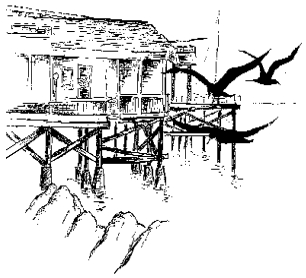
The Monterey County Chapter

California Association of Marriage and Family Therapists

September / October 2021 Newsletter



Benefits to MC-CAMFT Membership:

- Reduced fees at our events
- Invitation to our Members only annual gatherings
- Access to Members only Salons, which are intimate workshop offerings taught by fellow Members
- Periodic Newsletter with relevant CAMFT informa tion and Member created writing
- Opportunity to contribute your writing to our News letter, including things such as a column, book re view, workshop or conference review, poem, opinion piece or article
- Free advertising in our Newsletter and "Classifieds" section of our website
- Inclusion in our "Find a Therapist" website directory
- Access to Member and Announcements Forum on our website where you can seek feedback from other members and post things to the community
- Opportunity to submit a proposal to host a Salon for our Members
- Option to join us on the Board as a volunteer com mittee chair or ad hoc committee member
- Opportunity for MC-CAMFT to co-sponsor your workshop, so you can offer CEUs to your attendees
- Free Mentoring by experienced clinicians
- Invitation to suggest any member activity you find interesting, and we'll consider it!

Benefits to MC-CAMFT Website:

◊ Current Member Directory
◊ Classifieds Page for Members
◊ Chapter Board Contact
◊ Specialized Forums
◊ Online Newsletter
◊ Networking Opportunities
◊ Chapter Documents Access
◊ Sponsorship Opportunities
◊ Membership Information

MC-CAMFT CALENDAR

OCTOBER 2021 - Save The Date!

Road to Licensure

Date: October 2nd, 2021
Time: 10:00a.m. to 12:00 p.m. (Pacific Time)
Place: Online Webinar – Details at Registration
Fees:
Pre-licensed MC-CAMFT Member $10
Licensed MC-CAMFT Member $10

OCTOBER 2021 - Save The Date!

Law and Ethics Presentation

Date: October 22nd, 2021
Time: 9:00a.m. to 4:30 p.m. (Pacific Time)
Place: Online Webinar – Details at Registration
Fees:
Licensed MC-CAMFT Member $40
Pre-licensed MC-CAMFT Member $30

In This Issue...

2021 Board/Committee	pg. 2
President's Message	pg. 3
Featured Book	pg. 4
Events & News	pgs. 5-8
Couples Corner	pg. 9
Guest Articles	pgs. 10-17
Member Ads	pg. 18
Newsletter Deadlines	pg. 19

2021 MC-CAMFT Board Roster

2021
Board of Directors
- Officers -

President:
Jennifer Farley
jennifer@shamanhealingmonterey.com

Treasurer:
Susan West
831-206-7639

Secretary:
Rochelle Hall
rochellehall.consult@gmail.com

2021
- Committee Chairs -

Membership Chair: OPEN
Public Relations: OPEN
Programs Chair: OPEN
Pre-Licensed 3000 Hour Club Chair: OPEN

Legislative & Ethics Chair:
Michael Newman

Mentorship Chair:
Pat McDermott, LMFT
patmcdermft@comcast.net

Newsletter Editor:
Ross E. Farley III
ross@shinealight.info

Hospitality Chair:
Olivia Fae Stadler
olivia.stadler@yahoo.com

Continuing Education Chair:
Raceal McWhorter, LMFT
racealarttherapist@gmail.com

Member-At-Large:
Carmen Martin, LMFT
lovehealing@me.com

Member-At-Large:
Sarah Lauterbach, LMFT
sarahlauterbach.lmft@gmail.com

Like Us on Facebook!
Connect with your colleagues through the Monterey Chapter CAMFT Facebook page.

Jennifer Farley

2021 Board President

I'd like to call your attention to an addition we included in this particular newsletter; we have a "featured book" in this edition. A dear community member, Robin Defilippi, connected us with Martha Paradis- author of the book Flowers & Locusts. Martha was scheduled to do an in person workshop for us right as the reality of the pandemic set in, and we've been in communication ever since working on the possibility of rescheduling her for an event. The bad news is that this won't be able to happen. The good news is that Martha has written a very expressive book that shares about her life experience growing up in Ethiopia. Martha, currently a trauma psychotherapist based on the east coast, brings a distinct lens to the work of helping people heal their unresolved trauma that is influenced by her unique life experience. I highly encourage you to read more about her and her book, and to purchase it! Martha has told me that she is hoping to donate the proceeds from her book to support a scholarship for an Ethiopian student.

We do have a couple of virtual CE events planned for October. To support our pre-licensed members (and perhaps clinical supervisors who'd like to brush up on licensure requirements), we are offering a Road to Licensure workshop. In the theme of understanding the fundamentals, we also have a 6 hour Law and Ethics workshop planned for later in October. If you are in need of your L&E CEs, we've got you covered!

Lastly, I'd like to thank all of you who took the time to fill out the in-person event survey. We had a great pool of participation, which gives us valuable information needed to plan for the future. In the midst of things continuing to change, it is really helpful to understand what our membership prefers. Thank you again!

Welcoming in a hint of autumn...

May You Be Well,

Jennifer Farley

Flowers & Locusts

by Martha Reid Paradis

Synopsis:

MY CHILDHOOD IN ETHIOPIA

In an era when only a few weekly flights served the royal capital and television had not yet come to Ethiopia, the memoir Flowers & Locusts chronicles the tumultuous childhood of an American girl whose father served as adviser to the legendary Emperor Haile Selassie.

From the girl's earliest memory as her family drives through embattled streets during an attempted revolution, to the poignant ending as she is torn from the people she has come to love, the author brings to vivid life momentous events in this ancient African land. At nights when hyenas roam her neighborhood and during enchanted days of adventures and misadventures with a beloved younger brother, the girl's voice - in recounting her father's kidnapping, a gala party at the Palace, or her touching relationship with a young girl in an orphanage - memorably captures the deep emotional texture of her experience.

Known to the ancient world as Abyssinia, Ethiopia is the stage on which are played out universal themes: the longing we all share for the lost innocence of youth, and the family relationships, struggles of childhood growth, and early loves that shape us. While the Ethiopia of her childhood no longer exists, Flowers & Locusts offers a chance to enter into a bygone world whose mysteries linger in the author's mind and that of its people.

