

The NEATS

A Child & Family Assessment

*Neurobiology, **E**xecutive function,
Attachment, **T**rauma, & **S**elf-regulation*

ALSO BY JANE GILGUN

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The NEATS

A Child & Family Assessment

*Neurobiology, **E**xecutive function,
Attachment, **T**rauma, & **S**elf-regulation*

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may enjoy.

Preface

The NEATS is a child and family assessment that directs practitioner attention to five areas of human development and functioning that research has established as fundamental. These areas are neurobiology, executive function, attachment, trauma, and self-regulation. The title *NEATS* draws from the first letter of each of the five areas. The assessment is competency-based and ecological. It guides practitioners to identify resources, strengths, competencies, and resilience within the ecologies in which children and families live their lives.

These ecologies include families, extended families, neighborhoods, peer groups, social networks, schools, and the influences of social services, community resources, and social policies. Considerations of opportunities and access issues related to race, gender, ethnicity, socio-economic status, ability, and religion are also part of the assessment.

I developed the NEATS over many years of research, practice, teaching and consultation. The NEATS prepares professionals to do sound assessments on which to base case plans. These professionals include social workers, case managers, psychologists, counselors, nurses, psychiatrists and other medical doctors.

Children thrive when they feel safe and engage in reciprocal relationships of love and care. Safety is ensured when adults provide routines and structure, are clear in their expectations, recognize and praise appropriate behaviors, explain reasons for rules, and provide guidance for alternative behaviors when children behave inappropriately. Adults have power over children. Children are safe when adults recognize their power and use it to promote children's well-being. The NEATS assessment guides practitioners to develop case plans that provide opportunities for children and their parents to thrive.

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1

Description of the NEATS

The NEATS is a child and family assessment that focuses on five areas that research has established as fundamental to human functioning and development. These areas are neurobiology, executive function, attachment, trauma, and self regulation. The title *NEATS* draws from the first letter of each of the five areas.

The five elements of the NEATS are inter-related. For example, neurobiology provides a foundation for the development of attachment relationships and executive functions. Secure attachment relationships, in turn, are the basis of optimal brain development and help to build executive skills based on the foundation that neurobiology provides. Executive functions include judgment, planning, and capacities for the management of emotions and the effects of trauma. Furthermore, negative experiences such as trauma, loss, and neglect, can affect brain development as well as capacities for attachment, self-regulation, and executive function.

The NEATS draws upon the notion of ecomap, which depicts the individual in ecological and developmental perspectives. An ecomap diagrams an individual's ecosystem as a set of nested circles that places individuals at the center and the family, extended family, community, and social policies and ideologies on the outer rings. These nested circles extend back in time and account for developmental history. The ecomap illustrates the multiple influences on child and family development and functioning.

The goal of a NEATS assessment is the development of comprehensive case plans that build on client strengths in an

effort to manage risks. To do so, practitioners identify risks and adversities as well as resources, competencies, strengths, and resilience processes in the multiple ecologies. The result is a case plan that uses resources to help manage risk and adversities and thus to promote optimal client functioning.

The NEATS is designed for practice with children and families, such as child protection, mental health, child and family services, youth corrections, and parent education. The NEATS alerts practitioners to important areas of child and family functioning and provides fundamental information about them.

The NEATS reminds practitioners of what is important and helps them to avoid falling back on what they have always assessed. The NEATS is a way of organizing client information in a systematic way. The case studies in the final chapters provide models of how to do this.

The NEATS is not a diagnostic tool. Diagnoses, such as those related to neurobiology and mental health, require specialized expertise that may be both medical and technological. Rather than diagnosing, the NEATS guides practitioners to seek basic information about the five areas of functioning that practitioners can use to guide their next steps in case planning. These steps include planning for how to acquire additional information, for seeking further collaborations, and for making referrals. The NEATS organizes a great deal of information and provides a focus for case plans.

The case plans that result from a NEATS assessment are much more likely to be effective if service providers first ensure that clients' basic human needs are met. These basic human needs include adequate food, safety, clothing, shelter, medical care, and stability. Sometimes services must be provided even when human needs go unmet. Case plans, no matter how grounded in comprehensive assessments, may not be achievable under these conditions.

The following describes the NEATS.

2

Neurobiology

Neurobiology is a branch of biology concerned with the anatomy and physiology of the nervous system, especially the brain, under various conditions of health, stress, and pathology. Neurobiological systems are the foundation for how we think, feel, and behave, while simultaneously, how we think, feel, and behave shapes the workings of our brains. Who we are as human beings is inseparable from how our brains work.

Neurobiology provides the basis for the formation of attachment relationships with care providers and also shapes children's capacities for planning and judgment and for managing emotions and trauma. These capacities are foundational to growth and development.

Neurobiology has become so important that some researchers believe that the integration of neuroscience with social work practice will determine which social service organizations will be effective and which will be ineffective. Whether agencies will be winners and losers in the eyes of funders as well as with the general public may depend on this integration.

Practitioners who do assessments using the NEATS must have basic knowledge of the neurological foundations of childhood conditions, an understanding of their origins, and familiarity with effective interventions and referral sources for these conditions.

Unfortunately, some of these services are hard to come by for people in rural areas. Even in urban and suburban areas, adequate services may be in short supply because of a national shortage of child psychiatrists and pediatric neurologists. Social policy and

programs have not yet caught on to the need for readily available services for children with neurological difficulties.

Some Basic Notions

Children are born with billions more brain cells, called neurons, than then they will ever use. Which neurons are kept, which are shed, and which develop into brain circuits that connect various parts of the brain depend upon experience and genetics. For example, children whose parents provide them with sensitive, responsive care will develop brain circuits that encode expectations that others will treat them well and will develop positive self-concepts. They also will develop capacities for sensitivity and caring for others and will encode these capacities in brain circuits. Such children are likely to develop good social skills, cooperate with adult directives, and persist when tasks challenge them.

This is the principle of from external to internal to external, where environmental influences such as sensitive parenting are internalized and that children in turn externalize in their own actions. This also illustrates mirroring where children imitate and internalize how they were treated. How they treat others and how they conduct themselves in the world depends on how significant others treated them.

