when it may be most appropriate to take an ACEs history. As one study reported, the

prenatal period may be a more opportune time than the postpartum period as to prevent the likely influence of stress and postpartum hormones from influencing patient comfort with completing the questionnaires (Nguyen et al., 2019). Parents may also have a more well-established relationship with a provider seen routinely in pregnancy than with inpatient staff immediately following birth. Overall, more research is needed to determine appropriate developmental timing for ACEs history taking.

Clinical Implications

The studies included in the current review suggest that asking about ACEs as a preventative measure to improve maternal and infant mental health provides some benefits such as an increased communication and identification of trauma, as well as increased interest in the relationships between trauma and parenting. However, there are major cautions to obtaining an ACE history in the healthcare setting as limited research is available on adverse events related to asking about ACEs. Although parents across studies included in the current review reported varying levels of discomfort with completing the questionnaire, no research to date has identified the extent to which the practice of asking about ACEs in primary care may lead to re-traumatization, particularly for individuals with substantial trauma histories, and how to mitigate these negative outcomes. Research is needed to identify both short and long-term adverse outcomes of asking about ACEs. Furthermore, a randomized control trial conducted by MacMillan et al. (2009) found that asking about interpersonal violence had little impact in reducing rates of interpersonal violence. As such in the context of ACEs, consideration as to whether the benefits of asking about ACEs is worth the risk of parent discomfort, or whether universal implementation of trauma-informed approaches (e.g., fostering trust, transparency, and empathy with families) may be sufficient, is critical. For organizations wishing to implement ACEs history-taking practices, it is important to ensure adequate resources to support caregivers and young children with high ACE scores are available. These resources may include partnerships with social services within the community such as but not limited to, counseling services or housing aid services. Having additional personnel on staff such as social workers may aid in the creation of these partnerships. Lastly, as one of the major concerns reported by providers was how they should deal with patients who've

experienced trauma, healthcare providers considering adopting ACE-taking practices should ensure adequate trauma training is obtained prior to implementation.

Limitations

There are limitations to the current narrative review. The summaries generated in the current review were limited by the available evidence. Specifically, few studies reported on adverse outcomes related to ACE-history taking. This could be due to multiple reasons, such as publication bias, the low ACE prevalence across study samples, as well as the failure to collect data on adverse outcomes. For instance, most studies asked participants whether they were comfortable with being asked about ACEs, but not if patients experienced any discomfort or distress related to being asked. Future research should identify potential adverse outcomes of asking about ACEs in order to more accurately inform whether its implementation is appropriate. Another limitation of this review is that different questionnaires that asked about ACEs were used across studies. Therefore, comfort and other outcomes cannot be directly compared as they would be influenced by the type and format of the questionnaire (i.e. wording of questions), as well as the population being asked about ACEs. Research in this area would benefit from the development and use of an evidence-based standardized questionnaire. Furthermore, another limitation is because of the nature of the literature, our results were limited to the data that was available. Many studies reported the results in terms of "majority" and "minority", which limited the specificity of our results.

Conclusions

While the results of this narrative review suggest that there are some benefits to asking about ACEs in the prenatal and pediatric primary care settings, such as parents feeling more understood by health care providers and healthcare provider perceptions of improved relationships with families, these benefits were contingent on trauma-informed training and the availability of resources and interventions for families. There remains a large need to evaluate whether asking about ACEs in the primary context improves patient outcomes. Organizations or practitioners who are considering implementing a system to identify the trauma experiences of the young children and parents they work with should consider whether specifically asking families about these experiences is necessary and whether other trauma-informed approaches, such as universal training for staff and

the availability for resources for families presenting with difficulty, would be sufficient (Racine et al., 2019). The implementation and inclusion of an ACEs questionnaire in primary care should be carefully considered in the context of both the potential benefits and limitations.

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Breaking the Cycle: Could Attachment Disrupt the Intergenerational Transmission of Adverse Childhood Experiences?

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Abstract

Mothers who experienced adverse childhood experiences (ACEs) and specific childhood maltreatment (CM) may exhibit specific risk for negative parenting behaviors; however, it is imperative to investigate potential mechanisms that may prevent the intergenerational transmission of such experiences. For example, ACEs/CM and negative parenting behaviors have been associated with mother-young child insecure attachment, but these variables rarely have been examined collectively. Thus, this study examined mother-young child insecure attachment patterns as mediators in the relationship between mothers' ACEs/CM and negative parenting behaviors in a sample of 146 mothers with young children who ranged in age from 1½- to 5-years. Results indicated that mother-young child avoidant, anxious, and disorganized attachment patterns mediated significantly and fully the relationship between mothers' ACEs and negative parenting behaviors and between mothers' CM experiences and negative parenting behaviors. These findings suggested the need for trauma-informed parenting interventions with ports of entry that could support facilitation of mother-young child secure emotional connections and decrease the risk for maltreatment potential in mothers with histories of ACEs/CM themselves.

Decades of literature have described an intergenerational model for the ongoing cycle of adverse childhood experiences (ACEs), or experiences of childhood maltreatment (CM; i.e., abuse and neglect) and household dysfunction, that can occur in families. Unfortunately, little is known regarding *why* such intergenerational cycles continually repeat. Formative in providing an empirical estimate of these intergenerational cycles, Kaufman and Zigler (1987) suggested that approximately one-third of individuals who experienced CM maltreated their own children. More recently, parents who reported CM were found to be more than two times as likely to have children who also experienced CM (Madigan et al., 2019). As may be expected, those parents who endorsed more chronic and frequent CM or multiple types of CM were even more likely to display abusive behaviors towards their own children (Jaffee et al., 2013; Pears & Capaldi, 2001). For example, higher rates of CM in parents were related to greater instances of physical punishment, child neglect, sexual abuse, and reports to Child Protective Services (CPS) in the children of these parents (Banyard, Williams, & Siegel, 2003; Widom, Czaja, & DuMont, 2015). A meta-analysis of 47 studies found wide-ranging support for this intergenerational cycle of CM, albeit with small to medium effect sizes (Thornberry, Knight, & Lovegrove, 2012). Certainly, although mothers with CM histories may exhibit a heightened risk for negative parenting behaviors (Lang, Garstein, Rodgers, & Lebeck, 2010), not every mother who experienced CM will go on to maltreat her own children (Madigan et al., 2019; Pears & Capaldi, 2001). Rather, mediating factors in the relationship between mothers' ACEs/CM and their parenting behaviors with young children should be examined to help further the understanding of how these intergenerational cycles may occur (Thornberry et al., 2012).

Fundamental to the discussion of ACEs and CM experiences is the consideration that 91% of children are reportedly perpetrated against by a parental figure (USDHHS, 2018). As the very nature of caregiving necessitates providing safety for children, this paradox has striking implications for parent-young child attachment. The

negative relationship between ACEs, CM experiences, and attachment was supported by a meta-analysis of 55 studies, with findings suggesting that children with CM experiences displayed significantly fewer secure attachment behaviors and significantly greater insecure or disorganized attachment patterns with their primary caregivers (relative to children without CM experiences; Cyr, Euser, Bakermans-Kranenburg, & van IJzendoorn, 2010). Overall, CM was associated with future difficulties in forming secure attachments when mothers had their own children (Berthelot et al., 2015; Iyengar, Kim, Martinez, Fonagy, & Strathearn, 2014).

According to Bowlby's (1969) seminal attachment theory, the internal working models formed during early childhood are determined largely by reciprocal interactions with primary caregivers and are displayed consistently across generations. Thus, it can be inferred that a mother's insecure attachment to her own childhood caregiver (i.e., the 'ghosts in the nursery'; as described by Fraiberg Adelson, & Shapiro, 1975) may impact that mother's ability to facilitate secure attachment with her own young children (Iyengar et al., 2014). Bolstering the notion of the intergenerational cycle of attachment (van IJzendoorn & Bakermans-Kranenburg, 2019), young children of mothers who themselves had experienced CM had a greater likelihood of being classified as insecurely attached on the Strange Situation (Berthelot et al., 2015). Thus, there likely is a complex relationship between ACEs, CM experiences, and attachment.

In turn, quality of attachment has been related closely to parenting behaviors. Dykas and Cassidy (2011) posited that, in parent-young child dyads where the child is attached insecurely, parents likely process attachment information in a negative fashion, thereby contributing to poor parenting behaviors and reinforcing insecure attachment. Further, mother-young child insecure attachment predicted significantly greater contacts received by mothers from CPS (Spieker, Bensley, McMahon, Fung, & Osslander, 1996). In contrast, mothers with young children who were attached securely in the

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Strange Situation were observed to use more questioning techniques, were less intrusive, and were less likely to change the direction of their young child's behavior during structured and unstructured tasks (Booth, Rose-Krasner, & Rubin, 1991). Moreover, mothers who understood and acted on their young children's emotions exercised more adaptive parenting behaviors that increased mother-young child security, whereas mothers who exhibited low reflective ability with regard to their young children's emotions experienced increased risk for insecure attachment and problematic parenting behaviors (Fonagy, Steele, & Steele, 1991).

In their comprehensive review of attachment and parenting behaviors, Jones, Cassidy, and Shaver (2015) concluded that parents' own attachment insecurity was related consistently to negative parenting behaviors. Mothers with CM histories (and who widely had insecure attachment histories) exhibited lower quality of interactions with their infants and decreased ability to soothe their infants' distress (Lang et al., 2010). A recent study suggested that, in mothers who had experienced CM, their dismissing and unresolved states of mind (originating from their attachment to their primary caregivers) were linked to insensitive parenting with their own children (Zajac, Raby, & Dozier, 2019). Although these data lend support for the link between mothers' ACEs and CM experiences, attachment to their childhood caregivers, and negative parenting behaviors (Zajac et al., 2019), research has yet to examine the relationship between mothers' ACEs and negative parenting behaviors with insecure attachment patterns to their own young children as mediators.

Given the aforementioned findings, mother-young child attachment patterns may serve as an important mechanism for explaining the connection between mothers' ACEs and CM experiences and negative parenting behaviors (Jones, Cassidy, & Shaver, 2015). As a result, the current study aimed to investigate the predictive relationships among mothers' ACEs and CM experiences, negative parenting behaviors, and patterns of mother-young child insecure (i.e., anxious, avoidant, disorganized) attachment, with mother-young child insecure attachment patterns acting as mediators in these relationships.

Table 1. Participant Demographic Information.

Variables	(N=146)
Mother's Age	
M (SD)	32.08 (6.16)
Child's Age (Years)	
M (SD)	3.10 (1.11)
Child Gender	
Female	56.2%
Number of Children	
M (SD)	2.03 (1.41)
Race/Ethnicity	
White/Caucasian	76.7%
Latina	8.2%
Asian American	6.8%
Black/African American	6.2%
Native American	2.1%
Religious Affiliation	
Christian	56.2%
Agnostic	5.5%
Atheist	4.1%
Other (Muslim, Wiccan, Pagan, Hindu, etc.) "Spiritual", etc	6.8%
Marital Status	
Married	80.8%
Single	12.3%
Divorced/Separated	3.4%
Remarried	1.4%
N/A	2.1%
Education Level	
High School Diploma	11.6%
Vocational Training	2.1%
Some College	16.4%
Associate's Degree	16.4%
Bachelor's Degree	42.5%
Graduate/Professional Training	7.5%
Post-Doctoral Degree	3.4%
Employment Status	
Employed	68.5%
Socioeconomic Status	
\$10,000-\$20,000	3.4%
\$20,000-\$30,000	8.2%
\$30,000-\$40,000	14.4%
\$40,000-\$50,000	15.8%
\$50,000-\$60,000	15.1%
\$60,000-\$70,000	12.3%
>\$70,000	28.1%
No response	2.7%

Note. This same sample was used in two other studies (i.e., Khan & Renk, 2018, 2019).