About Martha Paradis

Martha Paradis spent her childhood in the remote country of Ethiopia, where her father served as legal advisor to the legendary Emperor Haile Selassie. Her family moved to London, England in the late 1960's, and she then pursued her university studies and career in her home country of the United States. For the past thirty years she has been a psychotherapist with a specialty in trauma resolution and healing childhood wounds. Ms. Paradis lives in suburban New Jersey with her husband Bob, and has two grown children. She maintains her lifelong interest in world cultures and still considers Ethiopia the home of her heart.

Link to purchase the book:
https://secure.mybookorders.com/mbo_index.php?isbn=9781545609910

October 2nd, 2021 - SAVE THE DATE!

"Road to Licensure"

This presentation is intended to provide an overview of the licensing process for pre-licensees as they work toward licensure in marriage and family therapy. Topics to be discussed include: the marriage and family therapy licensing process; supervised experience requirements for applicants; supervisor qualifications and supervision requirements; licensing examinations; and common employment issues pre-licensees encounter with their supervisors. This is an introductory learning level presentation.

Learning Objectives:

Participants will be able to:

· Record the number of hours and the number of weeks of supervised experience required

· Identify the "options" for counting hours currently available to pre-licensees

· Apply how the 90-day rules impacts their ability to count hours

· Differentiate how to advertise themselves in the various stages of licensing

· Organize their hours by documenting on the correct BBS related forms

· Review their incremental progress toward licensure and decide on their best strategies to take to complete their 3000 hours

Luke Matthew Martin, Esq., a member of the State Bar of California since 2011, joined CAMFT as a Staff Attorney in 2019. He holds a Master of Business Administration with honors and a Juris Doctorate Degree specializing in Child, Family and Elder Law with honors. Prior to coming to CAMFT, Luke ran a private practice focusing on civil litigation and represented several businesses with annual revenues in the millions. He has been recognized by the State Bar of California with the Wiley E. Manuel Certificate for Pro Bono Legal Services for his legal assistance in helping victims of domestic violence. In addition to his work at CAMFT, Luke is an adjunct professor for several universities lecturing on political science and business law and sits on University of Arizona's Faculty Senate.

PLEASE NOTE: This presentation is curated by state CAMFT and is being offered exclusively to our chapter members along with members of other chapters. At this time, we will be offering CEs for MFTs, LPCCs and LCSWs only.

October 22nd, 2021 - SAVE THE DATE!

"Law and Ethics Presentation"

Presenters: Bradley J. Muldrow, Esq., Alain Montgomery, Esq., Sara Jasper, Esq. & Mike Griffin, LCSW, Esq.

Location: Online

Date/Time: Friday, October 22, 2021, 9:00 AM-4:30 PM

Schedule:

9:00-10:30 ***"Avoiding Sour Notes and Broken Records: Guidance for Creating and Maintaining Effective Patient Records"*** presented by Bradley J. Muldrow, Esq.

10:30-10:45 BREAK

10:45 am – 12:15 pm ***"Guidelines for Writing Letters and Offering Professional Opinions"*** presented by Alain Montgomery, Esq.

12:15-1:15 LUNCH

1:15 pm– 2:45 pm ***"Updates and Resources for Providers Navigating Managed Care in California"*** presented by Sara Jasper, Esq.

2:45-3:00 BREAK

3:00 pm – 4:30 pm ***"Tarasoff and Dangerous Patients"*** presented by Mike Griffin, LCSW, Esq.

Number of CEs: 6

Pricing Categories/Respective Prices:

Licensed MC-CAMFT Member $40

Pre-licensed MC-CAMFT Member $30

PLEASE NOTE: This presentation is curated by state CAMFT and is being offered exclusively to our chapter members along with members of other chapters. At this time, we will be offering CEs for MFTs, LPCCs and LCSWs only.

October 22nd, 2021 - SAVE THE DATE!

"Avoiding Sour Notes and Broken Records: Guidance for Creating and Maintaining Effective Patient Records"

Description:
"How much detail should I include when recording notes?" "How long do I have to keep patient records following termination?" CAMFT staff attorneys receive numerous calls from practitioners who are curious about these and other recordkeeping topics. This workshop will provide therapists with the information they need to create and maintain effective patient records.

Presenter Bio:
As a CAMFT staff attorney, **Bradley J. Muldrow, Esq.** takes member phone calls regarding law and ethics issues and contributes articles on those subjects to CAMFT's publication, the Therapist. Prior to joining CAMFT's legal team, Brad worked on litigation and regulatory matters as an attorney for San Diego Gas & Electric Company. Since becoming an attorney, Brad has given law and ethics presentations to attorneys and judges as a member of the J. Clifford Wallace Inn of Court. He has also served as a board member for the Earl B. Gilliam Bar Foundation, a San Diego-based nonprofit.

"Guidelines for Writing Letters and Offering Professional Opinions"

Description:
Therapists are asked to write letters and/or offer professional opinions on behalf of a client. During this 90-minute presentation, CAMFT Staff Attorney Alain Montgomery will review the key legal and ethical standards for a therapist to consider before either providing a letter to a client or offering a professional opinion.

Presenter Bio:
Alain Lance Montgomery, Esq., is a member of the State Bar of California. Alain received a Bachelor of Arts degree in Political Science from the University of California at Berkeley and a Juris Doctor degree from Thomas Jefferson School of Law. Prior to joining the CAMFT legal department, Alain worked in public interest law as a legal advisor for the Superior Court of California where he helped self-represented parties navigate the complexities of small claims litigation. As a member of the CAMFT legal department, Alain has served as part of the support staff for the CAMFT Ethics Committee and has represented the Association at various state regulatory board meetings. After graduating from college and before attending law school, Alain worked as a ski instructor at Mammoth Mountain Ski Resort.

October 22nd, 2021 - SAVE THE DATE!

"Updates and Resources for Providers Navigating Managed Care in California"

Description:
California's managed care systems are complex and often difficult for even the most seasoned providers to navigate. During her 90-minute presentation, CAMFT Staff Attorney Sara Jasper will provide a brief overview of managed care, review new laws intended to improve patients' access to care and offer resources designed to support providers and patients. Ms. Jasper will also discuss the types of audits managed care providers may be subject to and the laws that govern providers' responses.

