



MiPSAC

Newsletter of the Michigan Professional Society on the Abuse of Children, Inc., the Michigan Chapter of APSAC.

Volume 12, Issue 1

Spring, 2007

President's Corner

by Colette Gushurst, M.D.

The goals this year for the Michigan chapter of the Professional Society on the Abuse of Children (MiPSAC) were nicely outlined in the last newsletter by our outgoing president, Rosalynn Bliss. They are to continue to increase membership, to provide educational resources for professionals in this field, and to continue to ensure that everyone affected by child maltreatment receive the best possible professional response.

MiPSAC is one of about ten active state chapters of the American Professional Society on the Abuse of Children (APSAC), and continued intra-state and inter-state communication is important to the APSAC mission. We plan to continue to work toward developing a website for the Michigan Chapter of the Professional Society on the Abuse of Children to reflect our own state's activities as the Wisconsin Chapter (WIPSAC) has done. Our challenge will be to accomplish this in six meetings and with limited resources. In past years, the national organization sent the active state chapters a portion of their members' national dues. They have decided to abandon this automatic reimbursement to the state chapters, although there may make state by state decisions based on the state chapter's activities or requests for grants. Thus, I will be providing them with our State Chapter's activity report as requested and remain in communication with the APSAC leadership so we will be up to date and informed with regard to their decisions.

Although our state chapter has not had many expenses in the past, MiPSAC has assisted in the support of nationally known speakers for the University of Michigan's annual child abuse meeting in Ypsilanti and has awarded the Ray Helfer Award and plaque each year to an individual in this state who has exemplified the ideals of the organization. Other activities, such as organization and publication of the newsletter and information shared through the listserv, are done through volunteered time by Board members. We would like to continue to do these things, but may need additional resources if we hope to develop a speaker's bureau, a website, and other collaborative efforts. Despite these challenges, we will continue to share ideas and advocate for abused children within and between our varying professional backgrounds.

Please remember that all members are welcomed at meetings. My hope is that as the president of MiPSAC this year, I am able to serve as facilitator in directing the energy and expertise of our state's members toward fostering the ideals of APSAC.



2007 MiPSAC President Colette Gushurst, M.D.

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Meetings & Conferences

MiPSAC Board Meetings

2nd Friday, even months, 12 noon – 2 PM
Michigan Children's Ombudsman's Office, Lansing
gushurst@kcms.msu.edu

16th National Conference on Child Abuse and Neglect:
Protecting Children, Promoting Healthy Families and
Preserving Communities. April 16-21, 2007 Portland,
Oregon. 16conf@pal-tech.com

APSAC 15th ANNUAL COLLOQUIUM
July 11-14, 2007, Boston Marriott Copley, Boston MA,
www.apsac.org

ISPCAN 18th International Congress
September 7-10, 2008 Hong Kong, China
www.ISPCAN.org

MiPSAC's Goals

- To bring together professionals working in the area of child maltreatment
- To foster networking
- To be an information resource
- To sponsor quality training

Join the MiPSAC member listserv
(sponsored by Wayne State University)

by contacting Vince Palusci at
Vpalusci@med.wayne.edu

*(reminder...you must be a member of APSAC in Michigan
or MiPSAC to participate)*

MiPSAC
P.O. Box 12264, Lansing, Michigan 48901

Michigan Professional Society on the Abuse of Children, Inc.
2007 MiPSAC Board of Directors (Board term)

President: Colette Gushurst, MD (05-07)
Kalamazoo Center for Medical Studies, Kalamazoo
gushurst@kcms.msu.edu

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Editor: Vince Palusci
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MiPSAC was founded in 1995 and incorporated in 1996 as the Michigan non-profit 501(C)3 state chapter of APSAC. The comments expressed in this newsletter reflect the views of the author(s) and do not necessarily represent the views of MiPSAC or the American Professional Association on the Abuse of Children. (APSAC).

MiPSAC Membership Information—

There are two ways to become a member of MiPSAC, the state chapter of APSAC in Michigan:

1. Join APSAC. Joining APSAC and paying your annual dues also makes you a member of MiPSAC if your membership address is in Michigan. A part of your annual dues is sent to MiPSAC to cover your membership. MiPSAC hears periodically (but not often enough) about new APSAC members, so please let us know if you think you are an APSAC member so we can make sure you receive MiPSAC communications.
2. Join MiPSAC only. Our changed bylaws have created an in-state membership category to join MiPSAC. This does NOT include APSAC membership. Please contact the membership chair at vpalusci@med.wayne.edu or mail us for more information. MiPSAC, P.O. Box 12264, Lansing, Michigan 48901

MiPSAC Board of Directors, 1996-2001

Editor's Note: Many people have been responsible for the founding and continuation of MiPSAC, our state chapter of the American Professional Society on the Abuse of Children. It is only fitting that we periodically honor those who have helped through the years since our founding and incorporation. These professionals are to be congratulated for their vision and persistence in working for the children of Michigan. If you find any errors in this listing, please let us know.