Method

Participants

An American community sample of mothers was recruited for participation through Amazon Mechanical Turk (MTurk), an online crowdsourcing marketplace. Initially, 1090 individuals attempted participation. Participants were disqualified for failure to meet eligibility criteria, multiple attempts to complete the survey, and incorrect answers on validity questions. Eligibility for participation included being at least 18-years of age, having a young child who was 1½- to 5-years of age, and residing in the United States. A sample of 146 mothers was included in final analyses. Mothers ranged in age from 21- to 52-years (M age = 32.08-years; SD = 6.16-years), with their young children ranging in age from 1½- to 5-years (M age = 3.10-years; SD = 1.11-years). Approximately 56% of these young children were female. The majority of mothers identified themselves as being White or Caucasian (i.e., 76.7%). This sample of mothers largely reported being married (80.8%), being employed (68.5%), and having at least a Bachelor's level of education (53.4%). Complete demographic data can be found in Table 1.

Procedure

This study was approved by the Institutional Review Board (IRB) at the University of Central Florida. Mothers were recruited online via MTurk, where the surveys were administered. Participating mothers first reviewed a consent form, for which no identifying information was collected. Following agreement to participate, mothers completed surveys assessing their ACEs, the frequency of their CM experiences, their parenting behaviors, and their attachment with their young children via the measures listed below. Upon completion, mothers were compensated \$1.00 for participation in the study. Mothers averaged 37 minutes to complete the study in its entirety.

Measures

Demographics. A brief demographic questionnaire inquired about mothers' general characteristics regarding themselves and their children (e.g., age, race, ethnicity, occupation).

Mothers' ACEs. The *Adverse Childhood Experience Questionnaire* (ACEs; Felitti et al., 1998) assessed the number of ACEs that mothers experienced through their first 18 years. Mothers indicated exposure to each item in a *Yes* or *No* format, with the sum of Yes responses yielding a Total score

that could range from 0 to 10. The ACEs demonstrated good internal consistency previously (α = .88; Murphy et al., 2014) as well as in the current sample (α = .86).

Mothers' CM. The 28-item *Childhood Trauma Questionnaire* (CTQ; Bernstein & Fink, 1998) assessed the frequency of CM experiences (i.e., childhood emotional, physical, and sexual abuse and neglect). Mothers rated items on a Likert-type scale ranging from 1 (*Never*) to 5 (*Very Often*). The CTQ demonstrated good internal consistency, reliability, and validity (Scher, Stein, Asmundson, McCreary, & Forde, 2001), with the total CTQ score displaying excellent internal consistency in a previous study (α = .91; Bernstein & Fink, 1998) and in the current sample (α = .92).

Negative Parenting Behaviors.

The *Alabama Parenting Questionnaire-Preschool Revision* (APQ-PR; Clerkin, Halperin, Marks, & Policaro, 2007) was used to assess mothers' current parenting behaviors. The APQ-PR is a revised version of the Alabama Parenting Questionnaire (APQ; Frick, 1991) meant for use with parents of preschool-aged children (5-years of age and younger). The 32 items on the APQ-PR are rated on a Likert-type scale ranging from 1 (*Never*) to 5 (*Always*). The Negative Parenting subscale displayed acceptable internal consistency previously (α = .74; Clerkin et al., 2007) and good internal consistency in the current study (α = .84).

Mother-Young Child Attachment.

The *Experience in Close Relationships* scale (ECR; Brennan, Clark, & Shaver, 1998) assessed mothers' perceptions of their anxious and avoidant attachment with their young children. Given that the ECR was developed originally to measure adult attachment, the ECR was adapted for measuring mother-young child attachment. For example, "I prefer not to show a partner how I feel deep down" was adapted to "My child prefers not to show me how he/she feels deep down." The ECR contains 36 items that are rated on a 7-point Likert-type scale ranging from 1 (*Disagree Strongly*) to 7 (*Agree Strongly*). The original ECR attachment subscales displayed excellent internal consistency (α = .91 for anxious; α = .94 for avoidant; Brennan et al., 1998). Additionally, the adapted ECR displayed good internal consistency previously (α = .86-.90 for anxious; α = .87-.95 for avoidant; McSwiggan & Renk, 2015) and in this study (α = .88 for anxious; α = .94 for avoidant).

The *Caregiving Helplessness Questionnaire* (CHQ; George & Solomon, 2011) assessed specifically mothers' perceptions of disorganized patterns of attachment with their young children. The 25 items on the

CHQ are rated on a 5-point Likert-type scale ranging from 1 (*not characteristic at all*) to 5 (*very characteristic*). The CHQ's Mother Helpless (α = .85) and Mother and Child Frightened (α = .66) subscales were related significantly to disorganized attachment and displayed adequate internal consistency previously (Solomon & George, 2011) as well as in the current study (α = .89 and α = .83, respectively).

Results

Descriptive Statistics

Following screening for violations of missing data, normality, outliers, and linearity, descriptive statistics were examined. In this sample, mothers endorsed an overall low number of ACEs and an overall low to moderate frequency in their CM experiences on the CTQ. Notably, 39 mothers (26.7% of the total sample) endorsed a high number of ACEs (i.e., four or more, as denoted by Felitti et al., 1998). Next, on average, mothers reported moderate levels of negative parenting behaviors on the APQ-PR. Finally, mothers reported overall low avoidant, anxious, helpless-disorganized, and frightened-disorganized patterns of attachment. See Table 2.

Correlational Analyses

Initially, multicollinearity was assessed to confirm that the variables of interest were not cause for biased regression analyses (Field, 2013). Next, Pearson correlations were examined. As was expected, mothers' ACEs, CM experiences, mother-young child insecure attachment, and negative parenting behaviors all were correlated positively and significantly (with a marginally significant relationship between ACEs and negative parenting behaviors). See Table 3.

Mediational Analyses

Two series of four mediational analyses each were examined. Either mothers' ACEs or CM experiences served as the independent variable, the four patterns of mother-young child insecure attachment served as mediators, and negative parenting behaviors served as the dependent variable. Baron and Kenny's (1986) four-step mediation method was utilized. First, regression analyses would need to confirm that mothers' ACEs or CM experiences predicted significantly negative parenting behaviors. Second, regression analyses would need to confirm that mothers' ACEs or CM experiences predicted significantly mother-young child patterns of insecure attachment. Third, regression analyses would need to

confirm that mother-young child patterns of attachment predicted significantly negative parenting behaviors. Finally, multiple regression analyses examined mothers' ACEs or CM experiences and mother-young child patterns of attachment as predictors of negative parenting behaviors to investigate whether mother-young child attachment would demonstrate a mediational pattern. See Figures 1 to 8.

Mothers' Total ACEs Predicting Negative Parenting Behaviors. Mothers' total ACEs predicted marginally negative parenting behaviors, $F(1, 144) = 3.64, p < .06, R^2 = .03$.

Mothers' Total ACEs Predicting Insecure Attachment. Mothers' ACEs predicted significantly all four patterns of mother-young child insecure attachment. Specifically, mothers' ACEs predicted significantly avoidant attachment, $F(1, 144) = 7.78, p < .01, R^2 = .05$; anxious attachment, $F(1, 144) = 7.65, p < .01, R^2 = .05$; helpless-disorganized attachment, $F(1, 144) = 12.73, p < .001, R^2 = .08$; and frightened-disorganized attachment, $F(1, 144) = 11.02, p < .001, R^2 = .07$, with their young children.

Attachment Predicting Negative Parenting Behaviors. Mother-young child avoidant attachment, $F(1, 144) = 51.25, p < .001, R^2 = .26$, and mother-young child anxious attachment, $F(1, 144) = 93.19, p < .001, R^2 = .39$, predicted significantly negative parenting behaviors. Further, mother-young child helpless-disorganized attachment, $F(1, 144) = 98.26, p < .001, R^2 = .41$, and frightened-disorganized attachment, $F(1, 144) = 112.65, p < .001, R^2 = .44$, predicted significantly negative parenting behaviors.

Avoidant Attachment Mediating the Relationship between Mothers' Total ACEs and Negative Parenting Behaviors. Mothers' total ACEs and mother-young child avoidant attachment predicted significantly negative parenting behaviors, $F(2, 143) = 25.68, p < .001, R^2 = .26$. When entered first, mothers' total ACEs alone predicted marginally negative parenting behaviors ($p < .06$). When mother-young child avoidant attachment was added to the equation, total ACEs decreased in significance ($p < .56$), whereas avoidant attachment served as a significant predictor ($p < .001$). As such, the relationship between mothers' total

ACEs and negative parenting behaviors was mediated fully and significantly by avoidant attachment.

Anxious Attachment Mediating the Relationship between Mothers' Total ACEs and Negative Parenting Behaviors. Mothers' total ACEs and mother-young child anxious attachment predicted significantly negative parenting behaviors, $F(2, 143) = 46.33, p < .001, R^2 = .39$. When entered first, mothers' total ACEs alone predicted marginally negative parenting behaviors ($p < .06$). When mother-young child anxious attachment was added to the equation, total ACEs decreased in significance ($p < .80$), whereas anxious attachment served as a significant predictor ($p < .001$). As such, the relationship between mothers' total ACEs and negative parenting behaviors was mediated fully and significantly by anxious attachment.

Helpless-Disorganized Attachment Mediating the Relationship between Mothers' Total ACEs and Negative Parenting Behaviors. Mothers' total ACEs and mother-young child helpless-disorganized attachment predicted significantly negative parenting behaviors,

Table 2. Descriptive Statistics for Variables of Interest.

Variables (Available Range)	<i>M</i>	<i>SD</i>	Actual Range
Mothers' Adverse Childhood Experiences (ACEs)			
Total Number of ACEs (0-10)	2.10	2.41	0-10
Mothers' Childhood Maltreatment Experiences			
CM Experiences (0-125)	43.44	20.88	25-112
Mother's Parenting Behaviors			
Negative/Inconsistent Parenting (0-40)	18.92	6.24	9-38
Mother-Young Child Attachment			
Avoidant Attachment (0-7)	1.93	0.95	1-4.50
Anxious Attachment (0-7)	3.05	0.98	1.06-5.83
Helpless-Disorganized Attachment (0-30)	10.47	5.52	5-29
Frightened-Disorganized Attachment (0-30)	10.48	4.63	6-25

Table 3. Correlations Among Mothers' ACEs, CM, Negative Parenting Behaviors, and Mother-Young Child Attachment.