Physical touch, love, sensitive and reciprocal interactions with care providers and others and sensory stimulation promote optimal brain development, as well as social and physical development. Infants and young children who are talked to and provided with other age-appropriate stimulation will encode these experiences that in turn will help them develop verbal skills and other capacities that enhance their brain's healthy development and their social and emotional development. A characteristic of brains, then, is plasticity, meaning that sensitive, responsive care and other environmental events shape brain development.

Some children are born with neurological conditions that place limits on how their brains develop. With sensitive, responsive care, these children will develop optimally, but some conditions permanently cause difficulties in functioning. Ceiling effects is the

term used when there are upper limits to the brain's capacity for development.

In general, brain functioning stems from both genetics and environmental influences. Genetics provides infants with innate capacities that are shaped by experience. Genetics can predispose children to neurological difficulties, but inadequate prenatal care, including poor nutrition and the ingestion of drugs and alcohol during pregnancy, also can influence brain development. Birth accidents, such as ingestion of amniotic fluids that late in pregnancy also contain fetal waste products, can affect neurological functioning. Trauma and stress can harm brain development and even kill some brain cells.

Children whose neurological development has been affected by trauma or physical injury can, with optimal care, develop new brain circuits. Furthermore, other parts of the brain can "take over" the functions of damaged areas. These findings lend further support to the idea that the brain is plastic; that is, capable of change and adaptation, although there are limits to brain development, called ceiling effects, as already discussed.

Thus, children can recover to varying degrees from physical and psychological trauma, but this takes a major commitment on the part of parents and other attachment figures to do so. Attachment figures must be willing to do whatever it takes on behalf of their children to help the children process past and present events in their lives. They must have capacities to change their own behaviors and expectations to help the children.

Unfortunately, some parents cannot do this. They may refuse to believe their behaviors affect their children, and they may refuse services that could support them in efforts to promote their children's optimal development. In addition, some parents might not even know these services exist. Finally, sometimes the services they receive are inadequate. Savvy service providers have a major responsibility to identify appropriate services. Policy makers and the general public have the responsibility to ensure that adequate and appropriate services exist.

Common Neurological Conditions

Conditions that result from compromised brain functioning include autism spectrum disorders, fetal alcohol effects, attention deficit hyperactivity disorders, depression, anxiety disorders, bipolar disorders, Tourette's, and some forms of oppositional behaviors, among others.

Often a combination of medications, psychoeducation, the meeting of basic human needs, optimization of parents' mental health, parent support groups, and psychotherapy can enhance the functioning of children with neurological conditions. Pediatric neurologists, child psychiatrists, and child neuropsychologists would be important members of teams that work with children and families where children have neurological issues.

Important recent research shows that with early intervention, children born with autism can develop new neural capacities that alter the course of the syndrome. Early intervention with children who have experienced the trauma of abuse and neglect can also gain or regain optimal neurological functioning. These findings show the brain's capacity to change and that experience shape brain development.

Children with neurological issues typically receive special education and have individual educational plans at school. School personnel want parents to be involved with these educational plans and can contribute a great deal to them. Parents, sometimes confused and frustrated with their relationships to school personnel, may appreciate the advocacy efforts that professionals can make on behalf of their children. Likewise, teachers frequently appreciate the support and information that knowledgeable social service professionals offer.

Parents Require Specialized Help

Children who have issues related to neurobiology may be challenging. Parents require specialized help to meet these changes. Experts in child neurology and psychology can provide guidance and care. These professionals include psychologists, psychiatrists, pediatric neurologists, and mental health specialists with training and experience in the area of child neurology

Parent support groups can be a source of empathy, emotional support, and information that can give parents' strategies for dealing with their children and validation of their worth and efforts

as parents. Day care and respite care can be of great help. In addition, personal care attendants who stay with children while in school can provide structure and support when children cannot manage their behaviors unassisted.

In some situations, even with the best of care, children's capacities may be limited because of their neurological make-up. As discussed earlier, the term "ceiling effect" stands for situations where children cannot progress beyond a certain point. For instance, the effects of alcohol on fetal brain development produces such ceiling effects even with the best of care.

Far-Reaching Effects of Neurological Conditions

Family stress, marital discord, and job issues related to child care are common in families with a child or children with difficult neurologically-based challenges. Other children in the family can be affected. Without realizing it, parents may not attend consistently to the needs of siblings because of their focus on a child with neurological issues. Parents may be too worn out themselves to realize that the other children feel left out.

The relationship between other children and a child with neurological issues must be monitored carefully, too. Sibling relationships contribute to children's capacities to form relationships with others as well as their sense of who they are, what they deserve, how others should treat them, and how they relate to others. The centrality of relationships is discussed in more detail in the section on attachment.

These are relatively new learnings that are an important part of competent service provision. In the past, children's difficulties were assumed to be the result of inadequate parenting, particularly mothering. Now, neuroscience has taught us that some behaviors are related to brain structure and function. While some behaviors are amenable to change under optimal conditions, others are not, no matter how competent the care.

In short, children's neurobiological makeup is the foundation for the development of capacities for attachment, executive function, and self-regulation. Conversely, trauma, neglectful attachment figures, and inadequate care can negatively affect

children's neurological functioning. Parents of children with neurological challenges require supportive services. Professional services can contribute significantly to children's optimal development.

Practice Note

Neurological conditions such as autism spectrum disorders, bipolar disorders, schizophrenia, and attention deficit hyperactivity disorder (ADHD) typically are transmitted genetically, although there are exceptions. When children have neurological issues, best practice leads to assessing parents, grandparents, and other family members for neurological issues. As part of the assessment, therefore, family trees or genograms can help identify the transmission of neurological conditions. Medical histories contained in genograms can help medical doctors and other service providers make accurate diagnoses and thus to develop helpful treatment plans.

For example, Jack is a six-year old boy whose explosive behaviors are so extreme that they require containment several times a day. A genogram showed that Jack's father was diagnosed with schizophrenia and his mother with bipolar disorder. Jack could have inherited a pre-disposition for a neurological condition.

A thorough NEATS assessment would require a review of the other four elements of the NEATS to get an idea of the contributions of parenting styles and family life to Jack's behavioral issues. If the parents manage their conditions well, there is reason to be optimistic about Jack's long-term outcome. However, if parents' conditions are untreated and unmanaged, chances are parents will be unable to provide stability and consistency of love and care that children require to develop well.

