SUPREME COURT
OF THE STATE OF WASHINGTON

In re Welfare of B.P.	)	No. 91925-9
State of Washington/DSHS,	)	
Respondent	)	
v.	)	
H.O. (Mother)	)	
Petitioner	)	
In re Welfare of K.M.M.	)	No. 91757-4
State of Washington/DSHS,	)	
Respondent	)	MOTION TO ACCEPT ADDITIONAL
v.	)	EVIDENCE ON REVIEW (RAP 9.11)
J.M. (Father)	)	
Petitioner	)	
_____	)	

1. IDENTITY OF MOVING PARTIES

Petitioners H.O. and J.M., through counsel, asks for the relief designated in Part 2.

2. STATEMENT OF RELIEF SOUGHT

Accept and consider additional evidence – namely, the attached submission by Dr. Joanne Solchany, Ph.D., ARNP, IMHS, Infant Mental Health Specialist, Child and Adolescent Psychiatric Nurse Practitioner, and PhD in Parent-Child Relationships and Attachment. (See Appendix A). Dr. Solchany, who contracts with DSHS to perform evaluations and services in

child welfare cases, is cited in the amicus brief submitted by the Center for Children and Youth Justice *et al*.

3. FACTS RELEVANT TO MOTION

The facts of these case have been more fully set forth in Ms. H.O.'s supplemental brief (filed on March 22, 2016) and Mr. J.M.'s supplemental brief (filed on February 19, 2016), and are hereby incorporated by reference. In both cases, the Petitioners Ms. H.O. and Mr. J.M. argue the Department of Social and Health Services (DSHS) failed to offer them necessary services.

By letter dated March 24, 2016, the Supreme Court requested information addressing matters related to services to remedy attachment issues and disorders.

Dr. Joanne Solchany, Ph.D., ARNP, IMHS, is an Infant Mental Health Specialist, Child and Adolescent Psychiatric Nurse Practitioner, and holds a PhD through the University of Washington School of Nursing in Parent-Child Relationships and Attachment. Dr. Solchany has demonstrated an expertise related to services to remedy attachment issues or disorders. Dr. Solchany's curriculum vitae is attached. (See Appendix B).

Dr. Solchany contracts with DSHS to provide evaluations and other services related to attachment, bonding, and parent-child relationships in child welfare cases. In addition, Dr. Solchany's work is cited in the brief of amicus curiae Center for Children and Youth Justice *et al*. She has authored a submission to this Court addressing bonding and attachment, based on current research in her field, and services available to remedy attachment issues or disorders. (See Appendix A). Nothing in this submission purports to apply any expert opinion to facts of either case; the submission simply summarizes information regarding the issue of attachment.

4. GROUNDS FOR RELIEF AND ARGUMENT

Ms. H.O. and Mr. J.M. move this Court to accept and consider the attached submission by Dr. Solchany. (See Appendix A). Ms. H.O. and Mr. J.M. urge this Court to consider this evidence and find that DSHS failed to offer them necessary bonding and attachment services. (See Petitioner's supplemental briefs (filed on February 19, 2016 (Mr. J.M.) and on March 22, 2016 (Ms. H.O.)), incorporated herein).

A. The Supreme Court should accept Dr. Solchany's submission because it complies with the provisions of RAP 9.11.

The Supreme Court may direct that additional evidence on the merits of the case be taken prior to decision if the following conditions are met:

> (1) additional proof of facts is needed to fairly resolve the issues on review, (2) the additional evidence would probably change the decision being reviewed, (3) it is equitable to excuse a party's failure to present the evidence to the trial court, (4) the remedy available to a party through postjudgment motions in the trial court is inadequate or unnecessarily expensive, (5) the appellate court remedy of granting a new trial is inadequate or unnecessarily expensive, and (6) it would be inequitable to decide the case solely on the evidence already taken in the trial court.

RAP 9.11(a).

Here, in order to resolve Ms. H.O. and Mr. J.M.'s arguments that DSHS failed to offer them necessary services, additional facts are needed, namely, the attached submission by Dr. Solchany, an individual with demonstrated expertise in the field of attachment. *See* RAP 9.11(a)(1). Nothing in the submission purports to render an opinion regarding the facts of either case.

This evidence would probably change the decision being reviewed. RAP 9.11(a)(2). It is DSHS's burden to show it offered all necessary services. (See Petitioner's supplemental briefs (filed on February 19, 2016 (Mr. J.M.) and on March 22,

2016 (Ms. H.O.)), incorporated herein). The comprehensive description of the services available to remedy attachment issues or disorders contained in Dr. Solchany's submission would probably show that DSHS did not meet its burden to provide necessary bonding and attachment services to Ms. H.O. and Mr. J.M.

It is equitable to excuse Ms. H.O and Mr. J.M.'s failure to present Dr. Solchany's submission in the trial court. RAP 9.11(a)(3). In both cases, the parents should be excused for failing to retain experts to outline the science relating to attachment and bonding, or to describe available services on these issues. Given that both Ms. H.O. and Mr. J.M. had remedied all identified parental deficiencies, neither parent's attorney anticipated the need for expending public funds on an expert related to these issues.

It would be inequitable under these circumstances for this Court to decide the case without Dr. Solchany's report. RAP 9.11(a)(6). Ms. H.O. and Mr. J.M. have important interests at stake, a fundamental liberty interest in the custody and care of their children. *In re Dependency of K.D.S.*, 176 Wn.2d 644, 652, 294 P.3d 695 (2013). Further, the briefs of Amicus Curiae Center for Children & Youth Justice *et al* submitted in both of these cases cite to articles authored by Dr. Solchany. (B.P. amicus brief, pg. 9, 10, 11; K.M.M. amicus brief pg. 19). These amicus briefs essentially offer new evidence, citing to scholarly articles regarding attachment and bonding. In light of these citations, it would be equitable for this Court to accept the attached submission of Dr. Solchany so that it may have a more comprehensive understanding of Dr. Solchany's work in the attachment field and her opinion on available services to address and remedy attachment issues.

Remedies other than accepting the attached copy Dr. Solchany's submission are inadequate. *See* RAP 9.11(a)(4) and (5). It is a prudent use of resources to accept Dr. Solchany's report at this time, especially in light of the Supreme Court's request for additional information relating to bonding, attachment, and services intended to address associated issues. The information Dr. Solchany provides is not specific to either case, but addresses the research and background generally relating to the Court's request.

For all these reasons, the Supreme Court should accept Dr. Solchany's submission under RAP 9.11.

B. The Supreme Court should waive the requirements of RAP 9.11 if necessary, and accept Dr. Solchany's submission

If this court finds that Dr. Solchany's submission does not meet the requirements of RAP 9.11, the court should waive the requirements of the rule: "[Even if] a literal reading of the rule suggests [Petitioners'] motion for receipt of additional evidence cannot be entertained, this court may waive or alter the provisions of any rule of appellate procedure in order to serve the ends of justice." *Washington Fed'n of State Employees, Council 28, AFL-CIO v. State*, 99 Wn.2d 878, 884-85, 665 P.2d 1337, 1342 (1983) (citing RAP 1.2). The Supreme Court may "alter the provisions of the rule in this case…" *Id.*

Should this Court find that Dr. Solchany's submission fails to meet all six criteria set forth under RAP 9.11, then this Court should waive the requirements of RAP 9.11 in the interest of justice. RAP 1.2(c); *Washington Fed'n of State Employees, Council 28, AFL-CIO*, 99 Wn. 2d at 884-87. The admission of new evidence is necessary for this Court's review. *Cf. In re Parentage of L.B.*, 155 Wn. 2d 679, 687 n.4, 122 P.3d 161, 165 (2005) (declining to waive the requirements of RAP 9.11 in the interest of justice, where

the Court was deciding purely legal issues, stating "the admission of new factual evidence is unnecessary for purposes of our review.").