Presenter Bio:
A member of the State Bar of California since 2008, **Sara Jasper, Esq.** joined CAMFT as a Staff Attorney in 2011. Before coming to CAMFT, she worked as the Legal Liaison and Administrative Officer for the Sacramento Police Department and as an Associate at Middleton, Young & Minney, LLP where she practiced education and employment law. During law school, Sara clerked for the California Judicial Council, Center for Children, Families and the Courts and for the National Center for Youth Law. Since joining CAMFT, Sara has become a Certified Association Executive and earned her certificate in Nonprofit Organization Management. As a CAMFT staff attorney, Brad takes member phone calls regarding law and ethics issues and contributes articles on those subjects to CAMFT's publication, the Therapist. Prior to joining CAMFT's legal team, Brad worked on litigation and regulatory matters as an attorney for San Diego Gas & Electric Company.

"Tarasoff and Dangerous Patients"

Description:
This 1 ½ hour workshop will discuss key issues involved when working with dangerous clients, including, relevant standards of care, the "duty to protect" (based upon Tarasoff v. Regents of Univ. of California, and Civil Code §43,92), "patient communication" (based upon Ewing v. Goldstein and Ewing v. Northridge Hospital Center), the "duty to report"(based upon Welfare & Institutions Code, sections 8100(b)(1) and 8105(c)), and relevant exceptions to confidentiality.

Presenter Bio:
Michael Griffin, Esq., LCSW has been a member of the CAMFT legal team since 2007. A graduate of the USC School of Social Work and Chapman University School of Law, Mr. Griffin earned his LCSW in 1982 and his California license as an Attorney in 2002. He has a broad professional background in various mental health settings (including Western Youth Services in Orange County, California, and Rady Children's Psychiatry Dep't in San Diego) as a clinician, administrator, supervisor, clinical case manager, school program coordinator, and outpatient clinic director, and has served as an oral examiner for LCSW candidates. In addition to his work for CAMFT, Mr. Griffin is a practicing psychotherapist with adults, adolescents and children in Laguna Niguel, California.

Member Article

Couples Corner

offered by EFT trained therapist **Amy Somers**

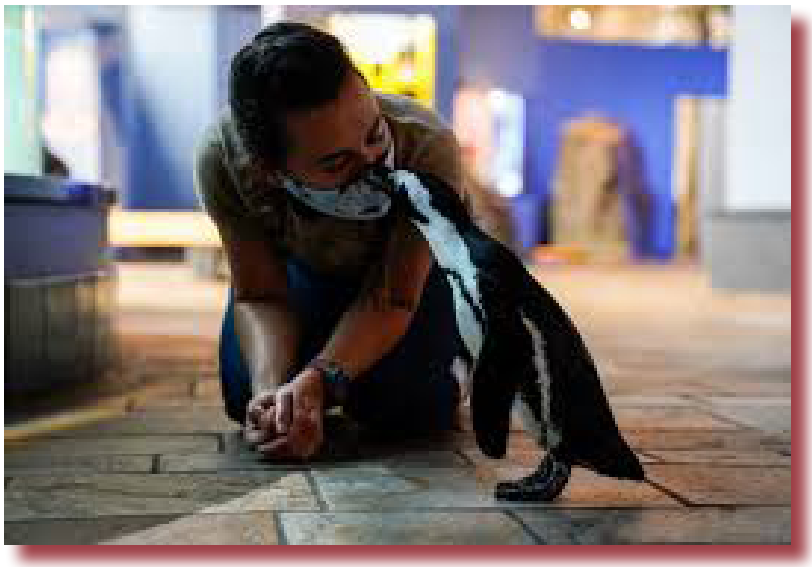
One of the hardest places to be in relationship for me is after my partner rubs up against a raw spot unknowingly and my activation goes through the roof. There is a physiological reaction that happens in my body that takes me via trauma time capsule to an earlier time of unmet needs. My heart starts racing and my blinders go on, black and white thinking surfaces to run the show and my neck, shoulders, and back bunch up to match my clenched jaw and fists. The color might leave the room too. I'm a mess and know it as soon as I sense the final flush on my face. Viscerally, I feel old grooves pulling me to yell and scream, shut down/dissociate or run away. I want to do all three. And then I remember EFT.

EFT tells me I can choose a different outcome and heal my attachment of origin. Because this is where the truth lies, even though everything in me tells me it's my partner that just did me wrong. Oftentimes I even forget what to do, I just know I have a different choice. This space is where my power sits. The power of forging a new neural pathway like a pioneer, to a place I barely know in that moment. Lately, I feel like it's an act of faith, a jumping off and hoping I land in our secure attachment, which we refer to as The Third. Last time this happened, I didn't even feel it, but I knew somehow it was there. So, I waded through all the solid partner wrongdoings list in my head (simply "content" in EFT) and jumped. I even narrated, something like "I don't even feel The Third right now, but I know it exists and I will meet you there."

The leap of faith (luckily) paid off. As soon I landed, all the body symptoms slowly cleared and I could see color again: in my thinking, my emotions and in my world. I didn't know what else to do so I belly breathed and waited. I waited a while. I squirmed. I wriggled.

I really wanted out of that vulnerable space, but I stayed. It felt so icky and awkward, excruciating even. My husband was slower, but he eventually followed me. "I'm here, waiting for you," I insisted, "I love you, you're safe, I'm here and It's okay." He joined me after a while (evidently a big part of EFT is patience and perseverance) and we decided how to reconnect.

I usually choose a slow dance, to match breathing, look into each other's eyes and feel our heartbeats. No words, just holding each other and re-connecting in a positive way; co-regulation. But this can be anything that feels right to both partners. It's good to have a go-to previously agreed upon. Saves time. So, we slowed danced our way back into secure attachment land for a while. I know there are potholes out there and my raw spots will continue to get rubbed up against and our tranquility may be short lived. But the more I practice the leap, the better I get at it. After 28 years we continue to learn. Thank goodness it's still together.



Guest Article

Pandemic Burnout and Compassion Fatigue

Are some in society at the low ebb of empathy and compassion for anti-vaxxers?

By Suzanne Degges-White Ph.D.