Sometimes children's behaviors appear to be neurologically based, but could be the results of unattended trauma and other adversities, such as chaotic parenting. Using ADHD as an example again, symptoms of this condition can also be symptoms of trauma. Evaluations by neuropsychologists, pediatric neurologists, or child psychiatrist could help make these distinctions. The symptoms must be treated but any final diagnosis much be withheld until the evidence supports it.

Trauma and family chaos may affect children's brain development, but a structured treatment plan remains the approach of

choice no matter the origins. A key part of a treatment plan is for parents to manage their own issues, whatever they may be.

A great deal of information is required for an accurate assessment and the formulation of an effective treatment plan when children appear to have neurological issues. Part of the treatment plan is a referral to professionals trained in neurobiology. They will do further evaluations in order to make conclusions about possible diagnoses.

Neurobiology affects many areas of child and family functioning. To do sound assessments, practitioners must have a good understanding of what each of the components of the NEATS means.

3

Executive Function

Executive function (EF) is a term that covers a broad range of capacities related to judgment, problem-solving, organization of self, anticipation of consequences, working memory, and following rules and directions. Regulation of emotions, thoughts, and behaviors is part of executive function as well, but in the NEATS assessment, self-regulation is a separate category because of its significance in social work and other applied settings.

The neurological basis of executive function is located primarily in the neocortex, which is in the front of the brain and is the seat of reasoning. The term “executive” fits these sets of capacities because an executive is someone who is in charge. The neocortex, however, is connected to many other areas of the brain, such as emotion and motor centers.

Like brain functioning in general, executive functions or skills arise from a combination of genetics and experience. Adequate nutrition and good prenatal care as well as genetics lead to good executive functions at birth. Subsequent experience contributes further to executive function development. With sensitive, responsive care, children build upon existing skills to continue their optimal development.

Stress, trauma, abuse, and neglect may undermine the development of executive skills in children with a good genetic makeup. These children can recover or develop new executive skills if their circumstances change for the better, where parenting is sensitive and responsive, except if the damage to neural circuits cannot be reversed.

Conversely, many children are born with brain functions that predispose them to executive function issues, but their quality of care is so high that they develop new neural circuits that appear to compensate for what might have been executive function deficits. How much neural growth is possible is related to genetic makeup and whether or not any brain damage has ceiling effects. For example, there appear to be ceiling effects for some of the executive functions of children with fetal alcohol effects.

Parents of children with executive function challenges may require emotional support and psychoeducation and the children's development of executive skills could take longer than with other children. Once again, however, there are limits to the brain's plasticity and some individuals may have life-long issues with executive functions.

Conditions Associated with Executive Function

Executive function issues include difficulties with attention, following directions and rules, organizing the self, self-soothing when stressed, and self-regulation, and impulse control. Impulse control and following involves capacities for holding information in working memory and in considering alternatives and consequences, as well as resistance to distractions.

Childhood issues connected to problems in executive function issues are those listed under "neurobiology," including fetal alcohol spectrum disorders, autism spectrum disorders, conduct disorders, oppositional disorders, and attention deficit/hyperactivity disorders (ADHD). In general, children may have good executive skills in some situations and not in others.

Children with executive function issues require structure in their daily lives, clear and simple directions in how to accomplish tasks, clear expectations, and heaps of praise when they show the smallest executive skill. They benefit when others show them how to do things and when the adults around them also have good executive skills.

As with other challenging child behaviors, parents of children with executive function issues benefit from psychoeducation,

parent support groups, and professionals who themselves have good executive skills. Parents' executive functions are compromised if they have chemical dependency issues and untreated mental illness.

Practice Note

Once practitioners have reason to believe that children have executive function issues, it is advisable to assess parents' executive functions. Children learn good executive skills from their everyday experiences of care that parents and others provide. The case of six year-old Jack who has a diagnosis of ADHD will illustrate this point. Almost by definition, executive function issues are part of ADHD. To develop an effective treatment plan for Jack, practitioners would assess parents for executive function skills as well and then recommend a course of action for them if they have executive function issues. Typical referrals are parenting classes, parent support groups, and psychotherapy, which can be a combination of individual, family, and couple treatment.

Another important application of the concept of executive function is to assess who is in charge of the family; in other words, who has the executive functions for the family. In traditional families, where fathers and husbands are in charge of household finances and child discipline, women may struggle with executive function issues if their husbands die or leave the family. An older child may assume executive roles, but not have the skills to fulfill them.

For example, Pang, a Hmong refugee, a widow, and the mother of six children ages sixteen to six, depended upon her sixteen year-old daughter Moa to use the cash card that county social services agency provided every month. Pang did not know how to use the card and asked Moa to do it. Moa spent the money on clothes and entertainment for herself and her friends, leaving the family in serious financial difficulties, and showing her poor executive functions in this situation. An effective treatment plan would assist Pang in taking on executive functions.

4

Attachment

Attachment is defined as behaviors that maintain contact with care providers who serve as a secure base from which to explore and to which to return under times of stress, as well as to serve as a source of nurturance, love and affirmation. Attachment is also a process, whose outward characteristics change as children grow and develop, but at its core attachment is a source of nurturance, problem-solving, affirmation, and even courage to try new things or to persist when times are tough.

Attachment relationships contribute to brain development, executive function, and self-regulation, including the regulation of stress and trauma. Without repair, breakdown in attachment relationships in infancy and childhood may have life-long effects.

Qualities associated with attachment also include reciprocity, attunement, and contingent responsiveness. Attachment is a complex set of processes. If professionals are to do effective assessments and case plans, they must have a good grasp of its complexities.

An example of attachment as process in infancy is when a child has a wet diaper and is uncomfortable. The child signals discomfort to the care provider through crying and other signs of distress. The care provider responds by figuring out what is causing the distress, removes the soiled diaper, washes the baby, and provides the baby with a fresh diaper.

These simple acts soothe the child's stress and affirm for the child that his or her bids for care will be attended to. Care providers feel satisfaction not only in the child's positive responses to being attended to, but also because the child stops crying. Some

evolutionary biologists believe that infant crying is aversive. When parental care stops the crying and the infant is happy, these actions are satisfying to care providers. This is a mutually satisfying interaction that ensures that parents will care for children. In terms of evolutionary biology, attachment behaviors are necessary for survival.