Variables	1	2	3	4	5	6	7
1. Total ACEs	-						
2. CM Experiences	.80**	-					
3. Negative Parenting Behaviors	.16a	.26**	-				
4. Avoidant Attachment	.23**	.42***	.51***	-			
5. Anxious Attachment	.26**	.32***	.63***	.62***	-		
6. Helpless-Disorganized Attachment	.29***	.40***	.64***	.66***	.57***	-	
7. Frightened-Disorganized Attachment	.27***	.41***	.66***	.69***	.69***	.81***	-

Note. ** $p < .01$, *** $p < .001$, a marginal significance ($p < .058$)

$F(2, 143) = 48.92, p < .001, R^2 = .41$. When entered first, mothers' total ACEs alone predicted marginally negative parenting behaviors ($p < .06$). When mother-young child helpless-disorganized attachment was added to the equation, ACEs decreased in significance ($p < .69$), whereas helpless-disorganized attachment served as a significant predictor ($p < .001$). As such, the relationship between mothers' total ACEs and negative parenting behaviors was mediated fully and significantly by helpless-disorganized attachment.

Frightened-Disorganized Attachment Mediating the Relationship between Mothers' Total ACEs and Negative Parenting Behaviors. Mothers' total ACEs and mother-young child frightened-disorganized attachment predicted significantly negative parenting behaviors, $F(2, 143) = 56.03, p < .001, R^2 = .44$. When entered first, mothers' total ACEs alone predicted marginally negative parenting behaviors ($p < .06$). When mother-young child frightened-disorganized attachment was added to the equation, total ACEs decreased in significance ($p < .75$), whereas frightened-disorganized attachment served as a significant predictor ($p < .001$). As such, the relationship between mothers' ACEs and negative parenting behaviors was mediated fully and significantly by frightened-disorganized attachment.

Mothers' CM Predicting Negative Parenting Behaviors. Mothers' CM experiences predicted significantly negative parenting behaviors, $F(1, 144) = 9.98, p < .01, R^2 = .07$.

Mothers' CM Predicting Insecure Attachment. Mothers' CM experiences predicted significantly all four patterns of mother-young child insecure attachment. Specifically, mothers' CM experiences predicted significantly patterns of avoidant attachment, $F(1, 144) = 31.21, p < .001, R^2 = .18$; anxious attachment, $F(1, 144) = 16.04, p < .001, R^2 = .10$; helpless-disorganized attachment, $F(1, 144) = 27.63, p < .001, R^2 = .16$; and frightened-disorganized attachment, $F(1, 144) = 29.27, p < .001, R^2 = .17$, with their young children.

Attachment Predicting Negative Parenting Behaviors. As stated above, mother-young child avoidant attachment, $F(1, 144) = 51.25, p < .001, R^2 = .26$; anxious attachment, $F(1, 144) = 93.19, p < .001, R^2 = .39$; helpless-disorganized attachment, $F(1, 144) = 98.26, p < .001, R^2 = .41$; and frightened-disorganized attachment, $F(1, 144) = 112.65, p < .001, R^2 = .44$, all predicted significantly negative parenting behaviors.

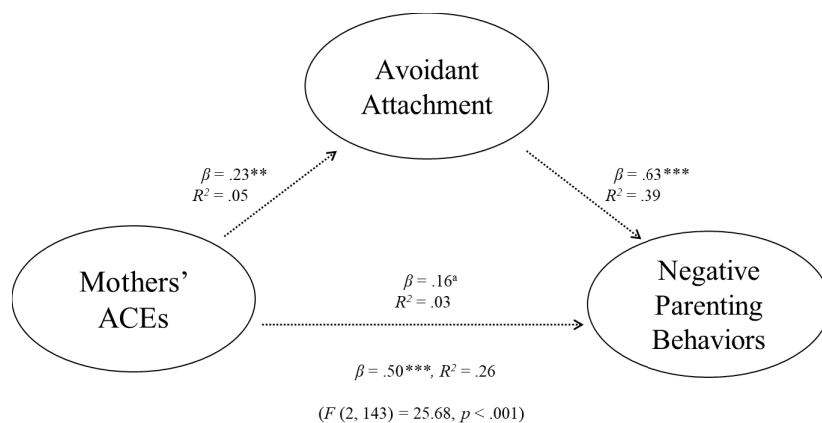


Figure 1. Avoidant Attachment Mediating the Relationship Between ACEs and Negative Parenting Behaviors. Note. ** $p < .01$, *** $p < .001$, a marginal significance ($p < .058$)

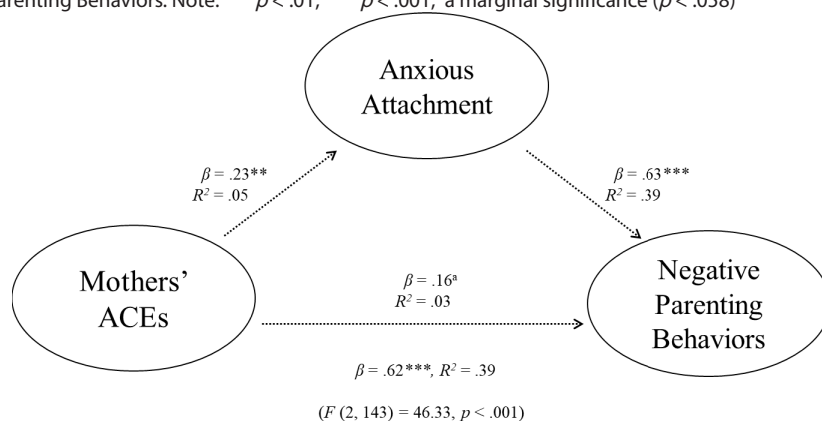


Figure 2. Anxious Attachment Mediating the Relationship Between ACEs and Negative Parenting Behaviors. Note. ** $p < .01$, *** $p < .001$, a marginal significance ($p < .058$)

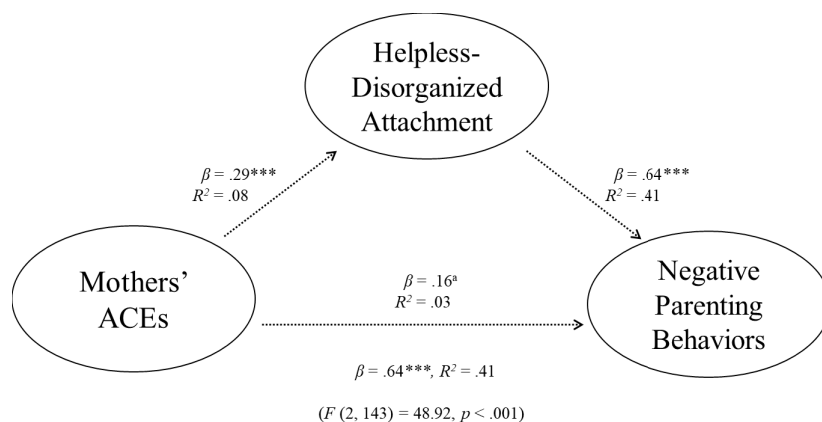


Figure 3. Helpless-Disorganized Attachment Mediating the Relationship Between ACEs and Negative Parenting Behaviors. Note. ** $p < .01$, *** $p < .001$, a marginal significance ($p < .058$)

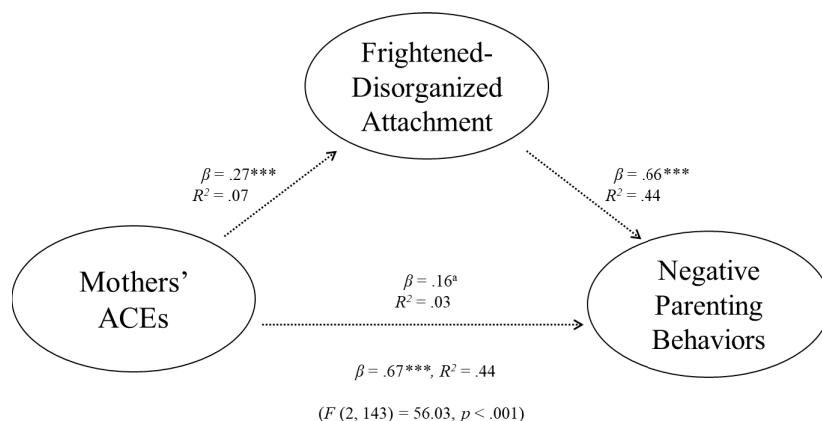
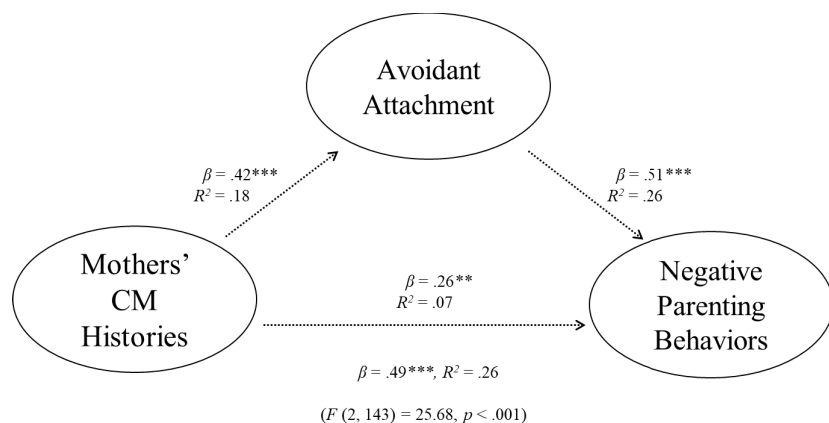
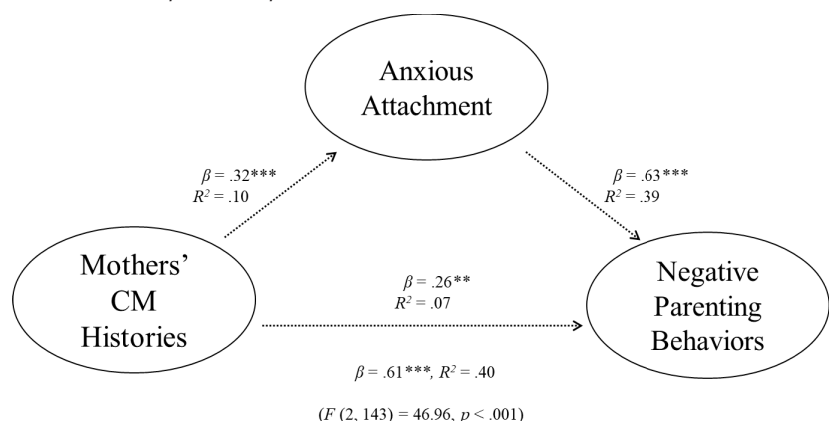