KEY POINTS

***Compassion fatigue is a normal development after long-term or intense exposure to trauma.**

***Burnout is sometimes called the erosion of the soul due to its destructive path.**

***Self-care is essential to helping heal from the pain caused by the pandemic.**

Whether it's in the airport, a school board meeting, a grocery store, or your own neighborhood, it seems that the dividing line between the vaxxers and the anti-vaxxers is one of the most clear-cut divisions we've seen between people in recent history.

Research indicates that 2020 was a year of ups and downs and highs and lows as we tried to make the best of the no longer so very "new" normal. In fact, a Gallup poll indicated that while we hit a low regarding our subjective assessment of our wellbeing in April of 2020, and ended the year at the third-lowest level since 2009. Our experiences of stress, worry, sadness, and anger all were heading up the chart to new levels as our well-being headed in the opposite direction.

It was a long and difficult year, but making it through to summer 2021, when we believed we'd be past the worst of the pandemic, was a motivating factor for continuing to keep moving forward. Between the pandemic and the political drama, 2020 was a painful year.

There have been several recent stories about the deaths of "COVID-deniers" to COVID-19 itself in the news. Family members are left behind who are grieving, but their loss and the loss of life are minimalized and treated as a punch line to a joke. Whether "karma" is referenced or a Twitter comment about the "ultimate irony," there is an "I told you so" reaction. However, the truths of science do suggest that refusing to follow safety protocols that minimize the risk of disease can result in infection, resulting in death.

Unfortunately, many people are now at the low ebb of empathy and compassion for others, especially those who do not see the world–or public health–in the same way. Folks who don't believe the value of vaccines or masking are being encouraged to protect their freedom by some political players and are thereby putting the wellbeing of others at greater risk. No longer is there a sense of "we're all in this together," but rather a feeling of "us vs. them" that keeps the divide between the two perspectives widening and deepening.

When people liken the choice to skip the vaccine and go unmasked to choosing to smoke even if we know it contributes to cancer or to skip the seatbelt even though we know wearing one saves lives, the big "but" in the comparison is that COVID-19 is a communicable disease that doesn't necessarily end its trajectory with one particular host–it jumps from person to person putting many more people at risk than just the one individual who is anti-vax or anti-mask.

Pandemic Anxiety and its Fallout

The loss of life to COVID-19 in the nation is an atrocity, and when we all have watched the death toll climb from a handful of deaths to over half a million, our ability to feel begins to fray. Caring and compassion for others take energy–and each of us has had our stores of emotional and mental energy depleted as we've all dealt with the pandemic anxiety that began in early 2020.

Our resources may be less fully stocked today than they were, even during early summer 2021 when we finally realized that we were getting past the pandemic. Now that we've seen that the numbers can tick back up and that virulent anti-masking/vaxxing political leaders can keep the numbers high, it can be hard to feel compassion for folks who are seemingly choosing to ignore best practices and to do what is in their own best interest for survival.

If you've found yourself at the end of your caring capacity, you're normal. Compassion fatigue typically comes from exposure to trauma, and many of us may feel as if the past 18 months have been one long public health/personal wellbeing/national trauma. It may also be Pandemic Burnout, which is not trauma-related but leaves us feeling exhausted emotionally and physically and leads us to withdraw from the world. Compassion fatigue can hit us with a wallop, and we suddenly realize just how overwhelmed we feel. Burnout, however, is more of a cumulative, slow burn that slowly sucks out the enthusiasm and positive energy we felt for life.

Easing Compassion Fatigue

Compassion fatigue and burnout both leave us feeling out-of-sorts, exhausted, doubting the meaning of what we do, and cognitively and emotionally exhausted. Compassion fatigue, however, can usually be more easily ameliorated as taking time away to recharge and refresh can help us care for ourselves so that we feel better able to return to the world of caring for others. Some self-help measures including finding a good friend or a helping professional to talk with; taking care of your body–exercising, eating right, getting enough sleep; taking time away from the job or the situation of concern (respite care for the caregiver), and finding interests that are unrelated to the area of concern to allow yourself space to let go of the worry.

Easing Pandemic Burnout

Unfortunately, burnout is more than fatigue–it's often felt as a loss of self or loss of soul. However, self-care and a break away from the situation that has led to burnout are two key factors in helping relieve this distress. Meditation, yoga, and other mindfulness-focused activities can be especially helpful in minimizing burnout. Getting enough sleep–but not overusing sleep as an escape plan–is important, as is diet and tending to physical needs. Making sure you schedule time for creative pursuits or other forms of relaxation gives you something to look forward to and something that helps you feel there is a reason to keep moving forward.

Researchers suggest that many people are planning to re-invent their career path, and this may be a result of pandemic burnout. Burnout often leaves us feeling that we don't care about what we once felt passionate about. Sometimes, finding a new passion can recharge and refill our emotional, mental, physical, and spiritual reserves when this feeling of emptiness is felt. Sometimes a clean break is needed to get away from the vacuum that has sucked out your life force.

Conclusion

If you're feeling pandemic burnout, if you can't muster any compassion or empathy for those suffering, and you feel that you want to lock yourself away from the world, take your feelings seriously. Reach out to a caring and concerned person or a professional helper. Life has been harder for many than it has been in our own histories, and it's okay to be overwhelmed.

*This article was copied from https://www.psychologytoday.com/us/blog/lifetime-connections/202108/pandemic-burnout-and-compassion-fatigue

Guest Article

Defining Attachment and Bonding: *Overlaps, Differences and Implications for Music Therapy Clinical Practice and Research in the Neonatal Intensive Care Unit (NICU)*

By: Mark Ettenberger, Łucja Bieleninik, Shulamit Epstein and Cochavit Elefant 5

Abstract:

Preterm birth and the subsequent hospitalization in the Neonatal Intensive Care Unit (NICU) is a challenging life event for parents and babies. Stress, anxiety, and depressive symptoms, limitations in holding or touching the baby, and medical complications during the NICU stay can negatively affect parental mental health. This can threaten the developing parent-infant relationship and might adversely impact child development. Music therapy in the NICU is an internationally growing field of clinical practice and research and is increasingly applied to promote relationship building between parents and babies. The two most commonly used concepts describing the early parent-infant relationship are 'attachment' and 'bonding'. While frequently used interchangeably in the literature, they are actually not the same and describe distinctive processes of the early relationship formation. Thus, it is important to discuss the overlaps and differences between attachment and bonding and the implications for music therapy clinical practice and research. Whereas providing examples and possible scenarios for music therapists working on either bonding or attachment, the distinction between both concepts is relevant for many health care professionals concerned with early parenting interventions in the NICU. This will hopefully lead to a more precise use of theory, and ultimately, to a more informed clinical practice and research.