Caregiver Attunement and Self-Regulation

As this example suggests, caregiver attunement to what children want and need builds secure attachments. Sometimes children do not want to interact with care providers and turn away. They have had enough interaction for the time being. They may be feeling over-stimulated or tired and want to re-regulate themselves into a more comfortable state.

Sensitive, attuned care providers notice this turning away and respect it. They allow children to regulate the duration and intensity of the interactions. In this way, children learn they have power and control to regulate interactions with others. When care providers respect children's wishes, children's stress levels go down. This brings comfort and relief.

Care provider attunement helps children to learn to regulate themselves. This includes regulation of the intensity of their emotions, physiological responses of fatigue and possibly heart rate and pulse, and behaviors. Children who develop capacities for self-regulation will have capacities to be attuned to others and to help others self-regulate.

The development of self-regulation through reciprocal, attuned relationships with parents is an example of the external to internal to external principle in child development. Children internalize their experiences, which are encoded in brain circuits. They in turn, exhibit the behaviors that they have experienced. This is the idea behind the principle that children live what they have learned.

Repair

Repair is another idea related to attachment. Care providers cannot always be responsive to children's bids for attention and

desires to be left alone. Children cannot always be immediately soothed by the attention, nor can care providers accede to child requests if children are in unsafe situations.

Children who do not get what they want may show their displeasure directly. In secure relationships children trust the stability of their attachments, and they can express both negative and positive emotions without fear. When children protest, attuned parents have opportunities to re-consider their responses. For example, children whose parents are sad and withdrawn may make increasingly vigorous bids for attention. Children have been observed pulling on parents' clothes, patting them on the face, and saying, "Mommy, it's me" when parents are unresponsive.

Responsive parents may realize what they are doing and change their behaviors. This is mutual regulation, this time from child to parent, but it is based on a history of parental responsiveness.

Another example is the actions of toddlers. Their actions must be supervised and corrected. When corrected, children may protest mightily through tantrums and aggression. Such behaviors can lead to temporary breaks in parental attunement and mutual responsiveness. When the tantrum is over, parents and children reconnect and once again become attuned to each other.

Connection, disconnection, repair, and reconnection are characteristic of mutual relationships. Over time, the nature of breaks in relationship change, but the essential quality remains: in secure relationships there are breaks that get repaired. Repair takes place through open expression of points of view and emotions, with adults allowing children to have their say without relinquishing their executive roles of providing safety and guidance.

When repairs are not made, attachment relationships become problematic. Repairs may be rare or even absent when parents and other caregivers are preoccupied with their own issues, dismissive of the significance of children's issues, or so disorganized that they respond in chaotic ways. Families in which partner violence occurs, where there is abuse and neglect, or where childhood traumas are unattended are at high risk for insecure attachments that arise because of lack of repair. Mistrust replaces trust.

Many issues affect parents' capacities for attachment and contingent responsiveness. Highly stressed parents, even those who under normal circumstances cope well, are unlikely to be consistently psychologically available and attuned to their children. Without realizing it, they may not be as attentive to their children as they want to be. Parents with untreated mental illnesses, chemical dependency issues, and unresolved trauma may offer inconsistent and even abusive and neglectful care. Their own issues distract them from attunement with their children.

Variations in Caregiver-Child Attachments

Researchers have identified various styles of attachment that fit individuals as children and as adults. For children, attachments may be secure and insecure. Within the insecure category are avoidant, ambivalent, disorganized, and disordered attachments. For adults, attachments are characterized as secure, and, when parents have traumas in their backgrounds, they are classified as resolved if they manage the trauma well, or as dismissive, preoccupied, and disorganized if they have not.

Adult attachment styles are assumed to have their roots in adults' relationships with their own care providers when they were children. Parent-child attachments typically mirror the kinds of attachments parents have had with their own caregivers.

Secure attachments. Secure attachments in infancy and young childhood are characterized by sensitive, responsive caregiving provided to children who have capacities to respond to such care, with the result that the parent-caregiver relationship is mutually satisfying and promotes optimal child and parent development. The parents of children in secure attachment relationships almost always have parents who secure attachment relationships with their own caregivers.

Children with secure attachments to care providers develop expectation that others will care for them and respond to their needs. They becoming trusting of others and in turn become trustworthy persons themselves.

Insecure attachments. Insecure attachments arise for the most part from inconsistent and detached styles of care giving associated with parental ambivalence, psychological unavailability, or rejection of parental roles. The kinds of insecure attachment relationships that children form roughly mirror their caregivers' own attachment relationships. Sometimes insecure attachments occur even when the caregiving is exemplary, such as when children have undiagnosed, untreated, or untreatable neurological issues or physical and psychological trauma that is left unattended.

Behaviors associated with avoidant attachments include showing little or no emotional responses to parents, little preference for the parents over others, and, over time, difficulty connecting to others and in self-regulation of emotions and behaviors. Children who show these behaviors typically have experienced emotional neglect, which in terms of the previous discussion means that contingent responsiveness and sensitive care were in short supply and psychological unavailability was the norm.

An example of parental statements that suggest avoidant attachment is the following: "They're good kids. They can play all day long without asking me for anything." This is not normal; children and parents interact with each other on and off all day long.

Behaviors associated with ambivalent attachments go from one extreme to the other. Children may show interest in being with parents but also are fearful. Upon being with parents after separation, children may at first be pleased to see them but then struggle to get away.

Disorganized behaviors are similar to ambivalence, but are more extreme and may include approach-avoidance behaviors and rapid changes of mood such as happiness, fear, and anger.

Reactive attachment disorders (RAD) are an extreme form of insecure attachments where the children avoid interaction with others or are indiscriminant in approaching others. RAD arises from pathogenic care, which is serious, chronic deprivation of comfort, interaction, consistency, and sensitivity. Many of the signs of RAD are also signs of trauma. In fact, chronic, multiple traumas are characteristic of RAD.

Insecure attachments are associated with mistrust and can set children up for problematic relationships with others, social isolation, and/or aggressive and other inappropriate behaviors. In some ways, their attachment relationships help “program” their brains so that they behave as if every human being and situation are as untrustworthy as their care providers.