In order for this Court to determine whether DSHS failed to offer Ms. H.O. and Mr. J.M. necessary services, it is imperative that the record reflect a comprehensive description of all available services to remedy attachment issues or disorders, presented by an individual with demonstrated expertise in the field of attachment. It is also imperative that this Court have such a comprehensive description of such services, given the potential effect this Court's rulings will likely have on future child welfare cases and DSHS's obligation to provide services.

5. PRAYER FOR RELIEF

Petitioners Ms. H.O. and Mr. J.M. respectfully request that this Court grant their motion above, accepting and considering the attached copy of Dr. Solchany's submission (Appendix A) as additional evidence for determination of these two appeals.

Dated this 22nd day of April, 2016.

Jill S. Reuter, WSBA #38374
Attorney for Petitioner, H.O.

Jodi R. Backlund, WSBA # 22917
Attorney for Petitioner, J.M.

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In re Welfare of B.P.	)	No. 91925-9
State of Washington/DSHS,	)	
Respondent	)	
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State of Washington/DSHS,	)	
Respondent	)	PROOF OF SERVICE
v.	)	
J.M. (Father)	)	
Petitioner	)	
_____	)	

I, Jill S. Reuter, of Counsel for Nichols Law Firm, PLLC, assigned counsel for the Petitioner H.O. herein, do hereby certify as follows:

On April 22, 2016, I deposited for first-class mailing with the U.S. Postal Service, postage prepaid, a true and correct copy of the attached Petitioner's Motion to Accept Additional Evidence on Review to the following:

H.O.
(address confidential)

Rebecca R. Glascow
Deputy Solicitor General
PO Box 40100
Olympia, WA 98504

Amy S. Soth
Assistant Attorney General
1116 W. Riverside, Suite 100
Spokane, WA 99201-1106

Having received prior permission, I also served the following with a true and correct copy of the same by email, at the following addresses: sharonblackford@gmail.com, talner@aclu-wa.org, lillian@defensenet.org, sainsworth@legalvoice.org, knowlesd@seattleu.edu.

Jill S. Reuter, Of Counsel, WSBA 38374
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I, Jodi R. Backlund, assigned counsel for the Petitioner J.M. herein, do hereby certify as follows:

I mailed a copy of the attached Petitioner's Motion to Accept Additional Evidence on Review, postage prepaid, to:

J.M. (father)
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I delivered an electronic version of the motion to:

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I filed the Petitioner's Motion to Accept Additional Evidence on Review electronically with the Supreme Court.

I CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF WASHINGTON THAT THE FOREGOING IS TRUE AND CORRECT.

Signed at Olympia, Washington on April 22, 2016.

Jodi R. Backlund, WSBA # 22917
Attorney for Petitioner, J.M.

APPENDIX A

JOANNE SOLCHANY PHD, ARNP, IMHS
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April 21, 2016

I am an Infant Mental Health Specialist, a Child and Adolescent Psychiatric Nurse Practitioner, and hold a PhD through the University of Washington School of Nursing in Parent-Child Relationships and Attachment. I am a founding faculty member of the Barnard Center for Infant Mental Health at the University of Washington and affiliate faculty in the School of Nursing. I am a graduate Fellow of Zero to Three, the Center for Infant Mental Health in Washington, DC. I am a member of the Advisory Board with the American Bar Association's Center for Children and Infant Mental Health Task Force, as well as the Advisory Board of the Nurse Family Partnership. I am currently in private practice treating infants, children, adolescents, and adults in Lynnwood, Washington. I am contracted with DSHS performing psychiatric evaluations with adults, teens and children, attachment/bonding evaluations, infant mental health evaluations, parent-child relationship evaluations, and parenting evaluations. I have authored numerous articles and books and have developed a program regarding maternal mental health issues that is being used in multiple countries and states. I have presented on a range of topics, including adoption, attachment, domestic violence, and child brain development, in a variety of venues including nursing, social work, judicial, legal, and public health. I have also been an expert witness on child development, infant mental health, trauma, parent child relationships, attachment, and adoption in over 100 trials, including Hague Treaty Cases and cases presented to the Appellate Courts of both Washington and Alaska. [CV Attached]

Attachment and bonding are terms frequently used to discuss the relationships built between children and the adults in their lives. These relationships have been studied and researched for over a hundred years, dating back to the early 1900's. In this submission, a general overview of bonding and attachment is provided, followed by a presentation of significant findings and facts reflective of the role of attachments and relationships for the child into adulthood.

Bonding is generally the term first used to describe the connection of the parent to the child, where attachment is the term used to reflect the connection the infant or young child first develops with their primary adult caregiver or the attachment figure. Throughout development, bonding becomes a term used to describe a connection, i.e. bonded to a person, a pet, a comforting stuffed animal. The term attachment comes to reflect changes as well, which are discussed below. The term attachment gets used in a lot of different ways in both lay people and professionals. The term "attachment" gets used in a lot of different ways that are not always accurate or equal, but generally represent some relationship dimension or concept. This can often generate misunderstanding and confusion.

Attachment is the connection an infant develops first with their primary caregiver—that person the child sees regularly, who care for him, nurture him, and so on[1]. This person becomes the infants "attachment figure". An infant is dependent on others for survival, they have to attach to someone to get fed, stay warm, have their diaper changed, etc. During this early period, the child actually begins to build attachments of varying degrees with others who frequent their lives, such as the secondary parent, day care providers, grandparents, family friends, and siblings. These early years will come to provide the foundation for other attachments the child will develop into childhood and even adulthood.

[1] Solchany & Pilnik (2008) Healthy attachment for very young children in foster care. Child Law Practice, 27(6).

A primary attachment is best understood in the way that child is able to use that specific relationship to seek comfort when in distress, for example how multiple individuals can unsuccessfully try to calm and sooth an upset infant who is then quickly calmed by one specific person, often the mother[2]. Attachment relationships differ from other social relationships in that the underlying construct is the use of the attachment figure for a sense of security, safety, and nurturance. When a child has this security established, they can then develop the ability to explore and feel confident to move away from the attachment figure.

As the child develops, the nature of the attachment relationship changes. The preschooler does not necessarily need to seek physical proximity to the attachment figure as the infant or toddler generally needs to do, rather a glance or "check in" will often suffice. The school age child can often just "think" or imagine their attachment figure in their mind for a sense of security. Over time they internalize this feeling of security—knowing the attachment figure loves them and is there for them, through this internal connection they begin to rely more on themselves and feel confident to be in the world, interacting and participating in things. As preteens and teens, the relationship focus developmentally shifts to peers and groups, however the confidence beneath this shift is built on the underlying foundations of their attachment to the attachment figures in their lives. The teen and young adult carry their attachment relationships "in their head", they do not need to maintain proximity or even regular verbal or physical check-ins with the attachment figure; rather, they depend the "narrative" or "working model" they have developed representing the attachment figure. For example, they are able to go off to college, ask someone out on a date, or take a risk on a new job, because they feel good about themselves and "know" they have these attachment relationships to fall back on. In times of distress, for example a soldier wounded in battle, one of their first responses is to want the person who was their primary attachment figure or to be home with the individuals they feel safe and protected with.

Attachment requires the presence of an attachment figure; the quality of the interactions and patterns embedded in the attachment is critical to understanding the nature of the attachment that is developed. Attachment can then be classified as secure or insecure[3]. A secure attachment reflects the child's ability to use their caregiver as a secure base, so they can feel connected and supported to explore the world and their environment. This classification reflects their ability to trust in others and be connected emotionally, for example the secure child would be the child who runs to the caregiver when a stranger enters, holds onto the caregiver's leg while they consider the stranger, once they feel stable their caregiver is present and sense the caregiver's comfort they can then begin to interact with the stranger, however if the stranger gets too friendly too fast the child retreats back to the caregiver. About 70% of American infants are thought to fall into the secure classification. An insecure attachment can be broken down into several subtypes, including anxious-avoidant (about 20% of American infants)—where the child avoids the caregiver or tries to stay away from them even when distressed, they often ignore the adult and don't seem to get upset when the person leaves; anxious-resistant (or ambivalent)(abut 10% of American infants)—where the child cannot depend on the person, they tend to withdraw and be wary, the underlying emotion is anger; and disorganized (rates vary, in adolescent parents the rates were about 30%[4], in mentally ill or drug abusing parents the rates were as high as 70-80%[5])—where the child cannot figure out what to do, they become confused and overwhelmed, fear and a lack of predictability are often present.