Keywords:

Music therapy; bonding; attachment; preterm infants; Neonatal Intensive Care Unit (NICU); family-centered care.

Introduction

The formation of positive emotional bonds between parents and their baby is one of the most significant foundations in the construction of a healthy parent–infant relationship and fundamental for the newborn's development later on in life [1,2].

This is a process that begins early in pregnancy, lasting throughout its entire period, and continues after childbirth [3,4]. How both mothers and fathers feel towards their unborn baby and the behaviors they show is influenced by many factors, including parental mental health, social support, complications during pregnancy, or previous pregnancies, among others [5]. While individual differences exist in terms of timing, duration, and form, the maternal–fetal relationship usually intensifies over time, although many mothers experience a significant shift when they notice the first fetal movements in the transition from the 2nd to the 3rd trimester [6,7]. This is also the time when the baby progressively reacts to external stimuli such as the mother's voice and touch [8,9] and thus it is no surprise that parents increasingly start interacting with their baby during this time. The paternal–fetal relationship is not yet as well investigated, but it has been shown that also men go through physiological and psychological changes in their journey towards fatherhood, which influence the quality of their interactions with the newborn after birth [10]. Additionally, the emotional bonds that parents form with the fetus are also affected by the early relational experiences with their own primary caregivers. Thus, the parents' own attachment representations can have an effect on their behavior pre- and postnatally and constitute some of the earliest moderators for child development [6,10].

When a baby is born preterm (defined as less than 37 weeks of gestation), this process can get interrupted. Often, preterm birth appears suddenly and unexpectedly, in a time when parents might not yet be psychologically prepared to become parents [11]. Preterm delivery differs a great deal from how parents imagine the labor situation and regularly takes place in an emergency context. Lack of control, uncertainty about the baby's health, medical complications in the course of the delivery, and a possible hospitalization of the mother herself may furthermore add emotional burden to parents postpartum. In the Neonatal Intensive Care Unit (NICU), having a preterm baby needing life sustaining medical treatment can trigger depressive symptoms in parents [12] or increase the risk for developing postpartum depression [13]. Anxiety, guilt, shame, anger, resignation, and the disruption of family life are further challenges that may alter the transition to parenthood or can cause symptoms of Post-traumatic Stress Disorder or Acute Stress Disorder [14–16].

This situation can pose a threat to the continuum or stability of the emerging parent–infant relationship. Consequently, several studies and reviews have highlighted the risks for an impaired bonding in parents of preterm babies and the possible repercussions for child development [17–19]. Yet, there is also contrasting information on this topic and not all parents experience these challenges similarly. A recent meta-analysis shows for example just slightly elevated stress levels in parents of preterm babies [20] and other studies found no differences in maternal attachment representations or in maternal sensitivity when compared to parents of full-term babies [21,22]. Thus, relationship building in the NICU requires a differential view. While the hospitalization in the NICU might be a stressor that can trigger parental mental health challenges and negatively affect the parent–infant relationship, coping mechanisms differ from family to family, and even from mothers to fathers [23]. Thus, an individualized view is required, taking into account the parents' own relational experiences, occurrences during pregnancy, their coping mechanisms, resilience, social support networks, mental health history, and socio-demographic factors.

This article will discuss two of the most commonly used concepts when describing the early parent-infant relationship: attachment and bonding. The overlaps and differences between both concepts are highly relevant for health care professionals, including music therapists. Distinctions in focus, measurements and definitions will be outlined and examples of possible scenarios for music therapists working on either attachment or bonding will be described.

Early Parenting Interventions and Family-Centered Music Therapy in the NICU

In recent decades, there has been increasing acknowledgement of the importance of early parenting interventions in the NICU. Such interventions usually focus on improving parental mental health, infant development, and on promoting healthy parent–infant interactions [24]. Music therapy (MT) has been applied in the NICU for several decades, but the integration of family-centered care models is a newer phenomenon [25]. In coherence with other early parenting interventions, family-centered MT addresses both infants' and parents' needs, as well as the emerging relationship between them [26]. While recent research confirms the beneficial effects of MT on immediate or short-term outcomes for infants during their NICU stay [27–30], assessing the parent-infant relationship is one of the main research gaps in the literature [31]. To date, only a handful of studies have evaluated the impact of MT in this regard and these studies report mixed results. Parent–infant bonding improved but did not differ significantly for parents who received MT in two small-scale Randomized Controlled Trials (RCTs) [32,33].

In two other studies, parents improved their bonding scores from pre- to post-intervention timepoints, but statistical significance was not achieved [34,35]. A non-randomized controlled study, which assessed parent–infant interactions at one-month post-treatment, found no significant differences between MT and control groups [36].

Thus, a systematic understanding of how MT contributes to the relationship formation between parents and preterm babies is still lacking. However, a variety of models, theories and interventions exist within the field of neonatal music therapy and specific focus on bonding and attachment can be found for example in the Rhythm, Breath, Lullaby (RBL) model [37], in Creative Music Therapy (CMT) [38], or in the before-mentioned family- centered music therapy approaches [26]. With respect to research, a current international multi-center randomized controlled trial entitled is also beginning to address this gap in knowledge by assessing parental bonding during hospitalization and up to 12 months of corrected age [39].

Attachment versus Bonding

Taking this into consideration, a critical aspect to better understand how preterm birth affects the parent–infant relationship, and if MT might act as a supportive factor in this process, is to clearly determine the phenomena under discussion.

Relationship building is a multifactorial and complex process and two of the most commonly used concepts in this regard are 'attachment' and 'bonding'. While both concepts are often used interchangeably in the literature, they are not the same [40,41]. Since concepts are the building blocks of theories and describe specific aspects of reality, it is therefore important to first clarify the overlaps and differences between attachment and bonding.

Attachment

The two pioneers in describing the bases of early relationship building were John Bowlby (1907–1990) and Mary Ainsworth (1913–1999). Both contextualized the develop- ment of relationships in the social context of the family, and, in particular, concerning the mother–infant relationship. As a result, they coined the notion of 'attachment' as one of the fundamental processes of how relationships emerge, build up, and mature during early childhood. Initially, attachment theory started to take shape in the 1930s and 1940s as a result of research about the personality development of children who required prolonged institutional care and therefore experienced regular changes in their primary caregivers during early infancy [42].