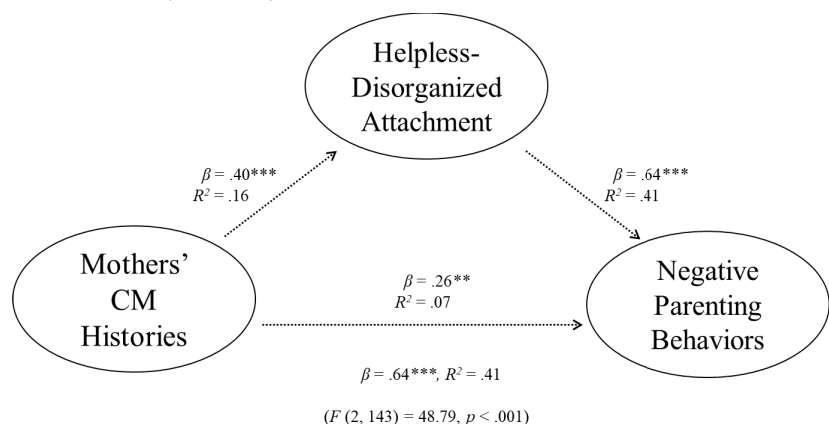
Figure 4. Frightened-Disorganized Attachment Mediating the Relationship Between ACEs and Negative Parenting Behaviors. Note. ** $p < .01$, *** $p < .001$, a marginal significance ($p < .058$)



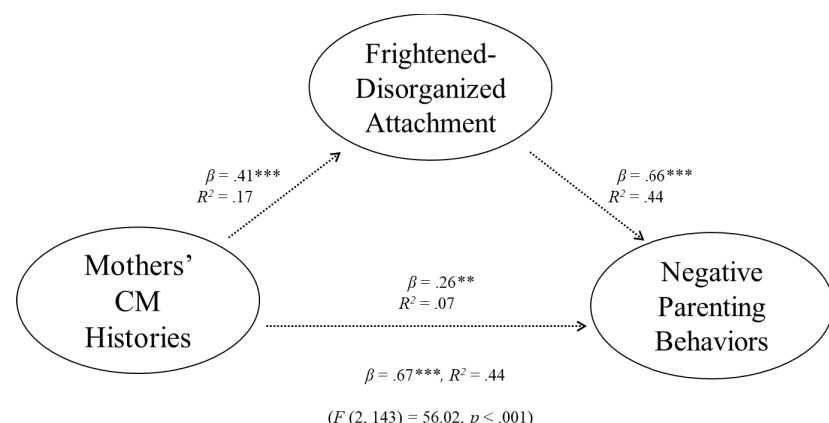
Avoidant Attachment Mediating the Relationship between Mothers' CM and Negative Parenting Behaviors. Mothers' CM experiences and mother-young child avoidant attachment predicted significantly negative parenting behaviors, $F(2, 143) = 25.68, p < .001, R^2 = .26$. When entered first, mothers' CM experiences predicted significantly negative parenting behaviors ($p < .01$). When mother-young child avoidant attachment was added to the equation, CM experiences decreased in significance ($p < .56$), whereas avoidant attachment served as a significant predictor ($p < .001$). As such, the relationship between mothers' CM experiences and negative parenting behaviors was mediated fully and significantly by avoidant attachment.



Anxious Attachment Mediating the Relationship between Mothers' CM and Negative Parenting Behaviors. Mothers' CM experiences and mother-young child anxious attachment predicted significantly negative parenting behaviors, $F(2, 143) = 46.96, p < .001, R^2 = .40$. When entered first, mothers' CM experiences predicted significantly negative parenting behaviors ($p < .01$). When mother-young child avoidant attachment was added to the equation, CM experiences decreased in significance ($p < .36$), whereas anxious attachment served as a significant predictor ($p < .001$). As such, the relationship between mothers' CM experiences and negative parenting behaviors was mediated fully and significantly by anxious attachment.



Helpless-Disorganized Attachment Mediating the Relationship between Mothers' CM and Negative Parenting Behaviors. Mothers' CM experiences and mother-young child helpless-disorganized attachment predicted significantly negative parenting behaviors, $F(2, 143) = 48.79, p < .001, R^2 = .41$. When entered first, mothers' CM experiences predicted significantly negative parenting behaviors ($p < .01$). When mother-young child helpless-disorganized attachment was added to the equation, CM experiences decreased in significance ($p < .99$), whereas helpless-disorganized attachment served as a significant predictor ($p < .001$). As such, the relationship between mothers' CM experiences and negative parenting behaviors was mediated fully and significantly by helpless-disorganized attachment.



Frightened-Disorganized Attachment Mediating the Relationship between Mothers' CM and Negative Parenting Behaviors. Mothers' CM experiences and mother-young child

frightened-disorganized attachment predicted significantly negative parenting behaviors, $F(2, 143) = 56.02, p < .001, R^2 = .44$. When entered first, mothers' CM experiences predicted significantly negative parenting behaviors ($p < .01$). When mother-young child frightened-disorganized attachment was added to the equation, CM experiences decreased in significance ($p < .76$), whereas frightened-disorganized attachment served as a significant predictor ($p < .001$). As such, the relationship between mothers' CM experiences and negative parenting behaviors was mediated fully and significantly by frightened-disorganized attachment.

Discussion

Researchers have long thought that investigation of mediating relationships would foster a better understanding of the intergenerational patterns of both ACEs/CM and attachment (Kaufman & Zigler, 1987; Vaillancourt, Pawlby, & Fearon, 2017). Such mediating relationships could help to identify protective factors for those children most at-risk for enduring ACEs and CM experiences at the hands of a parental figure (USDHHS, 2018). Consistently, more work has been needed to uncover the mechanisms that may be driving these relationships (e.g., Vaillancourt, Pawlby, & Fearon, 2017). Thus, the current study investigated the relationships among mothers' ACEs and CM experiences, mother-young child insecure attachment, and negative parenting behaviors.

As was hypothesized, mediational regression analyses suggested that avoidant, anxious, helpless-disorganized, and frightened-disorganized mother-young child attachment mediated fully and significantly the connections between mothers' ACEs or CM experiences and their negative parenting behaviors. These findings indicated that mothers' ACEs and CM experiences predicted most closely mother-young child insecure attachment patterns, which then predicted mothers' negative parenting behaviors in turn. Interestingly, although insecure attachment followed a mediational pattern in the context of mothers' ACEs and their negative parenting behaviors, mediational patterns were more robust in the context of mothers' CM experiences and their negative parenting behaviors. Thus, the chronicity and frequency of CM experiences, in addition to the number of ACEs experienced, may be particularly important for understanding intergenerational patterns. Further, insecure attachment explained 26% to 44% of the variance as a mechanism of action in the relationship between mothers'

ACEs or CM experiences and negative parenting behaviors. These data align with those of Zajac and colleagues' (2019), who proposed a focus on attachment, rather than on ACEs, in the hopes of identifying those at greatest risk for negative parenting behaviors. Given these findings, secure attachment between mothers and their young children should be examined as a potentially robust protective factor for buffering the risk for negative parenting behaviors in the context of mothers' ACEs and CM experiences.

Certainly, the findings of this study should be considered in the context of its limitations. Most notably, this study's cross-sectional design relied entirely on mothers' self-report data. Along with reporting biases that could be at play, it is imperative to consider the vulnerable nature of the questions included in this study. Relying on self-report alone likely results in an underestimation of the true rates of exposure to ACEs and CM experiences (Shaffer, Huston, & Egeland, 2008). Individuals who perceive their experiences as being "less severe" may be particularly prone to underreporting ACEs and CM (Shaffer et al., 2008). Moreover, fear or bias may prompt mothers to be less than forthcoming when describing maladaptive parenting behaviors with their young children (Pears & Capaldi, 2001). Collectively, mothers may underreport their ACEs and CM experience if they continue to struggle with strong feelings regarding how their ACEs and/or CM experience may be impacting their parenting (Lieberman & Van Horn, 2011). Thus, it may be that mothers in our sample who endorsed fewer ACEs and/or CM experiences also were less likely to endorse difficulties with attachment and parenting. It also must be considered, however, that some mothers, such as those with generally negative views of their lives or those who experience depressive symptomatology in particular, may hold negative views of their childhood experiences as well. Mothers' holding of negative views across these various domains may translate to discouragement and guilt about parenting, prompting such mothers to be more likely to endorse difficulties with attachment and parenting. Given that the current study cannot disentangle the responses of mothers who underreport versus overreport, future research should seek to examine and understand these potential biases in reporting further.

Given sole utilization of self-report in assessing parenting behaviors and attachment in this study, it is important to note that conclusions can only be drawn regarding mothers' *perceptions* of mother-

young child attachment and their negative parenting behaviors. To further this work, self-report of *perceived* mother-young child attachment and parenting behaviors should be combined with "gold standard" observational measurements (e.g., the Strange Situation) in future studies. It is recommended that future studies prioritize utilization of validated and multi-method assessment while simultaneously creating a safe environment in which participants may openly discuss their ACEs and/or CM experiences and their parenting. Although a recent meta-analysis concluded that support for the intergenerational transmission of ACEs and CM does not vary with methodological quality (Madigan et al., 2019), use of more in-depth data collection (e.g., longitudinal designs) and analytic techniques (e.g., structural equation modeling) may allow for further exploration of causal relationships among the variables.

An additional limitation lies in the lack of diversity within our relatively homogenous, low-risk sample. Specifically, mothers were predominantly Caucasian, married, college-educated, and of middle-class socioeconomic status. These demographic characteristics unquestionably compromise external validity for samples who are more diverse with regard to their ethnic/cultural backgrounds, education, and socioeconomic status. Additionally, approximately 26.7% of the sample (i.e., 39 mothers) reported exposure to four or more ACEs (i.e., a high level of ACEs), suggesting that this sample was relatively low-risk overall. Although previous studies demonstrated significant findings from much lower percentages of high levels of ACEs (e.g., 6%; Felitti et al., 1998), there would be significant utility in focusing on high-risk parents in future studies (e.g., Zajac et al., 2019). In particular, future studies may consider the comparative relationships of ACEs/CM, parenting behaviors, and attachment across community samples of parents and foster parents, adoptive parents, and parents who are child welfare- and/or substance-involved.

In investigating potential ports of entry to break intergenerational cycles of ACEs and CM experiences, there are additional factors outside of mother-young child attachment that were not explored in the scope of this study. For instance, research found that having a supportive romantic partner and low levels of intimate partner violence buffered against the intergenerational cycle of abuse (Jaffee et al., 2013). Additionally, mothers' ability to recall more positive childhood experiences with their caregivers buffered intergenerational transmission of their

own trauma (Narayan, Ghosh Ippen, Harris, & Lieberman, 2019). Moreover, factors including type(s) of ACEs or CM experiences, sociodemographic factors, child age and gender, mothers' age, reflective functioning, substance use, residential stability, social support, coping style, and mothers' mental health, among others (Narayan et al., 2019; Savage, Tarabulsy, Pearson, Collin-Vézina, & 2019; St. Laurent, Dubois-Comtois, Milot, & Cantinotti, 2019), may potentially influence the cycle of ACEs and CM experiences.