Children develop "working models", which are ways of viewing the people in the world around them that one "holds" in their minds. A child with a secure, healthy attachment tends to have a working model that the world is a good place, they can trust others, and that people are generally good. These

[2] Bowlby (1982) Attachment, 2nd Edition, NY: Basic Books
[3] Ainsworth et al. (1978) Patterns of attachment. A psychological study of the strange situation. Hillsdale, NJ: Earlbaum.
[4] Broussard (1994) Infant attachment in a sample of adolescent mothers. Child Psychiatry and Human Development, 25(4), 211-219.
[5] Carlson et al (1989) Disorganized/disoriented attachment relationships in maltreated infants, Developmental Psychology, 25(4), 525-531.

children typically go on to do better cognitively, socially, psychologically, and emotionally. Children with insecure attachments also develop working models, but these often represent the world as a scary and unpredictable place or one of no one really caring, that others cannot be trusted and depended on, and that people are generally disappointing, inconsistent, and unreliable. These children can still function in some healthy ways but often struggle with different challenges, especially in their relationships and communication. They also tend to struggle more cognitively, socially, psychologically, and emotionally.

As the child ages and develops they expand their attachments to friends, teachers, coaches, etc. Some children's lives lead them to develop attachment relationships with foster parents, stepparents, or adoptive parents. All individuals continue to create new relationships, bonds, and various degrees of attachment as life goes on. The attachment relationships a child has had since infancy or early childhood can shift or change due to new experiences, loss and separation, trauma, interference by others, and the changing circumstances and experiences of those attachment figures in their lives. These changes can happen at anytime over the course of life, infancy through adulthood. For example, a primary caregiver might die and a stepparent enters the picture. Even if the first relationship was problematic and insecure, the relationship with the new caregiver can be secure and functional. Another example would be the child who had a secure relationship with their caregiver who then develops a significant alcohol problem and becomes absent, inattentive, unpredictable, and hostile, these circumstances can change the nature of that relationship.

An existing attachment or the relationship between a child and a particular person, even a parent, can be negatively influenced by others. If another adult interferes with the developing relationship between the infant and the parent the relationship can be harmed. For example, if another adult is domestically violent with the attachment figure, witnessing the domestic violence will traumatize the baby or young child, the attachment figure will be compromised and unable to consistently care for the baby properly, and the child will be exposed to the fear/chaos/anger that will be generated by the two adults, the infant might not understand it all but will feel it and it will impact their ability to develop a healthy attachment relationship.

The older child or teen will tend to have a better developed ability to understand what others tell him or her about the attachment figure. If the attachment figure is disparaged in any way, it can negatively impact the idea or representation the child holds in their mind of that specific attachment figure. For example, if a child is regularly told that their father is a deadbeat dad and has never cared for them, the child can begin to think of the father solely in those terms. That child will often begin to add to this negative scenario with a mix of their own ideas, including fact, fiction, and other's projections and opinions. Because a child is also a reflection of the biologic parent, they can extend this fear/avoidance/negative thinking onto their own self-image and develop low self-esteem and/or mental health issues.

If the child or teen experiences others telling them repeatedly that the relationship they have with a primary attachment figure is going to be ending or terminating they will often begin to withdraw from that relationship, prematurely. They may begin to refuse to see the person or display a lot of anger toward them. This is a protective mechanism, the child/teen has to "survive" and that means grabbing onto the relationship that has the most likelihood to move forward. It is often too difficult, if not impossible, to risk depending on the pre-existing relationship, especially if they were told it is not going to continue. Emotionally and psychologically, they cannot put themselves in that position, especially if they have had a history of failed or problematic relationships already. They have to demonstrate loyalty to the individuals who say they want them and will be there for them, if they do anything to derail those relationships they may end up with nothing and no one. For example if a child is told they are going to be adopted and will not be living with a previous attachment figure, they have to climb on board with the adoption idea as it becomes the only safe alternative for them. The child/teen cannot risk being

rejected or abandoned so they reject first. They cannot show a preference or even a fondness for the other party as that may jeopardize the current relationship with the party taking care of them and making them promises. Even if the child/teen begins to ask for the current relationship to continue, it is most often based on getting their immediate needs met—not losing friends, not changing schools, keeping their room/belongings, going on that promised trip—and wagering that what is known and current will remain a constant.

If a child is traumatized within the context of one of their primary relationships, for example physically or sexually abused, this will have an impact on that relationship. Even if the primary attachment figure is not the perpetrator, the child might blame that person for not protecting them or making things better. In the child's mind, an attachment figure should be able to protect them and keep them safe; they should be able to be "taken for granted". Even if it was beyond the attachment figure's control, for example in situations where visits are court ordered or the child is put in a particular placement, the child can come to feel betrayed, abandoned, and wronged.

In general, if that child learned early on how to trust others, connect with them socially, and feel a sense of pleasure from their relationships, they will tend to use the healthy strategies they developed to go on to form a healthy, secure relationship with others—as long as the other individuals do their part to connect to the child in healthy and supportive ways. These individuals go on to develop healthy self-esteem and self-images. If the child learned early that others cannot be trusted or counted on, if they were often tricked deceived, witnessed scary things like domestic violence, were abused or neglected, then they often struggle to get along with others, become withdrawn or attention seekers, and struggle to develop healthy friendships. For these children their self-image and their self-esteem are often problematic.

The following are some significant factors and issues related to attachment in varying contexts and over time.

- The attachment of the infant or young child to the adult is developed through specific behaviors, conditions, patterns, and interactions.

  The child's part of the relationship is to seek out the attachment figure and to use them to meet their needs, feel safe and learn. The attachment figure's part is to be consistent, sensitive, responsive, communicative, nurturing, predictable, and attentive. He or she must be able to meet the child's physical, emotional, developmental, and psychological needs.

- A child's attachments are hierarchical, they build on one another.

  The child first develops a "primary" relationship with an attachment figure, in typical families this is most often the mother as she is the one providing the majority of the care and nurturance. Quickly following the establishment of the primary attachment, a secondary attachment, usually to the father, is formed. From here, the child will expand the number and nature of their relationships. A child naturally has a number of attachment relationships that develop over time, some may be similar while others can be very different. A child who has an insecure attachment to an inattentive mother, can develop a secure connection with a daycare provider who cares for him daily and provides regular attention and nurturing. As the child develops, he or she can develop attachment relationships that are equal in quality and strength.

- "Attachments" or the relationship between a child and an involved adult <u>can be created</u> and <u>can be repaired</u> if there has been a disruption.

  If a child has experienced a disruption or even a trauma within the context of their relationship to a central attachment figure, it can be treated and often repaired. For example, if the attachment figure develops a medical illness like cancer and is required to go through treatments, be hospitalized, and cannot take care of the child, the child's relationship with that attachment figure will be compromised and the child, depending on the age, will have a lot of confusion, fear,

and inconsistency. When that adult recovers, the child and the adult will need to renegotiate their relationship and redevelop a sense of trust and healthy patterns of interaction.

In one family, the mother of the child would regularly make statements to or in front of the child that the father was "sociopathic", had murderous thoughts, and had been unable to properly care for the child when he was living with them. This led to the child being very fearful of the father and often tantrumming before and after visits, struggling with sleep at night, and the mother reporting other problematic behaviors. In fact, the mother was actually mentally ill and the father was a stable individual. The father and child worked in therapy to heal their relationship and then strengthen it. Therapy along with a step by step increase in visitation time eventually allowed the child to develop a healthy secure attachment and working relationship with her father. She became more stable in her father's care, sleeping well, eating well, becoming more independent and self reliant, and was overall more successful in his care. The problems when in the mother's care continued as they were due to her specific patterns of interaction with the child.