	Interim Board	1997	1998	1999	2000	2001
President	David Harrison	David Harrison	Vincent Palusci	Roger Pickering	Tracy Cyrus	Frank Vandervort
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Honorary		Richard Bearup	Richard Bearup	Richard Bearup, William Ladd, Clyde Owings, Patricia Walsh	Michael Harmon	Newman Brown, Vincent Palusci
Awards			MiPSAC Advocacy Award-Rep. Ed LaForge, Sen. Robert Geake	MiPSAC Advocacy Award-Leni Cowling		

MiPSAC Board of Directors, 2002-2007

	2002	2003	2004	2005	2006	2007
President	Annamaria Church	Patricia Siegel	Elaine Pomeranz	Charles Enright	Rosalynn Bliss	Colette Gushurst
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Honorary	Leni Cowling	Steve Yager, Lu DeLoach	Edie Kessler, Lynne Martinez, Nancy Skula	Edie Kessler, Lynne Martinez, Nancy Skula	Leni Cowling, Robert Geake, Edie Kessler	Leni Cowling, Mike Harmon, Edie Kessler, Verlie Ruffin
Awards		MiPSAC Ray Helfer Advocacy Award- James Henry	MiPSAC Ray Helfer Advocacy Award- Gerald Buchanan	MiPSAC Ray Helfer Advocacy Award- Barbara Welke	MiPSAC Ray Helfer Advocacy Award- Steve Yager	

Parent-Child Therapy for Families Assigned Child Welfare Intervention: A Description of the FIT Program at Michigan State University

By Kathleen Jager, PhD, LMFT, Erika London Bocknek, MA, LLMFT
Gera Weir, BS, Jennifer Bak, MA, Asha Barber, BA, Katie Bozek, MA
The Families In Transition Team, MFT Program, Michigan State University

Child welfare philosophy describes the importance of reunification, permanency planning, respect for families, unique needs of families and children, and support for children's optimal growth and development. When DHS intervenes, they must leave families better off than if there had been no intervention (DHS, 2006). There is a clear need for efficient monitoring of developmental, behavioral, social and adaptive functioning for children in foster care who are receiving mental health services (Landsverk, Garland, Leslie, 2002). Caseworkers, judges, and families may seek out family therapists to assist in addressing the aforementioned needs, as well as parental competency, input regarding placement, and treatment consultation (McWey, Henderson & Tice, 2006; Northey, 2004). Family therapists can play a critical role in the collaborative processes between social workers and the foster care system that involves developing clear understanding and intervention with the issues that affect maltreating families (McWey, Henderson, & Tice, 2006).

The Families in Transition Program (FIT), is a community-based family therapy program contracted by the Department of Human Services for four mid-Michigan counties. FIT provides services to support the needs of multi-stressed families involved in child welfare where family reunification is the goal. DHS refers birth parents and their children who have been removed from the home into foster care in order to accomplish goals including parenting education, improved parent-child bonding, child developmental assessments, and professional observation of appropriate parenting practices. At the same time, FIT affords doctoral level Family Therapist Interns at the Michigan State University Ph.D. program in Marriage & Family Therapy the opportunity to facilitate family therapy for parents and children who have endured trauma, violence and marginalization. Through intensive supervision by clinical faculty, doctoral interns facilitate therapeutic services to multi-stressed families where assessment, facilitation of family empowerment, advocacy and expert decision-making (Lindblad-Goldberg, Dore, Stern, 1998) are crucial. As often is the case for maltreating families, the same factors that make it difficult for them to emotionally engage with their children probably also make it difficult for families to connect with service providers (Erickson & Egeland, 2002). With this in mind, FIT therapists must speak to parents' benefit from services, the best interests of the children, and progress towards treatment goals (FIA v. Sayers-Gazella, 2003), while maintaining a therapeutic relationship that facilitates family growth and safety.

Programming Approach

The framework of infant mental health applies to clinical intervention by defining the *identified patient* as the parent-child relationship (Lieberman, Silverman, & Pawl, 2000). Many of the clients referred to FIT by DHS are single-parent caregivers and young children, birth to age six. The youngest children in state custody are also among the highest-risk children, most often experiencing multiple risk factors to their development including abuse or neglect, parental substance abuse, poverty, and/or unstable living environments in addition to disruption in their relationship with their primary caregivers (Reams, 1999). Thus an improved parent-child relationship is seen as an important protective factor in this context. The emphasis on the parent-child relationship, as opposed to a focus on either parent or child separately, blends with systems theory and family therapy fundamentals.