The findings of the current study may have significant implications for trauma-informed parenting and parent-young child interventions. In particular, interventions that introduce attachment-focused concepts, support the facilitation of mother-young child secure emotional connections, and combat insecure attachment may produce meaningful intervention effects in the context of mothers' ACEs and CM experiences. For example, Circle of Security-Parenting, which emphasizes concepts such as "following the child's lead" and "being with" young children in their emotions, has promoted shifts from insecure and disorganized attachment to secure attachment classifications in high-risk young children (Hoffman, Marvin, Cooper, & Powell, 2006). Similarly, by focusing on nurturance and synchrony, Attachment and Biobehavioral Catch-Up (ABC) has promoted increased parent sensitivity to young children's signals and decreased negative parenting behaviors using "in-the-moment" coaching (Bernard, Meade, & Dozier, 2013). Additionally, in mothers who experienced ACEs, the Group Attachment-Based Intervention (GABI) showed medium to large effect sizes in improving mother-young child reciprocity, increasing mothers' presence, and decreasing hostile parenting and child maltreatment risk relative to the outcomes of a control group (Steele, Murphy, Bonuck, Meissner, & Steele, 2019). Finally, in facilitating reflection of protective factors with caregivers (i.e., 'angels in the nursery' or positive 'angel memories'), Child-Parent Psychotherapy (CPP) buffered the intergenerational transmission of trauma from mothers to their young children (Narayan et al., 2019). By intervening through different ports of entry that can provide access to parents' recollections of their own ACEs and CM experiences, their attachment to their young children, and any negative behaviors that they may exhibit, the intergenerational cycle of ACEs and CM experiences can be broken.

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ACEs and IMH: A Selection of Online Resources

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WAIMH Perspectives Intern

As an intern for Perspectives, my first task included developing a resource list for the upcoming special issue on Adverse Childhood Experiences (ACEs) and Infant Mental Health (IMH). Holding in mind that subscriptions to journals and reading through academic literature is often a costly and time-consuming exercise, my goal was to find resources that can:

- Be accessed for free; and
- Provide reliable content as evidenced by references to salient research in the field.

There is a wealth of information on ACEs freely available online. Therefore, the resources I selected are not exhaustive but can be viewed as a starting point. I included resources that offer a variety of multimedia formats on the content. The table below provides a link and a description of the resources I have selected.

Highlighting some of the resources, I particularly enjoyed the TED Talk on Adverse Childhood Experiences by Dr Nadine Burke-Harris who speaks on "How Childhood Trauma Affects Health across a Lifetime". The talk is 16 minutes long and gives a vibrant and evocative overview on ACEs, and perhaps can be a starting point to a conversation on the link between ACEs and IMH.

Furthermore, the *Centers for Disease Control and Prevention* (CDC) website presents ACEs in graphics including a snapshot of the prevalence of ACEs by category for CDC-Kaiser ACE study participants, Waves 1 and Waves 2.

In addition, websites are noted that provide free toolkits in assessing and working with individuals, families and infants who have been impacted by ACEs.

Lastly, there is a link to a Journals blog which taps into the conversations taking place on the generational effect on offspring of parents who experienced ACEs growing up. I hope that this resource list and this Special Issue as a whole, can add to this important subject.

Website	Description
https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?share=19391661a0	TED Talk on ACEs by Dr Nadine Burke-Harris entitled "How Childhood Trauma Affects Health across a Lifetime".
https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-graphics.html	CDC website - Adverse Childhood Experiences Presentation Graphics. Includes a snapshot of the prevalence of ACEs by Category for CDC-Kaiser ACE Study Participants, Waves 1 and Waves 2.
https://www.cahmi.org/wp-content/uploads/2015/01/ACEs-Resource-Packet_all-pages_12_06-16.pdf	ACEs Resource Packet: <ol style="list-style-type: none"> 1. Adverse Childhood Experiences (ACEs) Basics; 2. The Science Behind ACEs; 3. What Can We Do? Including trauma focused approaches to treatment; and 4. Resources on ACEs and Resilience (Including links to Individual and Organizational ACEs Screening and Assessment Tools).
https://www.who.int/violence_injury_prevention/violence/activities/adverse_childhood_experiences/en/	WHO page on Violence and Injury Prevention that include the ACEs International Questionnaire.
https://www.acesconnection.com/	Resource website offering information, support and webinar training.
https://www.iowaaces360.org/resiliency-toolkit.html	ACEs Response Toolkit which includes a wealth of links for individuals, communities and professionals.
https://www.aappublications.org/news/2018/03/26/when-parents-have-experienced-adverse-childhood-experiences-what-is-the-effect-on-their-children-pediatrics-3-26-18	Journals Blog: When Parents Have Experienced Their Own Adverse Childhood Experiences, What are the Effect on Their Children?

As a result of this preliminary online search for publicly available material I note that there is a need for more resources that specifically link ACEs and IMH.

This list is a beginning and can easily be added to. As such, I would like to invite readers to be in touch with the Editors to contribute to this list which can be continuously updated as new information comes our way.

Going the Distance: Promoting Rural Participation in the Professional Development of Infant Mental Health Workers

By
Redmond Reams and Paige Light
USA

Throughout the United States (Harris-Usner, 1995; Neumann, 2019) and around the world (e.g., Dixon & Welch, 2001; Zhang et al., 2018), infants, toddlers and their families in rural areas experience higher risk than those in urban areas. In a parallel fashion, rural Infant Mental Health (IMH) professionals encounter more barriers to their professional development when they live in rural areas versus urban areas; regardless of whether they live in the U.S. (Harris, 2006; Thornburg & Scott, 2006) or around the world (Hyson & Roesli, 2017).

Without professional development, there is a greater risk for rural IMH professionals to leave the area (National Rural Health Association, 2008) and to be less prepared for the service challenges they face. Yet:

“successful professional development requires recognizing the unique challenges of reaching rural areas and the cultural distinctiveness of rural communities” (Thornburg & Scott, 2006, p.14).

Professional development can take varying forms for rural IMH professionals. One is early childhood professional development registries (Funk et al., 2017; Thornburg & Scott, 2006). The most established registry is the Infant Mental Health Endorsement® (Endorsement®) developed by the Michigan Association for Infant Mental Health (MI-AIMH) in the early 2000s and now pre-sent in 30 U.S. states, Western Australia and Ireland and moving into other Australian states and Japan, under the leadership of the Alliance for the Advancement of Infant Mental Health (for more information see Funk et al., 2017 as well as www.allianceaimh.org).

In Oregon, the Oregon Health Authority (OHA), a state government department, had included money to initiate Endorsement in their funding requests. Thus, in 2015 the Oregon Infant Mental

Health Association was in discussions about bringing Endorsement to Oregon. One concern in implementing the rollout of Endorsement was ensuring equity and diversity along multiple dimensions, including geographic: the rural/urban divide. A local Oregon foundation focused on rural development, The Ford Family Foundation, stepped forward and initiated the idea of providing funding to support Endorsement reaching all the corners of Oregon.

Early planning identified areas of focus including raising awareness about Endorsement throughout the state, removing barriers to initiating Endorsement for rural IMH professionals, and assisting those professionals to effectively navigate the multiple steps to achieve Endorsement. These goals led to the creation of rural success strategies. Some strategies were implemented by the statewide Endorsement Director and others by our contracted local indigenous Rural Endorsement Specialists.

Endorsement Director Strategies

Strategies provided by the central office included:

- offering scholarships for all fees associated with Endorsement,
- outreach through presentations at statewide meetings of infant and early childhood rural decision makers,
- creating Endorsement materials in Spanish and contracting with Spanish speaking staff, providing trainings at rural locations,
- providing distance-based video reflective supervision/consultation groups for rural applicants,
- holding monthly meetings of the rural IMH endorsement specialists (described below) for the purpose of mutual support, sharing strategies, and celebrating progress,
- contracting with local indigenous IMH professionals who: had lived and worked in their communities for a minimum of two years; had some initial knowledge of IMH principles and practices; and who were also

active in the community outside of their work sector.

Rural Endorsement Specialist Strategies

Our local indigenous contracted Rural Endorsement Specialists delivered individualized, community targeted supports in their communities including:

- presentations at staff meetings of agencies serving infants, toddlers and their families, staffing informational tables at regional trainings for rural IMH professionals,
- providing support and advising to Endorsement applicants,
- hosting open houses about Endorsement in their rural locations where interested professionals could drop in for information,
- extending outreach and information about IMH and Endorsement during other leadership activities within their rural counties,
- formally presenting to rural groups, both groups of leaders and groups of staff (Early Head Start, Healthy Families, Public Health) on Endorsement,
- identifying available local Endorsement-related resources, and those that were missing, and
- finding and inspiring rural promoters who would advocate for Endorsement.

Hannah was one of our rural IMH Endorsement specialists. She worked as a manager for an Early Head Start in a town of about 15,000 people on the Oregon coast. Hannah summarized her greatest success in helping rural applicants move through the Endorsement-related process as:

“my ability to be flexible – meet them at their job, at lunch; meet them in the evenings – a coffee shop or at their house for one person who had kiddos. ... going to where they were and meeting them in tiny little bits that they

had the time.”

An unanticipated benefit was the professional development of the rural Endorsement specialists themselves. Examples of their increased leadership included:

- influencing their own agency to expand IMH services,
- increasing public speaking skills,
- deepening connections with other IMH leaders within their communities,
- developing reflective supervision skills,
- becoming the known local IMH experts in their communities,
- creating the two-minute “elevator talk” about IMH and Endorsement, and
- envisioning a professional future roadmap for themselves.

For Hannah, she reported:

“I have a tendency to want to be behind the scenes, just a worker bee. But, obviously, knowing that’s not always the thing that’s needed – so, yeah, definitely confidence-building.”

Results

Based on the definitions of our funder¹, 59% of the 102 endorsees from 7/1/16 to 2/28/19 were rural professionals. By contrast, the US census reported that 29-37% of Oregon residents live in locations with less than 25,000-50,000. Thus, through our efforts rural professionals were actual-ly overrepresented among Oregon IMH professionals who earned IMH Endorsement®.

Implications

1. Rural participation in professional development initiatives, whether in IMH or not, can be in-creased with a systematic outreach strategy and this can be documented. Many initiatives in-tended to be universal do not track rural versus urban participation, and rarely do any special out-reach to rural individuals.
2. Creating and implementing a systematic approach to an initiative. Five possible barriers to a rural IMH professional were addressed with at least one of our strategies:
 - a) Awareness was increased through having Endorsement information

distributed by statewide IMH organizations, staffing informational tables and presenting at statewide and regional gatherings of IMH leaders and staff, and identifying and inspiring rural champions who would advocate for Endorsement® (e.g. early childhood college faculty to their students, mental health con-sultants to their consultees at Head Starts).

b) More in-depth education was provided at presentations at local IMH agencies by our Rural Endorsement Specialists, hosting Endorsement open houses in rural locations, and creating En-dorsement informational materials in Spanish.

c) Helping rural professionals over the hump of registering and initiating an Endorsement application was achieved through offering scholarships to offset registration and application fees, offering phone support from central office and Rural Endorsement Specialists about how to initiate an applications, and hosting rural open houses to provide information on how to apply. Computer skills are required to complete an application, as well as access to reliable internet, both of which can be challenges in rural communities.

d) Support, advice, and encouragement was provided over the phone and in-person by our Rural Endorsement Specialists both to individual applicants and in groups.

e) Distance-based video group reflective supervision was essential for applicants who needed more reflective supervision hours and for whom it was not available in their communities, which was often true in rural locations.