Children with insecure attachments may have had some experience with secure attachments. They thus have some capacities related to trust encoded in their brains. This means that under safe and secure conditions, they may show capacities for attunement and self-regulation. These capacities, however, may be built on fragile ground. Children with these issues require sensitive care that allows them to process their trauma and learn to manage its effects.

Adult Attachments

The capacities of parents and other caregivers for attachment are based upon the history of their relationships with their own care providers and significant others. Some parents have secure styles of attachment developed in infancy and childhood and maintained over their lifetimes. Such adults establish secure relationships with their own children in most cases, except when other issues such as unavoidable traumas occur or when children have neurobiological issues.

Many parents have histories of stress and trauma that affect their capacities for attachment. The term *resolved* is used to describe parents who have coped with, adapted to, and overcome their own adversities and trauma in their own lives. They acknowledge the difficulties they have had, recognize its affects on their development, and manage the effects. Such parents are able to establish secure relationships with their own children. Typically parents with resolved attachment styles have had successful therapy and have also established long-term relationships of trust with a spouse or significant other. Both secure and resolved parents seek support and guidance when they experience difficulties in their relationships with their children.

Secure and resolved parents also support and guide children's explorations of the world, their developing skills, and their development of autonomy. They are available when children need them, but they allow children to explore and learn on their own terms. They are attuned and empathic over time.

Parents with unresolved histories of trauma typically are inconsistent in their attunements to their children, and they establish various types of insecure attachments with their own children.

Parents with dismissive attachment styles do not acknowledge their own past traumas and hurts. They may idealize their childhoods and create a kind of fantasy for themselves. Others may acknowledge that they had some difficulties, but they tell themselves and others that their own problematic experiences have had little if any affect on them.

In turn, they do not acknowledge stresses and traumas that their children undergo. For instance, if their children have been sexually abused, dismissive parents may not recognize the necessity of helping children deal with the resulting issues. They believe variations of "I was sexually abused as a child. I'm fine. My child will be fine." They show a failure of empathy for themselves and others, including their own children.

Some dismissive parents appear to over-regulate their own emotions and can be thought of as distant parents with rigid boundaries between themselves and others, including their children. Emotional distance and disconnection are normal for them because of their own attachment histories. They bring this distance and disconnection to their relationships with others, including their own children.

When parents have preoccupied styles of attachments, they are self-focused, reliving their stresses and traumas without being able to regulate them, at least during times of stress. Unfortunately, some preoccupied parents are in continual states of stress. Such parents may shift their preoccupations to their children, becoming intrusive and overly concerned about children's well-being, to the point where they tell children how they should feel and think. They may force their meanings of events onto their children.

In brief, preoccupied parents do not allow children the autonomy children require to develop executive and self-regulatory skills. Unlike secure and resolved parents, they do not gradually relinquish their control so children can develop skills and capacities that help them to become autonomous but yet emotionally connected individuals.

In their intrusiveness and preoccupation, they usually are not attuned to their children. Under some conditions, however, they can be attuned and can allow children to think and feel on their own. Children then may have ambivalent responses to their parents, not knowing what to expect because their parents are unpredictable.

Some parents have disorganized styles of attachment that they bring into their relationships with their children. They show a range of behaviors in what appears to be random order. They may be preoccupied with their own issues at one moment, preoccupied with their children at another, dismissive of children's issues including not being aware that children are in danger, dismissive of their own issues, angry, withdrawn, and agitated. Such parents have difficulty with self-regulation, which in turn affects children's capacities for self-regulation. Under these conditions, children are confused and show disorganized, dysregulated behaviors themselves.

The following is an example of an account a woman gave of why child protection removed her children from her care three years earlier. She provides a good example of parental disorganization and issues with self-regulation. Not only it is difficult to make sense of her narrative, which is characteristic of disorganized attachments, but it appears that she did not understand that the children's behaviors were inappropriate. The children ranged in age from fourteen to four. Enid was the oldest child and Phyllis was the youngest.

You know like, we went through a tornado three years ago, and so we were stuck in a hotel room. The kids were going swimming, and they came back and they were horsing around naked, because, there's only two showers at a time, and I was trying to find a place to live, and Enid kind of hit the roof and I think Enid's reaction made an impres-

sion on Phyllis. More than anything they were doing, because I was right like, in the little. [She does not finish the sentence.]. I don't think too much could have been going on, but Phyllis talked about it at preschool, so they had to report it.

[Question: The kids being naked, you mean?]

Yeah, well, I think she more talked about how Enid—Enid thought it was really bad that we were naked and under the sheets together. And you know, we had to talk about boundaries. And it was certainly not something I condoned, but I didn't think it was—I mean we just lost—the tornado destroyed primarily the kids' floor. They just lost everything they had, and if they were going to find some self-comfort in their bodies, I was kinda ok with that.

This mother was an untreated father incest survivor who did not believe the incest harmed her in any way. She never sought therapy and resisted it when child protection made it part of her case plan. The incest lasted from early childhood until she left home at eighteen. Unresolved issues related to the incest probably contributed to a disorganized attachment style. She appeared to be unable to self-regulate and therefore did not have capacities to be the in charge of her children. Not recognizing the inappropriateness of these behaviors suggests a major issue with her judgment, an executive function.

In summary, parent-child attachment styles mirror adult attachment styles. Adult secure and resolved styles are associated with secure child attachment styles. Adult dismissive attachment styles are associated with avoidant child attachment styles. Preoccupied attachment styles are associated with ambivalent child attachments. Disorganized adult attachments are associated with disorganized and disordered child attachments.

Attachment styles are foundational to the formation of inner working models (IWM), which are internalized expectations about self, others, and how the world works, how to behave in the world, and the meanings of human actions and events. IWM are

encoded in brain circuits. IWM are ready to be activated depending on individuals' perceptions of events. There are schemas for every type of human action, thought, and feeling. IWM can be thought of as cognitive maps, schemas, tapes, and inner representations.

Over time, there are increasing numbers of sources of the components of schemas. Human beings are born with rudimentary or primary schemas such as sucking, crying, and other neurophysiological responses. Brain circuits become increasingly complex as individuals experience cognitive, emotional, and social developmental processes. For example, the capacities of a three year-old are vastly different from those of a ten year-old because of maturation of brain structures and functions, as well as maturation of other developmental areas.