Also consistent with family therapy practices, the infant mental health framework emphasizes the impact of intergenerational patterns on the parent-child relationship. In therapy at the FIT program, the parent's own developmental history is considered. FIT therapists blend education about child development milestones and structural parenting practices with specialized treatment plans reflecting each client's history and context. Traditional talk therapy

is employed when appropriate to access client representations of relationships and parenthood. Selma Fraiberg (1980) wrote eloquently about the process of infant-parent psychotherapy:

In treatment, we examine with the parents the past and the present in order to free them and their baby from old “ghosts” who have invaded the nursery, and then we must make meaningful links between the past and the present through interpretations that lead to insight. At the same time, we maintain the focus on the baby through the provision of developmental information and discussion. We move back and forth, between present and past, parent and baby, but we always return to the baby. (p. 61)

Through such a process, the parent engages with her baby via an increasingly co-constructed relationship.

As noted, the process always returns to the child. The emphasis on the child is what distinguishes infant-parent psychotherapy from family therapy. A major aim of infant-parent psychotherapy is to strengthen the parent-child relationship by aligning the parent’s perceptions and resulting caregiving behaviors more closely with the baby’s developmental needs as is relevant to the family context in order to protect and promote the child’s mental, emotional, and developmental health (Lieberman, Silverman, & Pawl, 2000). Though the parent-child relationship is considered the identified patient, it is considered so as a mechanism to enhance the child’s development. Because of this, an important aspect of FIT programming is the developmental assessment of the child. FIT therapists employ not only a burgeoning expertise in clinical intervention but in child development by assessing the educational and intervention needs of each child. Socioemotional, language, and motor skills are attended to with supportive learning activities targeting each area. However, the clinical environment is maintained as the therapist teaches the parent to provide the intervention. The therapist is indirectly seeking to intervene in the child’s development but is equally concerned with using learning opportunities to promote parent-child bonding, family empowerment, and parenting skills.

Structure of Intervention

The FIT program applies intervention techniques in several ways. To begin, clinical practice with parent and child occurs in traditional clinic center rooms. This is a structured environment in which parents and children engage in free play, structured tasks, and therapist directed interventions. Treatment plans include strategies in which the therapist is engaged at different levels, both inside of the room and via an observation booth. The latter technique encourages more natural interactions between parent and child, during which time parents can apply learned techniques and therapists can observe and provide feedback. Not only does this way of working provide needed structure and directives to parents, it also offers them more time to interact and strengthen family relationships. Additionally, FIT therapists complete home visits with families. As is consistent with community-based mental health services, FIT home visits allow therapists to support families in their natural environments and observe organic parent-child processes (Landy, 2000).

As mental health providers, family therapists have the practice skills to address therapy engagement with individual parents, couples, and multigenerational caretakers to take necessary steps to reconstruct a safe, nurturing environment (Gil, 2006) conducive to reunification goal achievement. Programs such as FIT aim to address the prevention of child maltreatment through intervention with the family system, and must implement a diversified balance of responsiveness and protocol (Daro & Donnelly, 2002) in the way in which individual, couple, parent-child and family therapy is facilitated.

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Reflections of Trauma in the Play of Physically and Sexually Abused Children

By Jennifer Bak, M.A.

Marriage and Family Therapy Program
Michigan State University

Much of what we work with as professionals is the reflection of our client's experience of their world. Healthy, normally developing children are able to engage in meaningful play that is comprised of a beautifully orchestrated balance of active involvement, direction, and creativity. Traumatized children however, experience a disruption in their normal development and consequently their play commonly lacks the vibrancy that is evident in the play of normally developing children. Children who have experienced the trauma of physical or sexual abuse often do not feel the sense of safety necessary to promote creative play (Ater, 2000; White, Draper, & Pittard, 2000).

Play therapy provides an effective and accommodating mode of treatment that can align with the traumatized child's unique needs (White, 2000; Williams and Steiner, 1998). The goal of play therapy is to allow traumatized children the opportunity to acquire a sense of mastery and control over their experience, and to feel empowered. In doing so, the child is involved in a corrective experience that aims to prevent future developmental deviations (Ater, 2000; Gil, 1991). An awareness of the characteristics of play behavior that reflect healthy as well as disrupted development is an important aspect of working with abused children.

The overarching patterns that pervade the play of children traumatized by abuse include literal/unimaginative play (Gil, 1991; White, Draper, & Pittard, 2000) and repetitive play (APA, 2000; Gil, 1991; White, Draper, & Pittard, 2000). Repetitive play is very clear; children, in somewhat of a ritualistic manner, set up the same scene every time they play. Once all of the characters are in place, a series of actions occur and the same outcome is reached every time, there is no resolution. In sharp contrast to healthy meaningful play, traumatized children exhibit play that lacks expression and enjoyment (Gil, 1991).