3. IMH organizations looking to enhance their rural outreach might broaden their focus for obtaining support to foundations looking to support rural development in their state. Our funder was a foundation whose overriding mission was not IMH but rather rural development, although they had an area of interest in early childhood.
4. As we were rolling out our strategies, we often were not sure how they might need to be adjusted midstream to fit the community of rural IMH professionals we were trying to reach and help. Our funder was very supportive and accommodating in understanding the need for flexibility and creativity in outreach to rural communities. There was a wonderful parallel process – our funder’s flexibility empowered us to be flexible and

encourage creativity for our Rural Specialists in identifying the unique barriers and strategies needed with each rural community, and with each rural applicant. This is an important implication for funders looking to support rural initia-tives.

5. Many publications have talked about the isolation of rural professionals (e.g., Harris-Usner, 1995). An implication is the risk of this for Rural Endorsement Specialists. Thus, we felt it was critical to provide support to them through monthly video conference calls, and quarterly in-person meetings with team building and reflective activities, with an emphasis on empowering and sharing their ideas to overcome hurdles. Hannah commented, “I always left (these meetings) feeling a kind of renewed purpose and I always got information that was helpful to me to kind of adjust things or just keep going.” We also provided immediate access to technical assistance when they were advising rural applicants, so that meeting time and the long travel time was not wasted because someone could not log in or navigate a glitch in the electronic system.

The hiring of these Rural Endorsement Specialists did not occur as it might in an urban setting. We found we couldn’t just post a job announcement and expect applicants. It was important to travel and meet with rural IMH leaders to brainstorm who locally might a good candidate to ap-proach and invite to apply. We also had to be flexible with work definitions and requirements; we split a job to a job share in one instance and realigned two counties as we learned about geo-graphic travel barriers.

6. Community is required to attend IMH-oriented continuing education and receive ongoing reflec-tive supervision annually to maintain their Endorsement status. Creating a community of rural IMH Endorsed professionals is challenging. We have to continue to tailor the IMH trainings pro-vided so that they can be accessed on the web or in locations around the state. Continued access to distance-based video group reflective supervision will be essential.

Future research

Future research would aim to:

1. Establish which of the strategies we used that made the most difference in the large number of rural Endorsees;

2. Look at rural applicants who did not complete their Endorsement and identify the barriers they face, with a view to develop new strategies to address those barriers; and
3. Research how generalizable our strategies are to rural areas in other states in the United States and in other countries.

Increasing rural participation in IMH professional development initiatives is clearly now possible. We hope our findings will inspire more organizations to initiate systematic outreach efforts to include rural IMH professionals. We welcome requests for more information at either red-mondreamsphd@gmail.com and/or paigelightlpc@comcast.net.

Notes

¹ The Ford Family Foundation defined a rural professional as working in a city of less than 35,000 and their city is not contiguous with a city of more than 35K (i.e., a suburb of a larger city), OR as working for an agency in an urban city, however, more than 60% of their caseload is rural.



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NEAR@Home for Home Visitors: Addressing ACEs in Home Visiting by Asking, Listening, and Accepting

By

Catherine Blair, Rhonda Crooker, Michelle Harvey, Jeanine Jeffers-Woolf, Leah Niezwaag and Carol Young

USA

I wish someone had shared ACEs research with me when I was a young parent. I didn't know then what I know now (NEAR@Home, p. 10).

Parents have the right to know the most powerful determinant of their children's future health. The most powerful people for reducing ACE scores in the next generation are parenting adults. Parents have the most opportunity and the most potential for changing the trajectory of the public's health for generations. But parents must actually know about ACEs and their effects in order to realize this potential (NEAR@Home, p. 12).

Many early childhood and infant mental health professionals are familiar with Adverse Childhood Experiences (ACEs) and are able to adopt a trauma lens in their work with families. Even with this awareness, the effects of ACEs can feel overwhelming for the parent and early childhood home visitor, and many find themselves asking "what can I do about it?"

In 2013, home visiting professionals from the Pacific Northwest region of the United States gathered to address the question: How do we bring ACEs information to parents in a way that feels safe and supported? Systems leaders, home visitors, and tribal leadership from Alaska, Idaho, Oregon, and Washington worked together to develop what is now the NEAR@Home toolkit, a free downloadable guide for home visiting professionals to facilitate conversations around ACEs.

Grounded in principles of social justice, infant mental health, and trauma-informed care, the NEAR@Home toolkit aims to support hope and resilience through five core elements of Preparing, Asking, Listening, Affirming, and Remembering.

NEAR combines the latest science from:

- Neuroscience;
- Epigenetics;
- Adverse Childhood Experiences: and
- Resiliency.

When used in the context of the home visiting relationship, these elements set the foundation for families to be seen, heard, and felt as parents reflect on their ACEs and resilience and how they want their child's life to be different.

In 2017 an in-person learning process was developed and refined through funding by the Region X MIECHV Innovation Grant. Over the past two years, five Infant Mental Health professionals were trained as NEAR@Home facilitators to support a total of 225 home visitors and 54 supervisors in learning the NEAR@Home process.

While learning NEAR@Home, early childhood teams are guided through reflective, relationship-based process in exploration of feelings and skills in discussing ACEs and NEAR science with parents of young children. Consideration for safety and wellbeing of home visitors is central to the NEAR@Home learning process: 81% of home visitors responding to a 2019 Region X Workforce Study reported a history at least 1 ACE, with 33% reporting 4 or more ACEs (Roberts, et al., 2019).

The work of NEAR@Home is deeply rooted in parallel process and facilitators work to create space for the home visitors and supervisor as they integrate their own experiences of being parented. Quality Reflective Supervision is central to the NEAR@Home process, as the home visitor and supervisor uncover their own stories in the process. For example, as part of the facilitated learning of NEAR, we ask that all home visitor's and supervisors complete the ACE questionnaire on their own, to have the felt experience of what we are

asking families to do, as well as to honor the parallel process.

Ideally, we hope that the program has quality and regular Reflective Supervision in place for home visitors and supervisors as we know home visitor's in particular come to the work often with similar stories or themes as the families they serve. The facilitators do a great deal of attuning, containing, and holding space during the facilitated learning process as we honor what is activated (unspoken or spoken) when trauma is directly talked about in a supportive, respectful way.

Aligned with the funding focus, to date we have focused on the home visitor experience and those of their supervisors. Home visitors have shared the following responses to learning NEAR@Home:

Learning about NEAR@Home has helped me to be more curious about a parents' experience early in their life and how those experiences might inadvertently be impacting the parenting relationship. It has also expanded my curiosity about other traumatic experiences such as historical trauma. It has changed the way I think about adversity (NEAR@Home, p. 15).

I thought it would be really difficult to think about what to do next. I'm remembering that sometimes the intervention is in being there. I thought I would need to have a lot of resources available but they're not asking for that – they're enjoying the awareness. The conversations that come afterward are what's important. The people I've done it with have not needed therapy afterward. I haven't had to figure out what to do next (p. 48).

For more information and to download the NEAR@Home toolkit, please see: www.nearathome.org.

For more information about the program: <https://givingcompass.org/article/reducing-childhood-trauma-home-visiting/>

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WAIMH Connectors and Collaborators Column



Recipients of the Sonya Bemporad Award Dr Miguel Cherro Aguerre and Dr Natalia Trenchi with Chair of Programme Committee Mark Tomlinson (in the middle) at WAIMH 14th World Congress Edinburgh in 2014. Photo by Simon Williams.

By Maree Foley, Switzerland, Deborah Weatherston, USA, Bob Emde, USA

This column features WAIMH members who are contributing to the fabric and virtues of WAIMH in their region and or community. It especially celebrates their tireless efforts to build working relationships across disciplines and sectors for the benefit of the infant and family mental health and development. In this column we introduce and celebrate Dr Miguel Cherro-Aguerre (Child and Adolescent Psychiatrist), from Uruguay.

The WAIMH Perspectives Editorial team would like to congratulate Dr Miguel Cherro-Aguerre who has recently been designated as an Honorary Member of the Academy of Medicine of Uruguay. As an Honorary Member of the Academy of Medicine of Uruguay, he gave his first lecture as an Academicist, in the subject of attachment. Of his work he said that:

I am very proud and happy to realize that actually in our country we have a lot of clinicians and investigators that are seriously working in early relationship. I still work giving lectures, supervising younger clinicians and giving support and advice to a pediatric palliative care team (Personal

communication with Dr Miguel Cherro-Aguerre).

In Uruguay, Dr Cherro-Aguerre was one of the pioneers of infant mental health. In 1977, he introduced attachment theory in the study of child development. Reflecting on this time, he said:

Previously an eminent etiologist, Professor Rodolfo Tálice, inspired in Konrad Lorenz, studied the theory in the animal realm. Then, following the suggestion of two friends, Salvador Celia (Brasil) and Juan Miguel Hoffmann (Argentina), I decided my affiliation to WAIPAD (World Association of Infant Psychiatry and Allied Disciplines) (Personal communication with Dr Miguel Cherro-Aguerre).

Continuing to reflect on his time as a member of WAIMH he recalled that:

The first congress that I attended was Lugano 1989 where our research team presented a follow-up study of identical twins. The principal supervisors of that work were Bob Emde and Joy Osofsky.

The great Master Serge Lebovici, also gave us some suggestions too. At that congress of 1989, WAIPAD changed her name to WAIMH (Personal communication with Dr Miguel Cherro-Aguerre).

Furthermore,

I should also thank the kindness of the editors of the books and journals of the Association, thanks to whom we were able to publish our papers on twins, teenage mothers, violence and primary attention in the community (Personal communication with Dr Miguel Cherro-Aguerre).

In addition to long standing organisational service to IACAPAP, Dr Miguel Cherro-Aguerre was a joint recipient with Dr Natalia Trenchi (Uruguay) of the WAIMH Sonya Bemporad Award. This award is:

Given in recognition of significant contributions to the advancement of social and public policies that contribute to the mental health and overall benefit of infants, toddlers, and their families. Nominees typically are not involved in service delivery or scientific or clinical studies of infants. Legislators, officials, advocates, media representatives, foundation directors, and concerned citizens may qualify for the award (www.waimh.org).

News of this award was published in Perspectives (<https://perspectives.waimh.org/2014/09/15/news-waimh-central-office-14th-world-congress-success/>)

Dr Miguel Cherro Aguerre, was especially recognized for “his leadership and good will as well as his clinical wisdom and ability to educate a wide range of people to better the lives of infants, young children and their families in Uruguay”. (<https://perspectives.waimh.org/2014/09/15/news-waimh-central-office-14th-world-congress-success/>)

In conjunction, Dr Natalia Trenchi was recognised for her:

... creative contributions in the public domain have included her newspaper columns, radio and regular television shows,

books and presentations for schools as well as for community organizations—all bringing advice on parenting and healthy development in the early years.

(<https://perspectives.waimh.org/2014/09/15/news-waimh-central-office-14th-world-congress-success/>)

Many WAIMH congress participants will have had the opportunity to meet Dr Miguel Cherro-Aguerre and Dr Natalia Trenchi and to hear about their work and research in Uruguay. Miguel mentioned that he had been attending WAIMH congresses from 1989 till more recently in Prague (2016) and that he

... always enjoyed the Meetings, not only for their profound teachings but also for the friendly climate that we felt in each of them ... There had been 30 wonderful years in WAIMH... I will continue working for the Infant Mental Health as much as I can, and doing so I thank WAIMH, all its members and especially, Bob Emde (Personal communication with Dr Miguel Cherro-Aguerre).