Many treatment interventions have been developed that clinically and successfully treat the adult, the child, and their relationship. Insecure or problematic relationships have been turned around; the child has been able to develop a secure relationship and the parent has been able to heal and learn how to parent in ways that promote healthy, balanced relationships[6]. The Circle of Security Program[7], The Attachment and Biobehavioral Catch-Up Program[8], Child-Parent Psychotherapy[9] and the Video-based Intervention to Promote Positive Parenting[10] are all interventions, with a strong research base for effectiveness, that address the attachment relationship between the child and the parent with positive outcomes.

- Studies have shown that "attachment" styles can be "passed on" intergenerationally or through the presence of a new caregiver[11].

  Research has shown that caregivers who have developed secure relationships themselves as they developed go on to parent children who develop secure relationships. Likewise, when a caregiver has an insecure-avoidant style of attachment, they tend go on to parent children who develop similar attachments. It is not the "biology" of a parent-child relationship that determines this; it is the patterns of interaction, the caregiver's view of the child and the way the caregiver relates to the child. The child learns similar patterns of interaction, developing a pattern of attachment that reflects that caregiver—which can be a parent, foster parent, relative, etc.

- Attachment expression changes over time as the child develops, the role the attachment plays will change as well.

  Attachment changes as the child ages. The infant needs proximity, to develop trust, to be able to take the caregiver for granted, and to be nurtured within the relationship. The two year old needs many of the same things but needs opportunities to explore and engage with other individuals. The three year old needs the same things as the one and two year olds but in different qualities. Three year olds often become good at separating for periods of time, they have learned that the caregiver will return. By school age, the child should be able to "hold the caregiver in mind" meaning they don't need to go check in physically as often, they can just "think" about the adult and feel reassured[12]. This "thinking about", plays a role in developing the child's conscience, when the child thinks about doing something naughty, they can think about their caregiver's response

[6] Zeanah et al (2011) Practitioner Review: Clinical applications of attachment theory and research for infants and young children 52:8, 819-833
[7] Marvin et al (2002) The circle of security project: Attachment based intervention with caregiver-preschool child dyads, Attachment and Human Development, 4, 107-124
[8] Dozier et al (2006) Developing evidenced based interventions for foster children: an example of a randomized clinical trial with infants and toddlers. Journal of Social Issues, 62, 767-785.
[9] Lieberman et al (2006) Child-Parent Psychotherapy: 6 month follow up of a randomized controlled trial. Journal of the American Academy of Child and Adolescent Psychiatry, 45, 913-918.
[10] Juffer et al, (2007) Promoting positive parenting: An attachment based intervention. Mahwah, NJ: Lawrence Earlbaum
[11] Bernier et al. (2014) Taking stock of two decades of attachment transmission gap: Broadening the assessment of maternal behavior, Child Development, 85(5), 1852-1865.
[12] Waters et al (2015) Secure base representations in middle childhood across two cultures: association with parental attachment representations and maternal reports of behavior problems, Developmental Psychology, 51(8), 1013-1025.

and it can provide some structure for their decision; they don't want to disappoint the adult. As the child progresses toward puberty, they want to be with peers more and more and often depend on their input and reject caregiver input at times, this is the extension of expanding their relationships and their sense of trust. Those children who had early secure attachments tend to be better at developing other relationships as they have learned how to trust, be sensitive, engage, etc. By adolescence their worlds are expanding more and more, they tend to want to be with peers, but when they get stressed or have problems they often want to return to caregivers for that sense of safety and security[13]. They "think" about their caregivers' responses to their actions. By adulthood, the child who has been secure tends to maintain secure, trusting relationships with the people they want in their lives[14]. If they have insecure beginnings, particularly anxious/avoidant or dismissive, they often struggle but can still develop strong, working relationships. For those who experienced disorganized relationships, the child often becomes an adult who struggles with all relationships, cannot keep friends, struggles with employment, etc.

- Sibling relationships are some of the most significant relationships in a child's life and should be valued, protected, and nurtured[15].

  A child's relationship with his/her siblings is among the longest relationships a child will experience in life. Children learn many things from their siblings including how to negotiate, how to play, how to relate in different ways, how to manage emotions, and even how to get frustrated and angry. In some instances older siblings actually become attachment figures for the younger sibling, then this relationship can take on a different level of meaning for the child, one of security and safety. Siblings who share the same parents or family can learn from each other and support each other to navigate any stressors related to the family.

- Meeting attachment needs in the young child leads to measureable physiologic responses[16].

  Certain hormones, such as cortisol, increase during distress. When the young child is comforted in response to this distress, their cortisol levels drop back to a normal range[17]. Cortisol and other hormones play important roles in the body, however when cortisol is too high and remains high for long stretches of time, certain body functions shut down and become altered. For example, too much cortisol decreases memory effectiveness, decreases appetite, increases hypervigilance, decreases attention, and interferes with emotional regulation. It is believed that all of these, if not intervened with, may become the precursors to mental health issues such as depression, attention deficit disorder, and anxiety.

- Adults with a history of poor attachments can heal and repair their ability to relate to others.

  Even adults who are struggling with insecure attachments and healthy relationships can work through therapy to a place of "earned security", where their pattern of relating moves to the "secure" way of relating. Past history, and even relationship based trauma, can be addressed and resolved. When adults who have equal amounts of abuse, neglect, or trauma embedded in their relationship and attachment history are explored, the ones who have resolved these issues either with the attachment figure they involved or have resolved it in their own hearts and minds, go on to have more secure patterns of interaction and demonstrate higher levels of functioning than those who remain stuck or enmeshed with the trauma of the past[18]. These findings suggest that working through and addressing relationship and/or attachment related trauma and associated issues as early as possible, frees the individual to go on to develop healthier relationships and thrive across developmental domains.

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[13] Waters et al. (2014) Caregiving antecedents of secure base script knowledge: a comparative analysis of young adult attachment representations. Developmental Psychology, 50(11), 2526-2538.

[14] Booth-LaForce et al (2014) The Adult Attachment Interview, Monographs of the Society for Research in Child Development, Wiley Online Library.

[15] Shumaker et al (2011) The forgotten bonds, Family Court Review, 49(1), 46-58.

[16] Dozier et al. (2006) Foster children's diurnal production of cortisol: An exploratory study. Child Maltreatment, 11, 189-197.

[17] Gunnar et al. (2002) Social regulation of the cortisol levels in early human development. Psychoneuroendocrinology, 27, 199-220.

[18] Solchany (2000) *The Impact of Maternal Childhood Trauma and Loss on Parenting*, invited speaker, Zero to Three, National Center for Infant Studies 15th annual National Training Institute, Washington D.C.

- Reactive Attachment Disorder (RAD) is a clinical diagnosis (just like major depression, anxiety disorder or PTSD) with specific symptoms set forth by the Diagnostic Statistical Manual of Mental Disorders (DSM); it is not a reflection of specific "attachment relationships".

  RAD develops due to a mix of factors, which can include trauma, a lack of a healthy or consistent opportunity to develop an attachment to an attachment figure, psychological symptoms, etc. It is actually quite rare and reflects only one construct of attachment. [19] *Just because a child has experienced disrupted attachments or trauma within their primary relationships does not mean they have RAD. It often means they have some attachment issues, which can be addressed within their existing relationships with attachment figures along with therapy or other interventions. RAD can be treated, as well, however, there are usually co-occurring issues that make the approaches to treating it very different than treating various attachment issues.*

- Children are often separated from primary attachment figures, the impact of this can be traumatic or the child can grieve and adjust to the loss, moving forward in healthy ways.

  Children go through grief when they are separated from their primary caregivers. The loss is a kind of harm but it can be mitigated through support and work on the loss. Sometimes a slow transition can be helpful and ease the stress, but if the adults are unable to manage their own emotions in healthy ways then a swifter transition is often necessary. The nature of the relationship between the child and parent plays a role in the stress and harm, as well.

- Multiple placement moves can have a negative impact on a child.