The following play behaviors common to children who have experienced the trauma of physical and sexual abuse will be discussed: developmental immaturity, aggressive/oppositional behavior, withdrawn/passive behavior, belittling/destructive behavior, hypervigilance, dissociation, and sexualized play behavior (White, Draper, & Pittard, 2000). These characteristics do not comprise an exhaustive list but rather offer a starting point for consideration.

Developmental immaturity is demonstrated when the developmental level of play is not appropriately matched with the child's chronological age. These children may act infantile, cling to the therapist, take care of a baby doll and other doll family members, and may be overly compliant (Ater, 2000).

Aggressive/oppositional behavior is the most common play behavior of physically abuse children, particularly boys. Aggression may take the form of acting out the abuse, calling the therapist names, throwing toys, or acting violently toward the toys. These children may also get easily frustrated if things do not work out exactly as they had planned (White, Draper, & Pittard, 2000).

Passive/withdrawn behavior may present as hiding during session. The child may find a spot behind the puppet stage, or quietly play alone while facing away from the therapist.

Belittling/destructive behavior is reflective of children who have internalized their emotions. These play behaviors may take the form of anger being directed at particular toy. A child may tell a doll that it is a "bad" doll. Children sometimes come to believe that they deserve to be hurt and may take action such as banging their head on a wall (Ater, 2000; White, Draper, & Pittard, 2000).

Hypervigilance refers to traumatized children's heightened sensitivity to environmental cues of danger. Hypervigilance in play may take the form of excessively asking permission questions to determine if it is ok to play with certain toys. Also, children may easily startle and scan the room following any noise or event that disrupts their play (White, Draper, & Pittard, 2000).

Dissociation can occur when the play taking place becomes too stressful. For example, a child may be reenacting the abuse with toys in the play room and at some point become dissociated, staring into space, or becoming stiff. Traumatized children use dissociative measures to detach from the reality of their experience. The ongoing and repeated nature of this type of trauma elicits coping mechanisms such as self-hypnosis and dissociation, which allow for

mental escape. Children tend to develop numbness to physical pain and sexual activity, and also distance themselves emotionally (Ater, 2000; White, Draper, & Pittard, 2000; Terr, 1991). Therapists should continuously assess for this occurrence during sessions.

Sexualized play behavior is most unique to sexually abused children. These children may exactly reenact the sexual abuse, may attempt to take their clothes off during session, and may try to hug or kiss the therapist, or use puppets to do so. Sexually abused children may engage in symbolic play to attempt to gain an understanding of their abuse and the world they live in. This symbolic play is characterized by the child developing a representation of him or herself in the play (Ater, 2000).

Throughout my work, I have come to highly value the intricate, insightful, and powerful themes that pervade children's play. In many ways the nuances of play reflect a story of the interwoven experiences contributing to children's understanding of their world. The therapeutic use of play affords the opportunity to privilege a child's voice in a safe, trusting, and supportive environment. While engaging in play has many benefits, it is important for professionals to understand that play does not stand alone. Play therapy has the power to facilitate healing when implemented by an experienced and trained clinician.

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Some final thoughts:

It has been my privilege to practice child abuse pediatrics in Michigan for the past dozen years and to have served MiPSAC in several capacities. I was warmly welcomed by our state's child welfare community and have found remarkable people doing amazing things. But the years have been hard on our children. The Michigan Council on Children and Families now calls upon the Governor, legislators, and business leaders to fully replace the SBT revenue, support new revenue sources to be invested in children's prevention services, and to stop cutting children's services to balance the state's structural deficit. But we must do more if we are to improve (or at least maintain) things for kids and families and to integrate health care professionals into our child welfare systems:

- Make children and families a true legislative priority in this state, not merely a public relations ploy (as the American Academy of Pediatrics said: "Who's really for kids, and who's just kidding?");
- Increase the number of board-eligible child abuse pediatricians by supporting adequate reimbursement;
- Expand the use of medical professionals in DHS multidisciplinary teams and child 'life' reviews;
- Make mandated and adequately reimbursed comprehensive medical and mental health assessments part of every CPS investigation and foster care placement;
- Fully fund and expand the DHS Medical resource System throughout the state.

Vince Palusci

MiPSAC has new contact information!

Please direct questions about MiPSAC membership, the newsletter and other issues to:

MiPSAC
P.O. Box 12264
Lansing, Michigan 48901

Please contact APSAC directly about APSAC membership: APSAC, P.O. Box 30669, Charleston, SC 29417, apsac@comcast.net, (843) 764-2905