Supporting Vulnerable Babies and Young Children: Interventions for Working with Trauma, Mental Health, Illness and Other Complex Challenges

Wendy Bunston and Sarah J. Jones, Editors

UK: Jessica Kingsley, Publishers, 2020, p. 312.

Reviewed by: Deborah J. Weatherston

USA

Associate Editor, WAIMH Perspectives in IMH

This masterful collection, edited by WAIMH members, Wendy Bunston and Sarah J. Jones (Australia), is essential reading for the global community of health, mental health, early childhood and child welfare professionals. With attention to infants and very young children who face a range of challenges including serious illness, complex diagnoses, and exposure to adversity in the early years, the book offers a strong theoretical foundation, a variety of approaches and numerous case examples from around the world. Throughout, the editors and authors place an emphasis on the importance of relationships for health and healing, offering an array of strategies to promote infant and early childhood mental health.

As Bunston and Jones (2020) write in their introduction, the intent of this book is to:

“Make prominent the voice, experience and perspective of infants and young children who have endured considerable and complex vulnerabilities. This is through providing a range of expertise which brings together a disparate, contemporary and often underexamined areas of working with the world’s youngest children.” (p. 17)

Contributors to this important volume include an array of professionals from around the world – social workers, psychiatrists, community health workers, health care workers, to name a few – who give voice to this intent, e.g.: Julie Stone, Jennifer McIntosh, Christine Hill (Australia), Hisako Watanabe (Japan), Ben Gray (UK), Robyn Hemmens (South

Africa), Angelique Jenney and Natasha Whitfield (Canada). Each holds infants or young children in mind, placing them at the center of interventions, respecting “salient aspects of the infants’ and families’ historical, relational, cultural and subjective experiences” and inviting those experiences “to inform our ability to create a nuanced therapeutic relationship.” (Bunston & Jones, 2020, p. 18)

What lends strength to this volume are the case studies that bring to life the complexity of experiences that very young children and their families find themselves increasing the reader’s awareness of devastation for infants in crisis as well as the possibility for the restoration of health and hope through a variety of interventions.

The titles of chapters suggest the depth and breadth of the book, e.g. *Restoring Ruptured Bonds: The Young Child and Complex Traumas in Families*, *Keeping the Child in Mind when Thinking about Violence in Families*, *The ‘International Infant’: Examining the Experiences and Clinical Needs of Separated and Reunited Transnational Infant-Parent Dyads*, *Play With Us: Bringing Hope and Healing to KwaZulu-Natal’s Children*, *Infants and Young Children in the Aftermath of the Great East Japan Earthquake*, *Infants and Young Children Living Within High-Conflict Parental Disputes*, *Infants with Cancer: The Oncology Unit as their Second Home*, *Playing Behind the Barbed-Wire Fence: Asylum-Seeking Infants and Their Parents*.

The volume gives the reader a remarkable glimpse of the state of infants, young children and their families from around the world. Although the experiences described differ, the strategies offered by contributors are solidly focused on the social and emotional needs of very young children within the context of nurturing relationships for health and healing. This book is a must read for each of us in the infant and early childhood mental health community as we struggle to reduce grave risks of disorders of infancy and support

Edited by **Wendy Bunston** and **Sarah J. Jones**
Foreword by Graham Music

SUPPORTING VULNERABLE BABIES AND YOUNG CHILDREN

INTERVENTIONS FOR WORKING WITH TRAUMA, MENTAL HEALTH, ILLNESS AND OTHER COMPLEX CHALLENGES



the wellbeing of all children in face of conflict and crisis.

In sum, the volume heralds an international focus on the importance of infancy as a significant period that is in reality, an urgent plea to policy makers, program developers and providers to respond with services that will hold babies and families in mind around the world. It is a valuable resource for those new as well as those more seasoned in the art of infant and early childhood mental health.

Babies in Refuge: Online resource

As a follow up to “How Refuge provides ‘refuge’ to Infants: Exploring how ‘refuge’ is provided to infants entering crisis accommodation with their mothers after feeling family violence (Perspectives in Infant Mental Health, Vol 26. No. 4. Fall 2018) by Wendy Bunston (Australia), there is an online resource by Wendy Bunston and Robyn Sketchley. The online resource offers learning modules for Refuge staff to support them in thinking about the perspective of the Infant.

The Link: <https://www.dvrcv.org.au/sites/thelookout.sites.go1.com.au/files/Refuge%20for%20Babies%20Manual%20FinalWEB.pdf>

Does Time Heal All? Exploring Mental Health in the First 3 Years

Miri Keren, Doreet Hopp, Sam Tyano

(L. Lazar, Trans.). Washington, D.C.: ZERO TO THREE, 2017

Reviewed by: Deborah J. Weatherston

USA

Associate Editor, WAIMH Perspectives in IMH

The book is dedicated to the babies we were...and the babies to come...

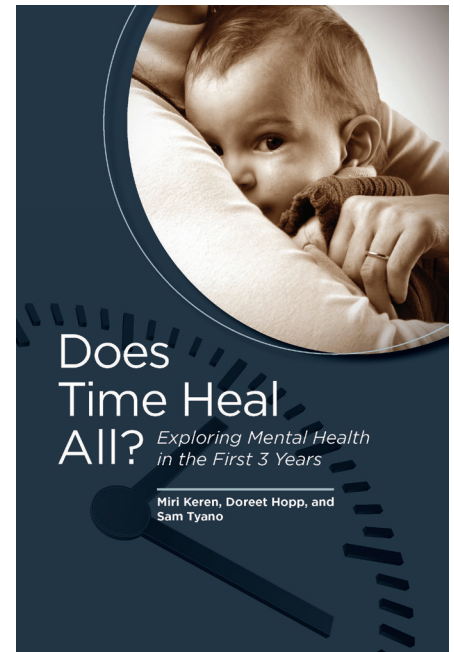
The dedication sets the frame as the book unfolds, beginning with the baby's place throughout history and exploring parenthood from an historical perspective, continuing with concepts embedded in infant psychiatry and addressing significant challenges as experienced by the baby - crying, self-regulation, sleep and eating - and sensitive to the parents' experiences. The authors are careful to present normative developmental pathways before moving to atypical disorders of infancy and the diagnostic process as well as treatment methods.

The range and depth of issues warranting attention in the early years are numerous and urgent, pertinent to the work of infant and early childhood mental health professionals working across systems, in a variety of settings and at multiple levels of risk. For example, Chapter 10: I'm Sad, asks how it is possible that babies can be depressed, followed by discussion of the etiology of depression in infancy, e.g. loss of a parent and prolonged grieving, emotional deprivation and neglect, maltreatment, terminal illness in the baby, chronic physical pain.

In addition to offering ways to consider or diagnose depression, the authors include differential diagnosis and comorbidity, the courses of treatment of depression in infancy that are possible, often including dyadic or triadic work with families, with references to the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) the impact of depression on a child's development over time.

Case studies enrich this chapter, as in many of the chapters, and recommended references invite further study. The authors are careful to keep the needs of the baby in mind, preserving the infant's voice. This is well balanced with empathic response and attention to the needs of parents. Of great importance is the message that early identification, preventive intervention and treatment are essential to the wellbeing of children across the world. Time does not heal all.

In summary, the book *addresses real-life situations in the world of babies and toddlers and the thin line separating norm and pathology. It contains up-to-date theoretical knowledge on child development (from birth to 3 years old) in clear, easy-to-understand language, peppered with detailed stories, folktales, and contemporary adult literature. These combine to form a book that is fascinating, informative, and innovative (ZERO TO THREE, 2018).*



WAIMH at the European Society for Child and Adolescent Psychiatry (ESCAP) Conference, Vienna, June 2019

By Maree Foley

Switzerland

In June 2019, WAIMH was represented at the *European Society for Child and Adolescent Psychiatry (ESCAP)* conference in Vienna, Austria. It was the 18th International Congress of ESCAP with a theme of: Developmental psychiatry in a globalized world.

There were three WAIMH focused activities during this conference:

1. A daily WAIMH promotion stand and promotion of the WAIMH Congress in Brisbane, June 2020 (Minna Sorsa and Sari Miettinen);
2. A Perspectives administration meeting (Maree Foley, Kaija Puura, Miri Keren, Deborah Weatherston (via skype), Hi Fitzgerald (via skype), Minna Sorsa and Sari Miettinen); and
3. A WAIMH invited symposium (Miri Keren and Kaija Puura).

The WAIMH Invited Symposium was titled: *Premature babies at the NICU: The interface between pediatrics and infant psychiatry*. It was chaired by Miri Keren (past president of WAIMH). The symposium was very well attended with standing room only. The participants were very engaged throughout the symposium as illustrated by their sustained attention, presence, and thoughtful questions.

The symposium comprised four engaging papers. First a paper by Professor Kaija Puura (WAIMH Executive Director) from Tampere University Hospital, Tampere, Finland. Kaija's paper, the *Co-creation of family centered care for neonatal intensive care unit of Tampere University Hospital* outlined a socratean oriented multi-disciplinary training project that was conducted with NICU staff. The training project aimed to, and successfully promoted good parent-infant interaction in the NICU; a shared space with infants, their families and NICU staff.

Second, a paper by Dr Miri Keren (WAIMH Past President) Assistant Clinical Professor at the Child and Adolescent Psychiatry department, Tel-Aviv, Israel. Miri's paper, *Detecting at risk mother-infants dyads at the NICU*, illustrated the use of "The Clinical



Maree Foley, Miri Keren and Kaija Puura presenting WAIMH at ESCAP congress 2019.

Interview for Parents of High-Risk Infants", the CLIP interview. The CLIP interview is a useful tool to help assess traumatic experiences related to prematurity and to identify parents of premature babies who would benefit from further intervention towards and after their discharge, so as to promote and protect the parent-infant relationship following a traumatic start to their relationship.

For further enquiry about The Clip Interview see: Meyer, E., Zeanah, C., Boukydis C., & Lester, B. (2006). A clinical interview for parents of high-risk infants: Concept and applications. *Infant Mental Health Journal*. 14. 192 - 207.

The birth and hospitalization of a preterm infant are stressful and emotionally demanding experiences for parents. (CLIP) is a semi-structured clinical interview that may be used as a one-time assessment or as a cornerstone for ongoing psychosocial work with parents. The interview assesses early parental adaptation and alerts the clinician to areas of concern as identified by the parents. The interview enables parents to consolidate emotionally their experiences relative to the infant's high-risk status. The CLIP has utility both for planning psychosocial care in

the intensive care nursery, and for discharge preparation. The rationale underlying the design of the CLIP is presented, the interview is described, and clinical applications are discussed (Meyer, Zeanah, Boukydis & Lester, 2006, p. 192)

A third paper was presented by Assistant Professor Kenia Gomez (UMass Medical School, Pediatrics, Worcester, USA): *Screening for maternal mental health in an outpatient interdisciplinary NICU (Newborn Intensive Care Unit) Follow-Up Clinic*. Kenia reported on a project that involved an interdisciplinary outpatient NICU follow up clinic to screen for maternal depression in conjunction with providing medical and developmental evaluations of their infants. They found that parents of infants in the NICU experienced stigma and this inhibited them from seeking emotional and psychological help. Moving forward, an integrated approach to screening in mothers and parents of high-risk infants in the NICU offers a way to provide support and acceptance so as to decrease the potential experiences of stigma and increase help mental health seeking when needed.