  When a child repeatedly lacks an adequate and consistent period of time to make healthy attachments and development meaningful relationships, this will have an impact on their ability to generalize relationships to others. It is the multiple moves, not necessarily where they are moved or whom they are with, whether foster care, group homes or relative care. An additional concern is that with every move children tend to blame themselves, a reflection of typical childhood thinking. They begin to feel rejected, unwanted and abandoned, for example "why don't they like me, did I do something wrong, I thought they cared about me, no one cares about me…"

- Attachment strategies or patterns of relating remain stable over time throughout childhood into adulthood as long as the individual's life is relatively stable.

  If life significantly changes, becomes unpredictable or even tumultuous, the nature of the child's attachment strategies can become vulnerable or fragile and be changed. For example, if a teenager raised by a single parent with a history of depression marries a healthy, well functioning secure partner, that partner can influence the teen who can move from insecure patterns of attachment to secure. If a child who had secure early relationships is removed to foster care and subsequently goes through multiple moves in both home and school, the strategies that they had relied on can become vulnerable and they may begin to demonstrate patterns consistent with insecure relationships.

- Attachment figures are NOT interchangeable; each one has their own emotional underpinnings.

  An attachment figure cannot just be replaced, however, equally significant attachments can be developed. Each relationship existed and played a role in the child's life and how they came to see the world. New relationships with other attachment figures can be developed, but these will not "replace" the earlier ones. For example, a mother who dies cannot just be "replaced" by a new mother, but a new relationship with a new woman in a mothering role can be developed and come to be just as significant, if not more significant, as the child's original attachment relationship with the biologic mother. Even if the child fully accepts the new woman and begins to view her as her mother, it is still a different relationship.

[19] Zeanah & Smyke (2009). Disorders of attachment. In C.H. Zeanah (Ed.), Handbook of infant mental health (3rd edn, pp. 421–434). New York: Guilford Press.

- The adult half of the child's attachment relationship is responsible for a large portion of how the child goes about developing the attachment and the quality of that attachment.

  The adult in the relationship with the child has to do their part to allow the child to develop a secure and healthy attachment relationship. A child cannot securely attach to an individual who is not available, emotionally present, or willing to make the child a priority. The adult half of the equation depends on many factors including sensitivity, emotional availability, their attachment pattern, consistency, ability to maintain an adult role, synchrony with the child, attentiveness, communication patterns and effectiveness, emotional regulation, and the ability to put the child first (this is only a partial list).

- The classification and quality of an attachment can be measured or assessed.

  The gold standard for measuring attachment in an infant is called the Strange Situation.[20] Other tools have been developed to measure attachment at different developmental stages. In adolescence and adulthood, attachment can be measured using a tool called the Adult Attachment Interview. However, these tools are not used clinically or for diagnostic purposes, they are generally used in research to better understand the relationships that develop and operate throughout life. Most of these measures are costly, time consuming, and require specialized training.

  Clinically, portions of these measures can be used and applied. However, the nature and the patterns of interaction and the behaviors present between the child and another person take on the most meaning. Secure base behavior or how the child uses the significant adults in their lives can be observed and described. Patterns of communication and responses can be observed and assessed. Synchrony within the child-adult dyad can be observed. Assessments such as the Emotional Availability Scale, which is an evidenced based assessment tool, provide an evaluation of the child-adult dyad and the quality of the relationships present.[21] The qualities of the relationship can be observed, measured, qualitatively evaluated, and assessed for strengths, struggles, and atypical parent behavior. For example caregivers who are intrusive, mocking/teasing, emotionally miscommunicate, are unable to maintain a parent role with the child (role confusion), withdraw or push the child away, frighten the child, dissociate, or only "go through the motions of parenting" without any emotion all contribute negatively to the relationship and can lead to a very confused, struggling child whose attachment relationships are not secure or healthy.[22]

- Visitation between a parent and child will have an impact on the relationship between them.

  First, the visitation or time together must be adequate to allow the parent and child the opportunity to be together; the younger the child the more frequent visitation should be, where the older child often does better with more time for each visit. Second, the quality of the time together needs to be positive; a parent visiting a child but ignoring them, being hostile, or being intrusive will not help their connection and will negatively contribute to the quality of that relationship, where a parent who is attentive, emotionally stable, active, and who can share a sense of pleasure with their child will promote a healthy, secure relationship. Third, the child needs to be supported in the visiting; foster parent/social worker/relative caregiver can impact the child's willingness to go to the visit, participate in the visit, and relate to the parent. Children, of any age, can sense tension and the emotional tone of the people around them. If they get the sense no one thinks visiting their parent is a good idea or that it upsets those with them most of the time, the child has no choice but to resist seeing the parent—they are dependent on the substitute caregiver and often do not want to risk upsetting them as it may lead to having to leave or being rejected. If the child gets the sense that the substitute caregivers are in favor of the visits and demonstrate that this is positive time, a priority (rather than a bother), and a time to be

[20] Ainsworth et al. (1978) Patterns of attachment. A psychological study of the strange situation. Hillsdale, NJ: Earlbaum.

[21] Biringen (2000) Emotional availability: Conceptualization and research findings. American Journal of Orthopsychiatry, Vol 70(1), Jan 2000, 104-114.

[22] Benoit (2000) Atypical caregiver behaviors and disorganized infant attachment. Newsletter of the Infant Mental Health Promotion Project, 29, 1-3

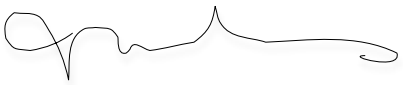
valued, the child will be more likely to value the visit and go into it with a positive attitude and open to connecting and relating with the parent.

- Developmental stages of the child will have a significant impact on the operationalization of the relationship between the child and a particular adult.

  Essentially, the infant goes from needing and seeking proximity to an adolescent/adult who has developed a "narrative" of that early attachment relationship. It is the narrative they carry in their minds that reflects the patterns of behavior, thought, and emotions that they will use to relate to others.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct. Dated this 21st day of April, 2016 Signed at: __Bothell, WA_____

Respectfully submitted,



JoAnne Solchany, PhD, ARNP, IMHS

APPENDIX B

JOANNE SOLCHANY PHD, ARNP, IMHS
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LICENSES & CERTIFICATION

Registered Nurse, State of Washington
Advanced Registered Nurse Practitioner, Psychiatric w/ Prescriptive Authority, State of Washington
DEA, Prescription Authorization
Clinical Specialist, Child and Adolescent Psychiatric and Mental Health Nursing, Board Certified
Infant Mental Health Specialist

EDUCATION

PhD, Nursing, University of Washington, Seattle, 2000
MSN, Nursing, University of California, San Francisco, 1991
BSN, Nursing, University of Alaska, Anchorage, Anchorage, AK 1989
BA, Psychology, Western Washington University, Bellingham, WA 1981
Associate of Arts & Sciences, Everett Community College, Everett, WA 1979

PROFESSIONAL EXPERIENCE

Infant, Child, Adolescent & Adult Psychotherapist, Consultant and Psychiatric Nurse Practitioner, Private Practice, Seattle, WA (95-present)

Private practice and consultation with infants, children, adolescents and adults. Providing mental health consultation and training to several groups in the mental health, legal, and child development areas, nationally and internationally. Provide psychiatric, attachment, relationship, and parenting evaluations [over 300] of adults, adolescents, children and infants for DSHS, Snohomish, Whatcom, and Skagit County School Districts, Parent Defense Organizations, and private individuals. Provide expert witness testimony for state and private cases [including Hague Treaty and Appellate cases]. Provide therapy and/or medication management for adults and children. Provide research support. Reflective practice supervisor for Infant Mental Health credentialing.