IWMs build on each other. Children with secure attachment relationships have schemas that lead them to experience other people as safe, predictable, responsive to what they want and need and themselves as efficacious, loveable, and safe to be around. Children with secure attachments tend to evoke positive responses in others. Secure attachments thus set off feedback loops where success builds on success.

Children with insecure attachments may be confused and ambivalent about others. Some, especially those with dismissive, distant parents, may develop rigid expectations. They could be quite confident in their beliefs about themselves, others, and how the world works. For example, they may believe that antisocial behaviors are appropriate responses to perceived or actual slights or as means to get what they want.

Persons with insecure attachments could have good executive skills in some situations, but they are more prone than persons with secure attachment styles to behave in harmful or inappropriate ways.

It is unlikely that anyone has good executive skills in every situation. Under stress, persons with secure attachments can temporarily show poor executive and self-regulation skills.

Observations of caregivers and children are ideal for assessing quality of attachment. Signs of secure attachments include

children's use of care providers as a secure base from which to explore the environment and to which to return in times of stress, mutuality and reciprocity in care provider-child interactions, and contingent responsiveness which means that the parent calibrates responses to children according to child readiness to receive parental engagements. Securely attached children and parents also show sadness at separation and joy at reunion.

As infants develop into toddlerhood and beyond, parents of securely attached children also structure children's environments to provide them with opportunities to challenge themselves and to develop new capacities. For example, parents will give children toys that require slightly more advanced skills than the child currently have. This leads children to push themselves to learn new tasks.

Parents of securely attached children allow children to attempt new tasks on their own and will show children how to perform tasks when children appear to require some guidance and are ready for their assistance. Willingness to be of help when indicated is yet another indicator of contingent responsiveness.

Throughout childhood and the teen years, securely attached parents provide love, warmth, safety, structure, and clear expectations. For instance, a quality associated with well-functioning teenagers is parental supervision of children's whereabouts and clear expectations for when children are to be at home.

Services that Promote Attachment

Services that promote secure attachments must include children and their parents or other primary care providers. Effective services have support and educational groups for parents, structured play groups for children, and activities that include both parents and children. In addition, home visiting is an important part of attachment promotion programs. To the extent possible, these programs involve fathers as well as mothers in their educational and support efforts.

Often, principles of infant mental health are part of these programs, where the operating principle is support, education, and even therapy for parents as foundational to optimal child development.

The programs also have well-established collaborations with

medical, mental health, preschools, and child care, among others. Many of these programs are part of university-based programs that combine service and research.

“Holding” and “re-birthing” programs are discredited methods of promoting secure attachments. They are based upon misuse of research on attachment and have led to several deaths. It is best to confer with licensed professionals to identify reputable and effective programs that promote secure attachments.

Practice Note

Observations of parent and child interactions as well as conversations with parents and children provide information on styles of attachment. In Jack’s case, practitioners would observe how parents manage Jack’s executive skills issues, which he would have because he has ADHD. Questions to consider include whether six year-old Jack behaves as if his parents serve as a secure base for him, whether they supervise him while at the same time allow him to experiment with new tasks on his own, and whether they help him structure his time so he completes tasks expected of a child his age.

Other questions are whether they help him manage his behaviors, understand when he has done something well, and praise him when he has behaved appropriately. There are many other attachment related behaviors that require assessment, but these are some important ones.

Parental executive function issues are interlaced with capacities for effective attachment and parental capacities. Parents with executive function issues may not be able to be consistent, responsive, contingent caregivers without the help of professionals who can help them to provide the structure and guidance children require to develop well.

5

Trauma

Trauma is an event that is life-threatening or psychologically devastating to the point where persons' capacities to cope are overwhelmed. Any number of events may be traumatizing, including abuse and neglect, witnessing violence, death or other kind of loss of parents or siblings, abductions, car accidents, plane crashes, social dislocation, and war. Following trauma, individuals relive the traumatic event, fragmented memories related to the trauma arise unexpectedly, cognitive, emotional, and behavioral dysregulation occurs, and there is avoidance of reminders of the event. In some cases, survivors of trauma become preoccupied with the traumatic event and may play them over and over in their minds or act them out. Trauma may change brain structures and circuits related to memory and emotion.

Trauma and Neurobiology

Traumatic responses are expectable to extraordinary, overwhelming events. A kind of "hot button" or trigger becomes encoded in the emotion centers of the brain. Schemas can be reactivated when persons experience reminders of the original trauma. Reminders can involve any of the five senses. An example is nine-month old child who screams when he sees a woman with blonde hair because a social worker with blonde hair took him from his biological family into foster care. When hot buttons are triggered, persons young and old are at risk to dysregulate; that is, to relive the trauma.

In relation to neurobiology, the hippocampus, a pair of horseshoe-shaped structures located on each side of the midbrain, is an important storage point for traumatic memories. The hippocampus not only stores the traumatic event itself but also the context of the traumatic event. Sounds, smells, and contextual details become associated with the trauma. Whenever individuals experience these reminders of the event, memories of the trauma flood into awareness. Often the memories and reminders are stored as bits and pieces. When the memories are evoked the memories themselves are fragmented.

Cortisol, a stress hormone, is released in response to trauma and the retriggering of trauma. Cortisol can damage brain cells in the hippocampus and even kill them. Thus, some children and adults cannot remember major pieces of traumatic events, possibly because of damage to the cells of the hippocampus.

In addition, the hippocampus matures relatively late in life, perhaps into middle childhood or beyond. This accounts for the relatively few memories that individuals have of their early lives. Children who have trauma early in life, therefore, may have not memory of these events.

However, another brain structure, located near the hippocampus, matures quite early and can store the emotional component of trauma, though not the memories themselves. This structure is the almond-shaped amygdala, which also comes in pairs. Very young children who have experienced trauma may have no memory of the trauma, but the trauma is encoded in the amygdala.

When children relive trauma and become dysregulated, reminders of the traumatic event trigger brain circuits that by-pass the neocortex, which is the brain's seat of reasoning. Researchers call this the low-road response because the response goes directly to the emotion center and does not engage reasoning which is located high in brain in the neocortex, as already discussed.