A fourth paper was presented by Dr Sabine Fiala-Preinsperger (Child Psychiatrist), Mödling, Austria. Sabine presented a narrative based case study: It is never too early to talk with premature babies and their parents. In her paper she spoke

from the perspective of the premature baby and the importance of engaging in meaningful conversation with voice, with the infant, in the presence of their parents. She showed a sensitivity to both the parents and the infant with regard to the context in which they were building their relationship; a neonatal unit in contrast to being in their own home. She describes this process in her abstract:

It is also necessary to help the parents looking at their baby and to tell the baby how exciting for mum and dad this moment is. Each step should become a little story by its own. You can tell the baby its own story, about the wish of the parents to have a baby and their longing to hold the baby into their arms. It is very helpful for mother and father to tell the baby everything that happens during the day and to mentalize the baby's feelings (Fiala-Preinsperger, S., 2019).

Finally, full abstracts for each of these papers can be viewed in the ESCAP abstract book: https://www.escap.eu/bestanden/Vienna%20congress/abstractbook_escap2019.pdf

Celebrate Babies 2019



Each year the [Michigan Association for Infant Mental Health \(MI-AIMH\)](#) dedicates one week to officially celebrate infants, toddlers, young children, their families and early childhood professionals in Michigan and across the globe! [WAIMH](#) invites their affiliates and others to join in this initiative, in their local area, during the week of October 21-25, 2019. We encourage you to share your activities with the WAIMH global community by sending a photo, a comment, or something similar to the WAIMH office (office@waimh.org). Let's join together and celebrate babies! #Celebratebabies2019 #WAIMH #MIAIMH

[2019 Celebrate Babies week Infographic Final \(1\)](#)



WAIMH2020

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*Creating stories in Infant Mental Health:
research, recovery and regeneration*



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News Alert: IMHJ welcomes a new editor, expands its focus to infant and early childhood mental health, and embraces social media tools

By Holly Brophy-Herb and Lynn Vollbrecht
USA

While the editorial board of the *Infant Mental Health Journal* remains as committed as ever to publishing relevant, applicable research on early relational contexts and Infant Mental Health, there are several key changes afoot at the journal. Below, some updates from the last few months of transition at IMHJ.

A new editor-in-chief

In July of 2019, IMHJ welcomed a new editor in chief, Dr. Holly Brophy-Herb of Michigan State University. Brophy-Herb has taken on the role with a commitment to enhancing the impact of the journal on the field, raising the visibility of Infant Mental Health research, and making the journal's submission and review process as streamlined and efficient as possible- all while promoting high-quality reviewers and highlighting the key findings and implications of the published work for policy and practice. Many thanks to Dr. Paul Spicer for his excellent work as editor for the past 5 years!

"As a long-time editorial board member, I'm so pleased to be taking the helm of a publication that's so vital to our field," says Brophy-Herb. "We're working to continue to build on the excellent foundation laid by previous editors, while also striving to expand our promotional reach and actual scope of research—now that we're including research on children up to the age of 5, the journal's focus will truly be in alignment with trends in the infant and early childhood mental health field, both domestically and abroad."

An expanded focus (up to age 5)

For many years, the *Infant Mental Health Journal* has published peer-reviewed research articles and reviews focused on early relational contexts, such as attachment relationships and early relationships within parenting, family, and caregiving systems, that impact the social-emotional development of infants and toddlers.

We're pleased to announce that *IMHJ* will also include research on early childhood mental health. Expanding the focus to include relational work on children prenatal to 5 years is a new endeavor for *IMHJ*; it is a move that will bring the journal into alignment with trends in the field, both nationally and internationally, that highlight the importance of infant and early childhood mental health. Examples of welcomed topics include areas such as:

- early childhood mental health consultation
- the quality of teacher-child relationships as contexts for early childhood classroom quality and children's social-emotional outcomes
- reflective supervision in early childhood contexts
- early childhood educator mental health

Stay in touch and Promote Your Research on Social Media:

Follow IMHJ on social media.

- [Twitter](#)
- [Facebook](#)
- [Instagram](#)
- [LinkedIn](#)

We're very interested in helping authors promote their research via IMHJ's social channels, and encourage them to share their social media handles with Editorial Assistant Lynn Vollbrecht to streamline this process.



Holly Brophy-Herb and Lynn Vollbrecht.

More accessible abstracts

All *IMHJ* articles will feature with the manuscript abstract three key findings and implications as well as a statement of the relevance of the work to the field of infant and early childhood mental health. Why? It's all part of an effort to make it easier for policymakers and practitioners alike to assess the ways in which they might be able to put research to work in very real-world ways.

Video Promotion

Authors now have the option to include short video bytes about their research that we will share on social media to help promote visibility of the work. While our publisher, Wiley, can produce video abstracts on an author's behalf, authors can also create their own short, 1 minute video byte. Talk to us for more information, vollbre3@msu.edu.

We look forward to working with you soon!

WAIMH Office News: Nominations to the Board, Awards and Changes in Bylaws

By Minna Sorsa and Sari Miettinen, Finland

Dear members

The membership year is ending and we are about to start the new year 2020. Remember that the WAIMH memberships are active from January each year until December. As you renew you can order the *Infant Mental Health Journal* at a reduced rate. In 2020 you will have a lower fee to the [17th WAIMH World Congress in Brisbane, Australia!](#)

Our new website offers the options for discussion and networking among members of WAIMH. If you have an idea of a group, and you would be volunteering to moderate such a group, please send the WAIMH Central office your suggestions!

Awards nominations

WAIMH offers four important awards in recognition of individuals from across the world who have made important contributions to the infant mental health community in the course of their careers. November- December 2019 is the time for nominations for the different Awards. These are listed more precisely on the WAIMH website, where you can also read more about the nomination process. There are 5 Award categories:

- WAIMH Award
- Sonya Bemporad Award
- Serge Lebovici Award
- René Spitz Award
- WAIMH New Investigator Award

Interdisciplinary by design, WAIMH invites nominations from the fields of health, mental health, early care and education, early intervention, hospitals, colleges and universities, legislatures, to name just a few.

Board nominations and President-Elect

The changes in the WAIMH Board are an important juncture for the association. Three current Directors on the WAIMH Board will end their four-year term of office in June 2020 and therefore a new nomination process is starting. Two directors will be elected by the members of WAIMH and one will be appointed by current President-Elect Campbell Paul as his term as President starts in June 2020.

The Call for Nominations was launched in mid-November 2019. First, the members will elect new board members. Second, members will also be presented with candidates for the role of President-Elect and will be invited to identify their preferred candidate for this role. Third, based on the vote and the supporting nomination information regards each candidate, the WAIMH Nominating Committee will make a final selection of potential President-Elect candidates. These candidates, will then be presented to the WAIMH Board of Directors Executive Committee. Fourth, the WAIMH Board of Directors Executive Committee members will hold a vote for the role of President-Elect on 6th of June, 2020.

World Congress

The WAIMH World Congress in Brisbane takes place only seven months from now and we hope that as many members as possible will be able to attend. It will be an inspiring event with a program full of interesting topics. This time all Master Classes are included in the congress fee. While we at the Office are involved in planning WAIMH events throughout the year, the individual WAIMH members get together every two years at the biennial general meeting which will take place this year on Monday 8th June. There will also be a Pre-Institute for Affiliates on running organizations in the different contexts on Sunday 7th June. [The overall schedule of the congress is available online.](#) ED Kaija Puura has written in more detail about the scientific program in her text (page 5).

Remember that registration for the event has started, and as a current WAIMH member you can attend at an affordable membership rate.

Changes in WAIMH Bylaws

At the WAIMH general meeting the biggest issue will be the changes in the WAIMH Bylaws. As time has gone forward, many changes have become necessary, e.g. due to technical changes. There will be specifications on the different roles of the Board members and the Affiliate council. The process started in June 2019 during the WAIMH Executive Committee meeting. The Bylaws were prepared by a small group and modifications will be approved by the Executive Committee at their meeting in November 2019. You as members are invited to submit your comments and suggestions on the draft. The WAIMH EC will look through the changes and a new suggestion will be prepared. The goal is to approve the Bylaws during the Brisbane World Congress at the general meeting on 8th June. This year we have reserved a longer time slot for the general meeting.

You, the members, are important and valuable to us. Please do not hesitate to contact us with any questions you may have regarding WAIMH!

Contact us:

Minna Sorsa, Senior Administrator,
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Sari Miettinen, Administrative Assistant,
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The scenery with Story Bridge from Brisbane, 17th WAIMH World congress in 2020.

WAIMH Affiliates Council Pre-Institute (WAIMH Congress, Brisbane 2020)

WAIMH 2020 Brisbane
Affiliates Pre-Congress
Institute

Running an Infant Mental
Health Organisation: Models
of Working

Chaired by Anna Huber (PhD)

7th June, 2020

The Brisbane Convention & Exhibition Centre,
Brisbane

By Anna Huber, Australia and Jane Barlow,
United Kingdom

This half day workshop, facilitated by the WAIMH Affiliates Council in response to feedback from Affiliates, will explore the realities, challenges and local solutions of running an infant mental health association.

Drawing on member examples from around the world, the workshop will present a variety of models of running an infant mental health association and share ideas about how common challenges might be addressed, including through our WAIMH connection.

Participants will gain an understanding of context specific as well as common needs and how different organisations have responded to these needs.

The first part of the morning will focus on presentations by invited Affiliate presidents or representatives, discussing how they have developed and responded to their social, political and economic contexts to build awareness, education and support for infant mental health.

Presenters from each organisation will briefly describe their organisation's history and current structure, the size and range of backgrounds of their membership, how the organisation is funded and their financial circumstances, activities they engage in to carry out their aims, their main operational challenges and the advantages of WAIMH Affiliation.

After a coffee break, the second part of the morning will involve moderated discussion about themes that emerge from the presentations. This discussion will also be informed by research from a study into



Picture from WAIMH Affiliates organisational training during WAIMH 15th World congress in Rome, 2016.

the sustainability of IMH organisations currently being undertaken by the Alliance for Infant Mental Health.

Specifically, panelists and workshop participants will be invited to share innovative solutions and ideas to address common challenges such as:

- Engaging and retaining members
- Becoming financially viable and generating adequate income to carry out aims
- Making the organisation sustainable over time

Finding ways to easily connect with other WAIMH affiliates and members to support these goals will also be discussed.

Current confirmed participating presenters and panel members include the following Affiliate Presidents (or their representative):

Europe:	Piret Visnapuu-Bernadt	Estonian Association
North America:	Claud Bisaillon	Quebec Association
	Sheryl Goldberg	Michigan Association for IMH
South America: (online)	Clara Schejtmann	Argentinian Association for IMH
Africa:	Nicole Canin	Gauteng Association for IMH
Australia/Oceania:	Gally McKenzie	Australian Association for IMH
Asia: and	To be advised	
Executive Director, Alliance for Infant Mental Health: Nichole Paradis		

If you would like any further information, please don't hesitate to contact Anna Huber or Jane Barlow.