Affiliate Assistant Professor, Family & Child Nursing, School of Nursing, University of Washington, Seattle, WA (11/07-present)

Clinical Supervisor, School of Nursing, University of Washington, Seattle, WA (95-present)

Assistant Professor, College of Nursing, Seattle University, Seattle, WA (9/07 – 8/09)
Assistant Professor, Family & Child Nursing, School of Nursing, University of Washington, Seattle, WA (2001-11/07)
Principal Research Scientist, NCAST, School of Nursing, University of Washington, Seattle, WA (00-01)
Auxiliary Faculty, Family and Child Nursing, School of Nursing, University of Washington, Seattle, WA (00-01)
Research Assistant, School of Nursing, University of Washington, Seattle, WA (95-2000)
Infant, Child, Adolescent and Adult Psychotherapist-Advanced Nurse Practitioner, Private Practice, Anchorage, AK (92-95)
Psychiatric/Mental Health Advanced Nurse Practitioner, University of Alaska, Anchorage, (94-95)
Adjunct Faculty, Clinical Instructor, University of Alaska, Anchorage, Anchorage, Alaska (94-95)
Clinical Supervisor, University of Alaska, Anchorage, Anchorage, Alaska (94-95)
Psychiatric Nurse Practitioner /Senior Clinician, Aleutians East Borough Health Department, Sand Point, Alaska (91-92)
Student Intern/ R.N., Children and Adolescent Sexual Resource Center (CASARC), San Francisco, CA (9\90-6/91)
R.N., McAuley Neuropsychiatric Institute, St. Mary's Hospital and Medical Center, San Francisco (90-91)
R.N., Psychiatric Emergency Team (PET) Charter North Hospital, Anchorage, AK (89 -90)
Assistant Program Director, Children's Psychiatric Unit, Charter North Hospital, Anchorage, AK (87-89)
Team Leader, Adolescent Unit Charter North Hospital, Anchorage, AK (86 –87)
Mental Health Worker, Adolescent Unit Charter North Hospital, Anchorage, AK (85 –86)

CONSULTATION & CONTRACTS

Infant, Child & Adolescent Psychiatric, Adoption/Foster Care, Parent-Child Relationship, Medication & Mental Health Consultant to:

Zero to Three/Early Head Start National Office, Washington, DC
Center for Families, Shoreline, WA
Navos Community Mental Health, Seattle, WA
Florida State University
Nurse Family Partnership, Local WA state and National
American Bar Association, Center for Children and Justice, Washington DC
Olympia Law Group, Seattle, WA
Tacoma Public Defender's Office, Tacoma, WA
Idaho State Maternal-Child Program, Boise, ID

Neighborhood House Early Head Start, Seattle, WA
Early Childhood Academy, Kent, WA
Children's Home Society, Kent & Auburn, WA
Eastside Healthy Start, Redmond, WA
Catholic Community Services, Bellingham, WA

Adoption Consultant

WACAP, Seattle, WA
American's Adopting Orphans, Seattle, WA
Families with Children from China, Seattle, WA

Contracts

Attorney General of Washington—expert witness
OPD, State of Washington—evaluations and expert witness
DCFS/DSHS, State of Washington, PhD, ARNP—Psychiatric Evaluations (adult and child), Parenting Evaluations, Infant Mental Health Evaluations and Treatment, Therapy
Northwest Educational Service District 189—evaluations and medications
Center for Families, Shoreline, WA
Florida State University
Center for Children, Youth & Justice
New York Justice Center, NY, NY—providing judicial trainings on child development and related issues, consultation on development of court related bench book and websites
Navos Community Mental Health Infant Mental Health Program, West Seattle, WA—Providing reflective supervision to therapists and case consultation/training
American Bar Association, Center for Children—Trainer, Infants & Children in the Court
Navos Community Mental Health—Consultant and Clinical Supervisor, Infant Mental Health Program

PUBLICATIONS

Books

Solchany, J. (2014) *Promoting Maternal Mental Health During Pregnancy: Theory & Assessment, Volume I, Second Edition,* Seattle: NCAST Publications, University of Washington.

Solchany, J. (2014) *Promoting Maternal Mental Health During Pregnancy: Intervention, Volume II, Second Edition*, Seattle: NCAST Publications, University of Washington.

Solchany, J. (2011) Practice *and Policy Brief: Psychotropic Medications and Foster Children.* American Bar Association.

Solchany, J. (2001) *Promoting Maternal Mental Health During Pregnancy: Theory, Assessment, & Intervention*, Seattle: NCAST Publications, University of Washington.

Articles, Book Chapters, and Other Media

[1]Peer Reviewed [2]Data Based

[1]Solchany, JE (2009), The Big Questions: Answering children's questions on adoption, feature article, *Adoptive Families*
[2]Solchany, J. & Pilnik, L. (2008), Healthy attachment for very young children in foster care. *Child Law Practice, 27*(6).
[2]Solchany, J. (2007), Consequences of divorce in infancy. Three case studies of growth faltering. *Zero to Three Journal*, 34-41.
[2]Solchany, J. & Barnard, K. (2006) *Can I trust you?* Translated into Japanese for the Infant Mental Health Journal of Japan, Tokyo, Japan
[1]Solchany, JE (2005), Making sense of adoption for the preschooler
[2]Solchany, J. & Barnard, K. (2005) *Can I trust you? Infant Mental Health*. Chapter 8 in J. Lombardi and M. Bogle (Eds.) *Beacon of Hope*, Washington D.C.: Zero to Three Publications.
[1]Solchany, JE (2005), Making sense of adoption for the preschooler, *Adoptive Families*
[1]Solchany, JE (2005), Did I come from your tummy? Understanding child-parent relationships, *Adoptive Families*
[1]Solchany, JE (2005), Oh, brother! Bringing home baby, impact on siblings, *Adoptive Families*
[1]Hill, S. & Solchany, JE (2005) Mental health assessments for infants and toddlers, *Family Law Review,* Fall.
[1]Solchany, JE (submitted for review, 2004) Internationally adopted children and their mothers: The role of fantasy. Journal of Reproductive and Infant Psychology.
[1]Solchany, JE (in press, 2004) When Internal Working Models Fail: The Work of Mothers Embracing Adoption, *Infants & Young Children*
[1]Solchany, JE, Mennet, L., Wiggins, N., & Barnard, K. (submitted for review, 2004) On my mind. Infant Mental Health Journal
[1]Brown, MA & Solchany, JE (2004) Two overlooked mood disorders in women: Subsyndromal and Prenatal Depression, *Nursing Clinics of North America, 39*(1), 83-96.
[2]Solchany, J. (2004,) Preschool Play, *Adoptive Families*
[2]Solchany, J. (2004) Talking to your preschooler about adoption, *Adoptive Families*, April, 2004.
[2]Solchany, J. (2004) The Only Child, *Adoptive Families*, January, 2004.
[1]Solchany, J. (2003) Issues of mental health in pregnancy. International Childbirth Education Association Journal.
[2]Solchany, J., Sligar, K., & Barnard, K. E. (2002) *Promoting maternal role attainment and attachment during pregnancy: The parent-child communication coaching program*. Chapter 4 in Infant and Toddler Mental Health, Models of Clinical Intervention with Infants and Their Families, Jesus Martin Maldonado Duran, M.D., Editor, Washington, D.C.: American Psychiatric Press.

Solchany, J. (2002, July/August) Parenting the child who waited. *Adoptive Families Magazine*, 55-56.

Solchany, J. (2002, May/June) Giving your child a vocabulary of feelings, Ages 3-5, *Adoptive Families Magazine,* 49.

Solchany, J. (2002) Regression in Children 6-8, *Adoptive Families Magazine*.

Solchany, J. (2001) Saying No to the 3-5 Year Old, *Adoptive Families Magazine.*

Solchany, J. (2001) 13 Plus: The Struggle for Independence, *Adoptive Families Magazine*.

Solchany, J. (January, 2002) Parenting the Child Traumatized within the Primary Caregiving Relationships, Bulletin of Zero to Three: National Center for Infants, Toddlers, and Families, Washington, D.C.: Zero to Three.

Solchany, J. (2001) 12 Points of Parenting the Adopted Child, Pamphlet, available from author.

[2]Solchany, J. & Barnard, K. (2001) Is Mom's mind on her baby? Infant Mental Health in Early Head Start. *Zero to Three*, Bulletin of Zero to Three: National Center for Infants, Toddlers, and Families, 22(1), Washington, D.C.: Zero to Three.