The high road response involves the triggering of traumas, but the individual is able to manage the trauma and not dysregulate because the brain circuits present in the neocortex are engaged. Without the engagement of reasoning, the child truly is on automatic. Whatever is encoded in the emotion circuits will be activated. Children with histories of witnessing violence or of being

victims of abuse and neglect are at high risk to respond inappropriately, antisocially or self-destructively. Repeated exposure to trauma leads to complicated responses and is called complex trauma.

Parents as Source of Trauma

For many children, parents are the sources of trauma. The very persons to whom children turn for safety and love are the sources of overwhelming fear and mistrust. This sets up conflicts in children that cannot be resolved without competent professional help.

Children who have witnessed domestic violence often have these responses to parents. They may want love and reassurance from parents who have been victimized, but also show a great deal of fear and avoidance because the parents remind them of the violence that traumatized them. In addition, they may be fearful of aggressor parents and avoid them, while at the same time want assurance that the aggressors will not hurt them. These are expectable child reactions that researchers call ambivalent attachment styles related to trauma.

Parents who have been victimized and parents who victimize may be so preoccupied with their own issues that they are unresponsive to their children's trauma. In addition, they could have avoidant styles of attachment that lead them to minimize the effects. Domestic violence has complex effects of children, but it is a source of trauma.

Because parents in domestic violence situations typically cannot help their children to cope with the trauma, children and their parents require safety and opportunity to work through the effects of trauma. Sadly, their services often are unavailable. The trauma creates what can be a permanent disconnection between parents and children because of lack of opportunity for repair.

Parents and other adults are key to helping children work through and manage the effects of trauma. This requires direct and supportive interventions to help children deal with the trauma and build new neural circuits. The effects of trauma can only be worked through in the safety of secure relationships. Children with histo-

ries of secure attachments, good executive skills, and relatively resilient brain structures may be more likely to seek and use help when traumatized and more likely to seek and use help when effects of trauma are triggered.

Children with histories of insecure attachments, compromised executive skills, and vulnerable brain structures may cope in avoidant, ambivalent, disorganized, and disordered ways. Parents of insecurely attached children may be unavailable psychologically or they may reject children's bids for help.

Through experience, insecurely attached children have learned that adults are not consistently trustworthy, or they may not believe parents care, or they do not want to upset parents.

Children with reactive attachment disorders are so fearful of attachment figures that they are unlikely to seek help and will express the effects of trauma through their behaviors which can be withdrawn, aggressive, and otherwise inappropriate.

School age and older children may make seek peers as confidants. Some peers can be helpful, but others are not. They also may seek other adults besides their parents for help with trauma-related issues. Examples of trauma where children seek help outside of their families are child sexual abuse, physical abuse, and partner violence, including physical and psychological abuse.

Children, especially those with multiple, complex traumas, may have prolonged episodes of dysregulation when traumas are triggered. They may need to scream and cry for hours when they relive trauma. The origins of trauma are important to understand so that appropriate interventions can be tailored to children's particular situations.

Children become dysregulated when they re-experience trauma. Parents, teachers, others may mistake dysregulation as oppositional behaviors. Persons involved with children who have experienced trauma require a great deal of psychoeducation. Most of all, parents and professionals must engage their higher order reasoning, take the high road, and not let themselves be triggered by what could be extreme child behaviors.

When children are reliving trauma, they must be made safe and precautions must be taken to ensure the safety of others. The

children should not be left alone but a caring adult must be present, sometimes softly describing the child's behaviors, but overall allowing the emotions to take their course.

Once the children become re-regulated, adults can talk to children about what triggered these responses. For some children, simply re-integrating them into family or school activates is all they can handle. With sensitivity and consultation, adults can make judgments about the timing of verbal processing of trauma.

Eventually children who experience such responses will learn positive ways of coping when their traumas are triggered. Compassionate responses help traumatized children develop new executive skills to manage their dysregulated behaviors.

Children who have experienced trauma require parents and other adults who are psychologically and physically available to them. Adults must be able to manage their own traumas, which can be triggered when dealing with children who have experienced trauma.

Parents may require their own therapy, and they often require a great deal of instrumental, social, and emotional support and encouragement. Dealing with traumatized children is difficult. When children have neurological issues that predispose them to dysregulation, their responses to trauma may lead to a high degree of dysregulation.

In summary, trauma brings out complex issues that require intervention not only with the affected children but with the adults who are entrusted with their care.

Practice Note

Trauma does not go away on its own, but must be dealt with directly with relationships where children feel safe. Thus, some kind of secure attachment must be established for children to process and manage trauma. As a general principle, a goal in trauma work is to help children develop high road response so that when their traumas are triggered, they immediately engage their executive skills.

If six year-old Jack experiences trauma, an early response would be to assess his parents' capacities to ensure his sense of safety so that he can process the effects of the trauma with them.

However, even parents with a history of secure or resolved attachments and excellent executive skills may require psychoeducation and emotional support in order to respond effectively.

If his parents have issues with executive functions independent of Jack's trauma and also have problematic attachment styles, they will be unable to respond to Jack effectively and consistently. They may dismiss the effects of the trauma, believe it has gone away if he is not showing direct signs of trauma, or they may become preoccupied.

In brief, when children have experienced trauma, a first line of professional action would be to assess parents' capacities for sensitive, compassionate responses and then offer appropriate services.

6

Self-Regulation

Self-regulation is defined as capacities to manage and make sense of one's own thoughts, emotions, and behaviors in times of stress and in the course of everyday life. Some view self-regulation as one of the executive functions. Capacities for self-regulation are both genetic and experiential in origin. Subjectively, children experience dysregulation as a loss of control, of unmanageability of thoughts, emotions, and behaviors. Heart rate and breathing may become accelerated.

When dysregulated, individuals throughout the life course may become fearful, anxious, withdrawn, depressed, hyperactive, lethargic, and experience emotional outbursts, bed wetting, sleep disturbances, and oppositional behaviors. Some individuals are euphoric while in dysregulated states. Dysregulation typically is very painful and persons seek to re-regulate as a means of managing the emotional pain.

Self-Regulation as Process

Learning to self-regulate is a process. Temper tantrums in toddlers is normative and is a type of dysregulation. Parents and other adults help infants and young children re-regulate when they have tantrums. Children eventually develop internalized capacities for self-regulation in response to sensitive, contingent caregiver characteristic of secure relationships.