The full theory however was not published until the late 1960s with the first volume of the book trilogy "Attachment and Loss" in 1969 [43], and the second and third volume in 1973 ("Separation Anxiety and Anger") [44] and 1980 ("Loss, Sadness and Depression") [45].

According to Bowlby, the survival value of attachment was not limited to physical needs. He described attachment as a spatial concept, related to the proximity of a new-born and his primary caregiver (i.e., 'mother-figure') during the first months of his life. 'Attached to' means " . . . that he [a child or older person] is strongly disposed to seek proximity to and contact with that individual and to do so especially in certain specified conditions" (p. 31) [42]. Additionally, the types of relational experiences that a baby encounters with its primary caregiver will shape its attachment behavior later on, described as a first a set of behaviors that the infant shows in times of stress, pain, fatigue or in the absence of the mother-figure. Once acquired, attachment behaviors can then fluctuate and reappear within different relationships and people, but regularly remain active during the complete life span.

Kraemer (p. 493) [46] describes four essential components of the attachment theory:

First, attachment is an instinctive behavior, a form of imprinting. The baby is already born with a set of behaviors towards his mother-figure, which do not need to be learned or reinforced by her.

Second, attachment is a 'goal corrected system', which means that attachment serves the purpose of maintaining a perception of security within the infant, in a situation in which the infant actually is safe.

Third, attachment requires the development of internal representations or working models. The infant uses these working models of the mother-figure and the surrounding world in order to foresee their behavior and to regulate its own behavior.

And fourth, 'the secure base'. This concept refers to the fact that if maintaining security would be the only goal for the infant and if the mother-figure would be the source of this security, there would be no motivation to disrupt this contact. However, the presence of the mother-figure makes the exploratory behaviors of infants possible in the first place. Thus, external conditions always work in relation with internal, psychological conditions that seek for homeostasis in order to work properly.

Mary Ainsworth refined Bowlby's theoretical foundations and identified initially three (and later four) different attachment styles (i.e., secure, insecure avoidant, insecure ambivalent-resistant, insecure disorganized) that can be observed during an experimental setting called the 'Strange Situation Test' [47].

In this test, which usually takes place when the child is about one year old, the infant is separated from his or her caregiver for a short period of time and left alone with a stranger. The response to the reunion with the parent
—rather than the level of distress during the separation — is then analyzed and classified according to the four attachment styles mentioned above. Since the development of the attachment theory, an extensive body of literature demonstrates the correlation of insecure attachment styles with increased psycho-social and mental health impairments over the child's lifespan as compared to secure attachment styles [48,49].

Bonding

Mother–infant bonding was first described in the 1970s by the American pediatricians Marshall H. Klaus (1927–2017) and John H. Kennell (1922–2013). From their clinical experience, Klaus and Kennell noted that some preterm babies were re-hospitalized after discharge because they were not able to thrive despite the lack of organic diseases or due to injuries caused by their parents [50]. At that time, animal studies suggested disturbances of parenting behaviors when the animal mother was separated from her offspring shortly after birth or when typical pre- or post-birth behaviors were suppressed [51]. Thus, Klaus and Kennell were especially interested in how early or prolonged separation would affect the mothers' behaviors of preterm or hospitalized infants, and if changes in hospital practices would improve the mother–infant relationship. In their landmark study from 1972, they found that mothers who were given additional and prolonged physical contact with their newborns shortly after birth, showed more protective and interactive behaviors and had higher maternal competences compared to control mothers [52]. As a result, they put forward the hypothesis of a 'maternal sensitive period', which was believed to be important for the emergence and development of a proper relationship between a mother and her child [51,53]. This 'sensitive period' encompasses the first hours and days after delivery, in which mothers are supposedly most likely to establish strong emotional ties with their newborns. Contrarily, if this bonding process did not happen adequately or was interrupted, alterations of the baby's development or negative maternal feelings and behaviors towards the baby were thought to be possible [54].

Formally, bonding can be defined as: " . . . a maternal-driven process that occurs primarily throughout the first year of an infant's life, but may continue throughout a child's life. It is an affective state of the mother; maternal feelings and emotions towards the infant are the primary indicator of maternal–infant bonding" [40] (p. 1319).

Since the publication of their influential book "Maternal-infant Bonding" [53], the bonding theory was quickly absorbed by both the academic and medical and popular discourse and has been a controversial topic since then. On the one hand, it led to positive changes in care philosophies and improved parental access to their newborns, including more humanized birthing practices and early physical contact. On the other hand, the idealization of a 'perfect birth' led to feelings of guilt and shame for the many mothers who were not able to hold their baby after birth, either due to inflexible hospital policies or due to medical complications of the mother or the baby [54]. In addition, the scientific validity of Klaus–Kennell's concept of emotional bonding has been questioned by a number of researchers [55] and up to date, there seems to be no definite answer to whether a 'sensitive period' exists or not. With respect to the effectiveness of prolonged physical contact after birth (i.e., skin-to-skin contact), however, recent meta-analyses demonstrate its positive effects on maternal health and feeding, such as a decrease in the third stage of labor or a greater success and prolonged duration in first breast-feeding attempts of the baby [56,57].

Overlaps and Differences

As stated in the beginning of the previous section, 'bonding' and 'attachment' are frequently used interchangeably although they differ substantially from each other. Clearly, both theories describe different aspects of the same phenomenon: how relationships are formed and how early experiences with the primary caregivers influences child develop- ment. There are however four major differences that are relevant to consider:

Focus: Although both Bowlby–Ainsworth and Klaus–Kennell clearly acknowledged the reciprocity and mutual interconnectedness of the parent-infant relationship in their theories, the most important difference is on whom the focus is laid. Attachment theory describes essentially how the child builds up a relationship with its primary caregiver and bonding theory describes the feelings, thoughts, and behaviors of the parent towards the baby. Thus, they focus on different sides of the early parent–infant relationship.

Time frame: Attachment usually implies a much broader time frame and develops over the course of the first year of life. Bonding theory is based upon a specific period of time shortly after birth including hours, days, or weeks.