Barnard, K. & Solchany, J. (2001) Mothering. Chapter 1 in M. Bornstein's (Ed) Handbook of Parenting. Mahwah, New Jersey: Lawrence Earlbaum and Associates.

Solchany, J. (2001) *12 Points of Parenting the Young Adopted Child*, FCC Adoption Bulletin, June.

[2]Solchany, J. (2000) *Attachment based parenting for the adopted child*. Our Silk Road, 6(2).

Solchany, J. (2000) Video: *Attachment based parenting for the adopted child*. Produced by Americans Adopting Orphans, Seattle, WA.

[2]Solchany, J. (2000) *The Nature of Mothers Developing Relationships with their Adopted Chinese Daughters*. Doctoral Dissertations, University of Washington.

[1]Solchany, J. (1998) *Anticipating the Adopted Child: Women's pre-adoptive experiences becoming mothers to adopted childre*n. Canadian Journal of Nursing Research, 30(3), 123-129.

[2]Spieker, S., Solchany, J., McKenna, M., DeKlyen, M., & Barnard, K. (1999) *The story of mothers who are difficult to engage in prevention programs*. Chapter 6 in J. Osofsky and H.E. Fitzgerald's WAIMH Handbook of Infant Mental Health, Vol. 3.

FELLOWSHIPS & AWARDS

- Community Award for Supporting Early Connections, 2012
- Early Head Start Community Partner Award, 2006
- Finalist for the Harris Publishing Award, 2004.
- Nominated for 2003 International Award for Nursing Excellence, Sigma Theta Tau International, April/03
- Recipient of the Region I Nursing Media Print Award for *Promoting Maternal Mental Health During Pregnancy*, presented by Sigma Theta Tau International, Honor Society of Nursing, Pinnacle Awards
- Community Partner Award from Families with Children from China, November, 2001
- Solnit Fellow, Zero to Three National Center for Clinical Infant Studies, Washington, DC (2/2001-02)
- Dissertation Scholarship Award 1999, Pediatric Nursing Journal

REASEARCH

- Co-Primary Investigator, Supporting Early Connections, (2007-2011)—This project provided in home therapy services to children under 2 and their families who are referred to dependency court. Project was a collaboration between King County Dependency Court, DSHS, and Navos Community Mental Health. It was facilitated by CCYJ.
- Primary Investigator, Pregnancy, Adolescence, and Dental Health, (2005-2007), funded by Center for Rural Health Care Disparities
- Co-Primary Investigator, Homeless Families Project (2005-2009), funded by Gates Foundation, $150,000.
- Primary Investigator, *International Adoption Project* (2002-2005). Study funded by the Van Hooser Award, $10,000.
- Co-primary Investigator with Kathryn Barnard, *On My Mind Project*, University of Washington, School of Nursing (2002-3) Two year study funded by the Center for Mind, Brain, & Learning, $158,000.
- Co-primary Investigator with Susan Spieker, *Clinical Case Studies of Attachment in Children 0-3*, University of Washington, School of Nursing (in progress).
- Primary Investigator, *The Nature of Mothers Developing Relationships with their Adopted Chinese Daughters*, doctoral dissertation. University of Washington, School of Nursing (1998-2000; partially funded by Hester McLaws Foundation and Journal of Pediatric Nursing).
- Co-Primary Investigator with Kathryn Barnard, RN, PHD, *Parent Protective Factors, Low Risk Population*, pilot study, University of Washington, Seattle, WA, School of Nursing (1997-1999, funded by a grant by the University of Washington, School of Nursing).
- Primary Investigator, *Maternal Bonding in an Adoptive Context*, Pilot Study, University of Washington, Seattle, WA, School of Education (1997).
- Research Assistant, *Early Head Start National and Local Research*, with Dr. Kathryn Barnard and Dr. Susan Speiker, University of Washington, School of Nursing, Seattle, WA (11/96-present).
- Research Assistant, *Single Mother's Breast Cancer Study*, with Dr. Fran Lewis, University of Washington, School of Nursing, Seattle, WA (9/95-1/98).
- Principle Researcher, *Social and Sexual Behaviors of Children Who Molest Other Children*, Research Project Proposal, University of California, San Francisco, School of Nursing (1991).
- Rater for Inter-rater reliability check on newly developed projective test, PAIR: Pictures of Adult Infant Relationship Test, developed by Peggy Wilson, UCSF Doctoral Program, (1/91-6/91).

PROFESSIONAL & ACADEMIC MEMBERSHIPS

- International Honor Society of Nursing, Theta Omicron Chapter, College of Nursing, University of Alaska, Anchorage
- Child and Adolescent Psychiatric Nursing Association
- Zero to Three National Center for Clinical Infant Programs