Children with insecure attachments have a much harder time with self-regulation because parents and other adults have not consistently provided the soothing, comfort, and structure neces-

sary for internalization of capacities for self-regulation. In addition, these children may not trust adults to help them manage their strong emotions.

Four General Styles of Self-Regulation

When children and persons of whatever age are under stress, they seek to re-regulate which means to get themselves back on an even keel. For the purpose of the NEATS assessment, schemas that activate themselves in response to stress and trauma can be of four general types: prosocial, antisocial, self-destructive, and inappropriate.

Prosocial responses at their core are secure attachment behaviors, where children seek safe havens that will soothe them and help them to re-regulate. How children re-regulate varies with their experience and development. Young children may soothe themselves through thumb-sucking and seeking a soft toy or blanket. They may want to cuddle.

Older children may also seek attachment figures, but want to talk about what happened and to work out strategies for dealing with situations that triggered the dysregulation. Physical exercise, meditation on something pleasant, drawing, and writing out feelings are some of many different strategies that can contribute to prosocial self-regulation.

When schemas are associated with **antisocial, inappropriate, or self-destructive behaviors**, it becomes important to become aware of expectations, assumptions, and behavioral guidelines that children have internalized and to figure out how help children to redirect and manage behaviors, thoughts, and emotions, associated with particular inner working models.

Children raised in environments where violence is normative are at risk to act out their dysregulation anti-social ways such as defiance, aggression toward others, and destruction of property. Children raised in avoidant, repressive environments may react to their dysregulation through self-destructive actions, such as cutting, using chemicals, and over-eating.

Inappropriate behaviors include being unable to sit still or listen to directions. Sexual acting out can be attempts at re-

regulation. Children with these responses believe that parents or other adults cannot or will not help them cope with their dysregulation. Questions about quality of attachment are appropriate in these situations.

Some inner working models, formed during times of stress and trauma remain in their original undifferentiated state. They may sit inactivated for years within brain circuits but may re-activate when individuals perceive themselves to be in situations similar to those that led to their formation in the first place.

Children also learn to regulate, dysregulate, and re-regulate their behaviors through observing parents, siblings, peers, and others with whom they identify, including fictional characters in stories, films, video games, and cartoons. Strategies of self-regulation are linked to family traditions, culture, gender, and age.

The conditions under which children act out their dysregulation can provide cues for how to respond. For example, Terrell tore up the waiting room of a child and family therapy agency when he left his therapy session early and his case manager had left to go to the washroom. "I was only gone a minute," the case manager explained.

Terrell, alone in the waiting room, thought she had abandoned him. He relived the trauma related to other abandonments and apparently coped through destroying property. Obviously, abandonment is a therapeutic issue for Terrell. Adults uneducated about children's trauma and dysregulation may have responded in a punitive way. The case manager first assured Terrell that she was there for him and then she helped him put the waiting room back in order. She planned to talk to him and have him role play what he will do the next time he thinks someone has left him.

Helping Children to Self-Regulate

With intervention, children can learn to self-regulate. Typical interventions include sensitive, contingent responses to episodes of dysregulation that include the assurance of safety, permission to dysregulate while ensuring the safety of self, others, and property, and problem solving and empathy once the dysregulated episode is concluded.

As with other executive function issues, children with self-regulation challenges require safe, structured, predictable environments, clear expectations, and praise for any self-regulation capacities that they show. Parents of children with dysregulation issues will benefit from support groups and psychoeducation. If they have issues with dysregulation themselves, they and their families will benefit from therapy and perhaps self-help groups. Parents with chemical dependency and mental health issues may have particular difficulties with self-regulation, which limits their capacities to help their children with the children's self-regulation.

Professionals, such as teachers and social workers also must educate themselves about issues related to self-regulation and dysregulation and provide themselves with the support and practice guidelines they need to be helpful to children. If they find that their personal responses interfere with their effectiveness, then therapy might benefit them. -

Summary

Self-regulation is one of the executive skills. Children under the care of social services often have serious issues with self-regulation. Thus, in the NEATS assessment, self-regulation is a separate category.

Capacities for self-regulation are both genetic and environmental in origin. Children with histories of abuse and neglect, inadequate care, and trauma or who have parents who do not model self-regulation and help children to achieve it, are at high risk to have difficulties with self-regulation. Interventions that are effective in helping children learn to self-regulate must include both the children and the adults, such as parents, teachers, and

others who have responsibility for the care of children with self-regulation issues.

Practice Note

When children have issues with self-regulation, it is important to assess parents for their self-regulation capacities. Children develop optimal self-regulation in the natural course of events in parent-child attachment relationship, in response to parental structure and guidelines, and through observing how parents self-regulate. Issues that children have with self regulation often find their mirror images in how parents regulate themselves.

A NEATS assessment leads to comprehensive case plans. When parents are willing to do whatever it takes to foster their children's healthy development and when appropriate services are available, there is reason to hope that children will reach their potential and live full and satisfying lives. Even when services are in place and parents are doing their best, however, some children experience outcomes that no one wants, such as incapacities to live independently, to anticipate the consequences of unprotected sex, or to self-regulate when traumas are triggered.

All too often, services are inadequate and parents are unable to be physically and psychologically available to their children. Many children who grow up in these circumstances still manage to live full and satisfying lives, through great effort and perhaps good luck. Someone or several people step in and are there for them.

Optimal child outcomes are reasons to cheer. Less than optimal outcomes are reasons to figure out what went wrong and what can be done to make things right for children and their families.

7

For Further Reading

A science-based framework for early childhood policy: Using evidence to improve outcomes in learning, behavior, and health for vulnerable children. (2007). Cambridge, MA: Center for the Developing Child at Harvard University.

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Internet Resource List for More Information

Amen Clinics: <http://www.amenclinic.com/ac/>

Autism Society of Canada:

http://www.autismsocietycanada.ca/asd_research/asc_initiatives/index_e.html

Center for Early Education and Development, University of Minnesota, Twin Cities, USA. <http://cehd.umn.edu/CEED/>

Child Trauma Academy.

<http://www.childtrauma.org/ctamaterials/Professions.asp>

Medline Plus:

<http://www.nlm.nih.gov/medlineplus/childmentalhealth.html>

National Institute of Mental Health:

<http://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/index.shtml>

Trauma Center at Justice Resource Institute:

<http://www.traumacenter.org>

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