Proximity: While proximity is a common feature in both theories, attachment theory focuses more on proximity as a spatial concept and is related to the sensitivity and quality of the caregiver's response to the proximity-seeking child. In bonding theory, proximity is understood physically (i.e., skin-to-skin contact) and serves primarily to enhance the parent's acceptance of the baby after birth.

Measurements: The type of attachment style a child forms towards its primary care- giver is assessed through the Strange Situation Test when the infant is about one year old. Bonding is assessed mainly through self-rated questionnaires that parents fill out, e.g., the Mother-to-Infant Bonding Scale (MIBS), the Post-partum Bonding Questionnaire (PBQ) or the Parental Bonding Instrument (for an overview, see Perrelli [58]).

In their concept analysis, Kinsey and Hupecey [40] examine further the similarities and differences between 'attachment' and 'bonding' according to the principles of epistemology (clarity of definition); pragmatics (applicability of the concept); linguistics (consistency in use and meaning); and logic (differentiation of the concept from related concepts). They conclude that with regard to the differentiation of the two concepts . . . "inconsistencies in the research literature are numerous and require that clarification be made in order for concept advancement to occur. Advancement of the concept will allow researchers to utilise appropriate measurement of the concept allowing nursing interventions to be developed that will improve bonding, thus improving maternal and child outcomes." (p. 1315).

Discussion

As we have tried to highlight, bonding and attachment share many common features, but describe essentially distinctive processes. While this confusion seems to be superficial at first, it actually might have an important impact on how early parenting interventions inclusive of MT in the NICU are designed, implemented, and evaluated. As the impetus for defining the underlying neurological mechanisms of music and vocal interventions in the NICU continue to provide evidence for their effectiveness [30,59,60], a more thorough discussion with regard to the basic aspects of the early parent-infant relationship is still lack- ing. While authors within the fields of developmental psychology or child psychiatry have made a call for a better distinction between bonding and attachment for many years [61], this is now being recognized in recent systematic reviews on early parenting interven- tions [62]. How music therapists could adjust their interventions according to one or the other concept will be exemplified below. We will first address the potential consequences for clinical practice, and later discuss the implications for research in this context.

Clinical Practice–NICU MT for Attachment

Attachment theory describes how the child builds up its relationship with the parents. This is a process that typically develops during the first year of life and is mutually influ- enced by both the infant and the parent. Therefore, taking into consideration attachment, the music therapist in the NICU might focus on parent–infant interaction and communica- tion. This is important, because attachment is a feedback model: parental sensitivity is for example one of the most important moderator for developing a secure attachment style, but also paramount for successful communication with the baby. The baby, however, needs also to respond adequately to a fulfilled or unfulfilled need and in this way communicates to the parent that he or she has done well. Both aspects might be altered in the NICU: the first because of psychological distress; research shows for example that parents with increased anxiety levels are less sensitive to their infants' communicational cues [63]. The latter due to an underdeveloped nervous system and less capacity for self-regulation, which makes it harder for preterm babies to clearly manifest their needs or habituate less competently to novel stimuli than infants born at term [64]. Thus, MT can be an opportunity to practice successful interaction by helping parents to be sensitive towards their infants' states and needs and by helping infants in their self-regulation and arousal. For the first scenario, the ideal situation would obviously be working with the baby and the parent(s). Making music and singing for the baby is an excellent way to foster parental sensitivity through a process of joint observation → musical interaction → observation. At the beginning, the music ther- apist might observe the infant together with the parents and may ask questions to increase their involvement, such as: "How is the baby doing today?"; "What do you think he or she needs at the moment?" This can help the parent choose music more consciously, choosing music coherent with the baby's current state and needs, for example, singing a lullaby for sleeping, or a more energetic song for helping the baby to stay alert during feeding. While singing, the music therapist can encourage the parent to observe the baby's reactions and return an empathic response through musical or physical gestures.

It is common for music therapists in this type of work to notice the infants' subtle responses and notify the parents about it, for example by stating "Look, he was smiling"; "Have you noticed how she turned her head towards you while you were singing?". Such observations create an opportunity for parents to learn more about their infant's communicational abilities, as well as their ability to provide (musically and vocally) sensitive responses through adjusting the tone of their voices, the volume, or the tempo of the music, or by making pauses, among others.

Working solely with an infant, provides an opportunity for the music therapist to work on the infant's self-regulation capacities. One important feature of such sessions is for example the idea to entrain the music or singing to the with infant's breathing rhythm, gestures and facial expressions [29]. This supports the infant's ability to regulate its arousal, calm down, and orient towards the music therapist. When the infant is able to express its needs with more clarity, it might be easier for parents to understand them and provide an empathic and adequate response.

Clinical Practice–NICU MT for Bonding

Bonding describes the affective, cognitive, and behavioral manifestations of the par- ents towards the baby. Thus, when music therapists take into consideration the importance on bonding, they essentially work with parents' feelings, thoughts, or actions, and the ideal scenario might be working with the parents alone, either in individual or group settings. Initially, exploring how parents cope with the hospitalization and supporting their emotional release and processing of the early traumatic birth, can help to construct the therapeutic relationship and confidence to explore the feelings related to the baby itself. This is important, because potential negative feelings towards the baby are difficult to express for parents and are socially not well accepted. To be able to admit for example: "I feel angry with my baby", "I regret having this baby" or "I feel like hurting my baby" (examples from the Postpartum Bonding Questionnaire [65]), are certainly affirmations that can be challenging to acknowledge. However, even more subtle issues like feeling distant to the baby or wishing to have the 'old days' back without the baby can cause emotional tension in mothers and fathers. Helping parents to become aware of such feelings and thoughts, for example through music guided relaxations or other receptive MT techniques, may open a door to further verbal or musical processing [66].

Validating that many parents go through contrasting emotions during the NICU stay may additionally help release pressure. Improvisational approaches, shared music making, or MT songwriting are other potential approaches in creatively, interactively, and non-judgmentally being able to express conflictive feelings or thoughts. If required, a referral to the mental health care team or an interdisciplinary approach between music therapists, psychologists and parents might be used.

When working together with the parents and the baby in the NICU, the situation is somewhat different, since parents might feel inhibited to express such emotions in front of the baby or other staff. Letting parents choose for example songs that describe how they currently feel, and if necessary, adapt parts of the lyrics, is an approach that could help parents in expressing their hopes, fears, or worries in a way that can be more appropriate for them.