SELECTED PRESENTATIONS
[1]Peer reviewed [2]Invited

- [2]Reflective Capacity and Parenting in the Perinatal Period, Oregon Infant Mental Health Association, 9.15
- [2]Pregancy & Mental Health, Early Head Start, Portland State University 7.13
- [2]Psychotropic Medications and Foster Children, Judicial Training, Colorado State, 7.13
- [2]Parental Mental Illness and Parenting, Little Red Schoolhouse/Child Thrive, Snohomish County 4.13
- [2]Pregancy & Mental Health, Nurse Family Partnership, Snohomish County 5.13
- [2]Parental Mental Illness and Parenting, Child Mental Health Conference, Orlando 9.12
- [2]Psychotropic Medications and Foster Children, Judicial Conference, Virginia Beach 8.12
- [2]Psychotropic Medications and Foster Children, CASA Conference, Washington DC 6.12
- [2]Psychotropic Medications and Foster Children, Judicial Training, Washington DC 5.12
- [2]Psychotropic Medications and Foster Children, Judicial Conference, Vermont 6.12
- [2]Psychotropic Medications and Foster Children, Judicial Conference, Keystone, CO 5.12
- [2]Early Childhood Mental Health Conference: Working with Mentally Ill Parents, Anchorage, AK, 4.12
- [2]Early Childhood Mental Health Conference, Anchorage, AK, 5.10
- [2]Maternal Mental Health in Pregnancy, Minnesota, 6.10
- [2]Reasonable Efforts Symposium, Seattle, WA, 4.10
- [1]King County Court Project, Zero to Three National Training Institute, Dallas, TX, 12.09
- [1]Healthy attachment in foster care, Colorado Summit on Child Abuse and neglect, 6.09
- [1]Impact of the Court on Baby Brain Development, Colorado Summit on Child Abuse and neglect, 6.09
- [2]Child Development and Foster Care, ABA Law Conference, May, 09
- [2]Brain Development, Infancy through Adolescence, ABA Law Conference, May, 09
- [2]Child Development and Foster Care, National CASA Conference, April, 09
- [2]Child Development and Foster Care, Idaho State Bar Association, April, 09
- [2]Child Development and Foster Care, Series of Judicial Trainings, State of New York, June, July & August, 2008
- [2]Pregnancy and Mental Health, Head Start, Minnesota, October 2008
- [2]Infant Brain Development, American Bar Association Training, Bethesda, MD, October, 2008
- [2]Infant Mental Health, American Bar Association Training for Arkansas CASAs, Little Rock, October, 2008
- [2]Child Development and Foster Care, Princeton University Woodrow Wilson School of Policy, New Jersey Public Defenders, October, 2008
- [1]Healthy attachment in foster care, Children's Law Conference, Savannah, Georgia, August, 2008
- [2]AWHONN Canadian National Conference, Halifax, Nova Scotia, Canada, Opening Keynote on Pregnancy and Mental Health; Internal working models in parents; Bonding and Attaching in Adoption (televised), October, 2007
- [2]Florida State University, Tallahassee, FL, Perinatal Mental Health, June, 2007
- [2]Mental Health Association, Findlay, Ohio, Perinatal Mental Health & Infant Mental Health, May, 2007
- [2]American Bar Association, Harrisburg, PA, Children and the Courts, May, 2007
- [2]King Country Court, Seattle, WA, Reasonable Efforts Symposium on Child Neglect, May, 2007
- [2]Prenatal & Perinatal Association, Watertown, NY, Perinatal Mental Health, April, 2007
- [2]Harvard Law School and American Bar Association, Children & the Courts, Boston, April, 2007
- [2]Iowa State Foster Care Program, Attachment and Young Children, Statewide Training, March, 2006
- [2]King County CASA Training, Child Development and Needs of Young Children, Seattle, February, 2006
- [2]Domestic Violence Conference, Therapeutic Interventions with Young Children, Seattle, November, 2005
- [1-2]NCAST Institute: Infant Mental Health, Three Case Studies: Divorce Trauma on the Growth and Development of Three Young Infants, Bellevue, WA, August, 2005
- [2]Domestic Violence Symposium, Impact of DV on Pregnancy and Infancy, Kent, WA, May, 2005
- [2]Sigma Theta Tau Induction Ceremony: *Research with Young Children*, Seattle, WA, May, 2004
- [2]Idaho Children's Trust Conference: *Mental Health in Pregnancy,* Boise, ID, April 2004
- [2]AWHON, *Mental Health in Pregnancy*, Cheyenne, Wyoming, April, 2004
- [2]Family Nurse Partnership, Keynote: *Mental Health in Pregnancy* & *Promoting Maternal Mental Health During Pregnancy*, Hershey, PA, April, 2004
- [2]Public Health Nurses, *Mental Health in Pregnancy*, Longview, WA March, 2004
- [2]Parents as Teachers, *Mental health in Pregnancy*, Coeur de Lane; Boise; Pocatello, ID, September, 2003
- [2]Ruralcap*, Mental Health in Pregnancy & Working with Difficult Families*, Anchorage, AK, August, 2003
- [2]Public Health Conference, Mental health in pregnancy, Wyoming, August, 2003
- [2]Mental Health in Pregnancy, Infant Mental Health Conference, San Juan College, Farmington, New Mexico, 2003
- [2]A Client Centered Approach: Mental Health, Substance Abuse, MCH, and Primary Care—Integration Summit, Region II (New York, New Jersey, Virgin Islands, & Puerto Rico), *Stress, Pregnancy, and Mental Health*, Brooklyn, NY, March, 2003
- [2]Family Nurse Partnership, David Old's Program, *Working with Difficult to Engage Families*, Kansas City, Missouri, 4.03
- Zero to Three NTI, *12 Points of Parenting the Young Adopted Child*, Washington, DC, December, 2002
- [1]International Adoption Conference, *Attachment Focused Parenting*, Toronto, Canada, November, 2002
- [2]State of Colorado, Public Health, Old's Program, *Stress and Pregnancy & Working with Difficult to Engage Families*, November, 2002.
- [2]Early Head Start, New York University, *Stress and Pregnancy*, October, 2002
- [2]NCAST Institute, *Promoting Maternal Mental Health During Pregnancy*, Bellevue, WA, August 2002.
- [1]AWHONN, *Promoting Maternal Mental Health During Pregnancy*, Boston, June, 2002
- [2]New Jersey Perinatal Cooperative*, The Impact of Stress During Pregnancy*, Cherry Hill, New Jersey, May, 2002.
- [2]Child Therapy Association & U.W. School of Nursing, Trauma and Attachment, April 2002.
- [2]Seattle & King County Public Health*, Mental Health in Pregnancy*, Seattle, WA, March, 2002.
- [2]Regions 9 & 10 Early Head Start Conference*, Maternal Mental Health During Pregnancy*, Seattle, WA, August, 2002.
- *[1]Internal Working Models of Adoptive Mothers*, American Academy of Pediatrics Annual Meeting, San Francisco, CA
- *[2]Adoption/Foster Care/Kinship Placement,* University of Washington, Psychiatric Resident Program, March 2001.
- *[2]How Adoptive Mothers Develop Relationships with their Children*, Attachment Conference, Attachment Center NW, Shoreline, WA,

March, 2001
- [2]*Relationship Enhancement Parenting: Attachment Based Parenting in Adoptive Families*, WACAP/Americans Adopting Orphans, Seattle, WA, March/June/September, 2001/ March/June, 2002
- *Working with Difficult Families*, Early Head Start/Zero to Three, invited speaker, Washington, DC, January 2001.
- [1,2]*The Impact of Maternal Childhood Trauma and Loss on Parenting*, invited speaker, Zero to Three, National Center for Infant Studies 15th annual National Training Institute, Washington D.C., December, 2000.
- [1]*Program Engagement, Adult Attachment Status, and the Parent-Child Relationship*, International Society for Infant Studies, Brighton, England, July, 2000
- [1]Infant Observation of a Chinese Adopted Baby, Zero to Three, December 1999, Anaheim, CA.
- [1]Difficult and Easy to Engage Families, presented at Society for Research in Child Development, April 15, 1999, Albuquerque, New Mexico
- Play, Aggression, Sexuality & Emotion, Ages and Stages for 0-5, Head Start Training, Neighborhood House, Seattle 3.99
- Infant Observation with a Baby Adopted from China: A case presentation, Center for Object Relations, Seattle, WA. 2/5/99
- DC: 0-3: Assessment and Diagnostics of Children 0-3, San Mateo County, CA, co-taught with Jean Thomas, MD. Jan99.
- Diagnostic Mental Health and Developmental Disorder Classification for 03, University of Washington School of Social Work Continuing Education Program and School of Nursing, October and November, 1998
- [1]Head Start Research Conference, two Poster Presentations: Working With Difficult to Engage Mothers and Improving Parent-Child Interaction Through as Early Reading Program, 7/98
- Adult Attachment & Difficult to Engage Mothers, Zero to Three Board of Directors, April, 1998

PROFESSIONAL COMMUNITY ACTIVITIES

Expert Panel on Mental Health & Pregnancy, Member, Early Head Start & Zero to Three, Washington DC, 4.09-present
Snohomish County Nurse Family Partnership Program, Advisory Board, Everett, WA, 2007-present
American Bar Association Center on Children and the Law, Advisory Board, Washington, DC, 2006-present
Bright Futures, Federal Task Force on Pregnancy and Post-partum, Washington, DC, 2005-present.
March of Dimes, Prematurity Task Force & Steering Committee, Seattle, Jan. 2003-2006
Reviewer, Brooke's Publishing Co. Baltimore, Maryland, Oct., 2002
Infant Mental Health Task Force, Washington, D.C, Zero to Three (1999-2006)
DC: 0-3 Training Task Force, Washington, D.C, Zero to Three (1999-2004)
Expert Consultant, Civitas, Chicago, Contributed to Prenatal, Adoption, and Grandparenting Sections of 0-3 Project, (2001-2002)
Guest Editor, Journal of Transcultural Nursing, (11/00-12/00)
Member, Mental Health Training Task Force, Kent Regional Justice Center, Family Court, (4/99-4/00)
National Certification Exam Item Writer for Child & Adolescent Psychiatric & Mental Health Clinical Nurse Specialist Exam, American Nurses Credentialing Center, Washington D.C. (3/99-3/01)
Member, Infant Mental Health Eastside Group, Redmond, WA (1/99-2004)
Member, Ad Hoc Committee, Outcome Evaluation, Children's Home Society, Seattle, WA (2/99-12/99)
Member, Infant Mental Health Task Force, Seattle WA (11/97-04)
Consultant, KTBY Anchorage Channel 4 Project on Self-Esteem, (3/95-7/95).
Consultant, Friends of Children, Task force for Services for Sexually Abused Children, (3/93-12/94).
Board Member, Board of Directors, Abused Women's Aid in Crisis, "AWAIC"
Anchorage, AK (6/88-7/89)

ACADEMIC TEACHING

Masters Committees: Multiple Master's Committee Chair & Member Positions

PhD Committees: Multiple PhD Committee Chair & Member Positions in Nursing, Psychology, Education & Genetics

Multiple Courses Taught in Nursing, Child Development, Social Work, Education, & Medicine, Graduate, Undergraduate, and Post Graduate