MT Research in the NICU–Bonding or Attachment?

As outlined above, clinical practice might differ whether music therapists want to focus on bonding or attachment. However, this is also important for current and future research, in which both concepts are still blurred. An example hereof is the recently published research protocol by Yakobson et al. [67], measuring "parent-infant attachment quality" (p. 1) or parental "attachment levels" using the Maternal Postnatal Attachment Scale (MPAS). However, they state: "The MPAS is a self-report questionnaire including 19 items investigating parents' behaviors, attitudes, and feelings toward their infant" (p. 15), which actually refers to measuring bonding and not attachment. Another example is the current protocol for a Cochrane Review about the efficacy of musical and vocal interventions to improve neurodevelopmental outcomes for preterm infants [68]. In the objectives, the authors name bonding as one of the phenomena to be measured (p. 3). However, when specifying the outcomes the they claim to measure "attachment (measured with standardized scales, e.g., Postpartum Bonding Questionnaire)" (p. 4).

Thus, the lack of differentiating between the two concepts is striking even in high- impact studies and reviews. This could be a confounding factor and hinder the comparabil- ity of results from previous and ongoing studies. While attachment can be assessed through the Strange Situation Test, for example in a longitudinal study, during the NICU stay, bond- ing seems to be the more relevant concept for assessing the parent–infant relationship within a research project.

Conclusions

Bonding and attachment share many common features, but also important differences. This is so far not acknowledged in neonatal care but may have real-world implications. While the examples in this article are drawn from the field of music therapy, a better distinction could be relevant also for other health care professionals in the NICU concerned with the early parent–infant relationship, e.g., social workers, nurses, psychologists, neona- tologists, among others. Undoubtedly, relationship building is a complex process and develops reciprocally between parents and their baby along a continuum starting long before and going far beyond the NICU stay. However, the particularity of having a baby hospitalized warrants special attention. Further research distinguishing better between the two concepts is needed to understand how MT and other early parenting interventions might impact the parent–infant relationship in this setting. This will hopefully lead to a more precise use of theory and terminology, and ultimately a more informed clinical practice and research.

Author Contributions: M.E. had primary responsibility for the article development and writing— original draft preparation. Ł.B., S.E., and C.E. participated in writing—review and editing. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding. Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Conflicts of Interest: The authors declare no conflict of interest.

*A full list of references can be found at: https://www.mdpi.com/1660-4601/18/4/1733

FIGHT FOR THE THINGS YOU CARE ABOUT,
BUT DO IT IN A WAY
THAT WILL LEAD OTHERS TO JOIN YOU.

··· Ruth Bader Ginsburg

Job Postings

prelicensed.com
Follow Us on Facebook, Twitter, and LinkedIn!
Subscribe to our e-mail newsletter for important updates and special offers!

New Job Listings From Prelicensed.com

Bilingual Child and Family Clinician-Empower Youth!

Bilingual Therapeutic Visitation Clinician-Support Youth!

Equip

www.equip.health

Equip is hiring CA therapists for 20+ hours per week. All positions are salaried (guaranteed pay regardless of caseload) and come with health/dental/vision benefits, PTO, paid supervision and training, and remote work stipend. Salaries start at $40k for 20hrs/week.
Learn more and apply at:

https://equiphealth.recruitee.com/o/licensed-therapist

MC-CAMFT Members:

Your ad here can reach more than 130 MC-CAMFT members and over 30 local agencies and fellow CAMFT chapters
Contact Ross Farley @ ross@shinealight.info, or 831-313-4043 for details

Member Ads

****NEW SERVICE FOR CLINICIANS****

Do you have a guided meditation, imagery exercise, grounding/containment exercise, even a conference talk audio file that is full of ambient noise or not up to the quality you'd like?

I can professionally master and process your spoken word files, remove most noise/s, even add the music and/or soundscape that best suits you and your clients' needs. I have been producing and mixing music for 18 years and can help you bring more dynamic elements and add life to your audio

Contact:
ross@shinealight.info
for more info, samples of work, and/or pricing

MC-CAMFT
P.O. Box 3092 Monterey, CA 93942
www.mccamft.org

NEWSLETTER ARTICLES AND CONTRIBUTIONS INVITED

Make sure our newsletter reflects your experience as a clinician in our chapter. Contribute to your newsletter through book reviews, opinions, CEU experience, events, clinical expertise, announcements, successes or other relevant information.

Contact Ross Farley III, newsletter editor, ross@shinealight.info, 831-313-4043

NEWSLETTER ADVERTISING

Advertisements including classifieds and flyers must be placed prior to the advertising deadline. All ads must obtain approval by the Newsletter Editor, Advertising Chair and the MC-CAMFT Board President.
Advertisements should be submitted by email attachment as a Word document with the exact wording desired. Submission and approval for all advertisements, including payment, is due by the 12th of the month preceding publication.

NEWSLETTER DEADLINES

Newsletters are published at the beginning of the month, every other month (January/February, March/April, May/June, July/August, September/October, November/December). Deadline to contribute articles and advertisements is the 12th of the month preceding publication.

MC-CAMFT
Mission Statement

MC-CAMFT is dedicated to the advancement of marriage and family therapists, to the promotion of high standards of professional ethics and qualifications of its members, and to expanding the recognition and utilization of the profession in Monterey County.

She slept
with wolves
without
fear, for
the wolves
knew a lion
was among
them - R.M Drake

MC-CAMFT is pleased to acknowledge the service of its
PAST PRESIDENTS

1989 Jane Ellerbe
1990 Connie Yee
1991 Joan Mortensen
1992 Mark Willison
1993 Katherine Weller
1994 Jerian Crosby
1995 Janis "JC" Clark
1996 Steve Weiner
1997 Mary Jane Melvin
1998 Steve Mahoney
1999 Susan Ross
2000 Judy Masliyah
2001 Barrie O'Brien
2002 Stephen Braveman
2003 Lois Panziera
2004 Mary Sue Abernethy
2005 Elisabeth Wassenaar
2006 Mary McKenna
2007 Brenda Lang
2008 Abby Bukofzer
2009 Eileen Nazzaro
2010 Elizabeth Ramírez
2011 Heather Crimson
2012 Carolyn Kelleher
2013/14 Cheryl Fernandez
2014/15 Emily Lippincott
2016/19 Kristine Jensen