

Psychotherapy with Infants and Young Children

**Repairing the Effects
of Stress and Trauma on Early Attachment**



Alicia F. Lieberman
Patricia Van Horn

**PSYCHOTHERAPY WITH INFANTS
AND YOUNG CHILDREN**

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*To Mary Ainsworth and John Bowlby,
who provided our attachment lens*

*To Selma Fraiberg and Bill Harris,
who helped us uncover the ghosts and angels in children's lives
To Irving Harris,
who gave us the secure base to integrate them*

*And to the children and parents,
who breathe life into theory*

About the Authors

Alicia F. Lieberman, PhD, is the Irving B. Harris Professor of Infant Mental Health and Vice Chair for Academic Affairs at the University of California, Department of Psychiatry, San Francisco, and Director of the Child Trauma Research Project at San Francisco General Hospital. She directs the Early Trauma Treatment Network, a collaborative of four university-based programs that is a center of the SAMHSA National Child Traumatic Stress Network. Dr. Lieberman is president of the board of directors of Zero to Three: The National Center for Infants, Toddlers and Families. She is the author of *The Emotional Life of the Toddler*, which has been translated into several languages, and senior author of *Losing a Parent to Death in the Early Years: Treating Traumatic Bereavement in Infancy and Early Childhood* and *Don't Hit My Mommy!: A Manual for Child-Parent Psychotherapy with Young Witnesses of Family Violence*. She is also the author of numerous articles and chapters about infancy and therapeutic interventions in the early years. Dr. Lieberman's major interests include infant mental health, early trauma, and closing the service gap for minority and underserved young children and their families. She lectures extensively and is a consultant to government agencies and private foundations nationally and abroad. As a trilingual, tricultural Jewish Latina, she has a special interest in cultural issues involving child development, childrearing, and child mental health.

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Preface

I fear
What the past will do to me
In the future
—YEHUDA AMICHAI, *Concrete Poem*

Fears about the future mirror what happened in the past and live on as a burden in the present. Psychotherapy, at its best, can restore the capacity for present joy and hopeful investment in the future by revisiting harmful early experiences and reworking them in light of current understanding and capacities. This book represents an effort to contain and redirect the destructive impact of adversities before their effects are passed on and take root in the next generation. Child–parent psychotherapy (CPP) engages parents and primary caregivers as the most powerful agents of healthy development in young children. By harnessing parental love and devotion to their child’s well-being, CPP seeks to retrieve and create gratifying experiences of relationship that become engraved as new memories to modulate fear and promote trust in the child’s and the parents’ sense of each other and of themselves.

The book comprises 10 chapters. Chapter 1 presents a detailed overview of CPP as a relationship-based treatment for mental health problems of infancy and early childhood. It describes the integration of different theoretical perspectives into a multifaceted but coherent treatment approach that includes systematic attention to the child and the family in the context of their developmental, cultural, and ecological circumstances. The range of stressors facing young children and their impact on brain development are addressed in Chapter 2, which also

discusses the applications of this knowledge to treatment and describes a continuum of mental health and relationship difficulties that encompass temporary and circumscribed perturbations, more generalized and lasting disturbances, and pervasive, entrenched disorders. Chapter 3 outlines CPP theoretical goals, therapeutic modalities, and core clinical competencies for treatment across the range of problem severity. It describes the co-creation with the parent of a shared understanding of the child's developmental stage and unique individual characteristics, with the goal of translating for the parent what the child might be feeling and thinking in order to encourage responses that promote safety, correct misperceptions, modulate affect, and model affective attunement.

The role of initial assessment as the foundation for a comprehensive treatment plan is described in Chapter 4, which conceptualizes the assessment period not only as a time to gather information about the child, the family, and their circumstances, but also as an opportunity to test out the effectiveness of trial interventions in order to evaluate initial diagnostic impressions and revise the treatment plan. Chapter 5 illustrates the implementation of CPP with children and parents showing mental health perturbations as they attempt to master developmental milestones that challenge their capacity to adapt to new demands. The extension of these modalities to more severe clinical conditions is illustrated in Chapter 6, which describes in detail the treatment of a child, mother, and father with problems in the disturbance-disorder end of the continuum in the context of domestic violence followed by an acrimonious divorce. Chapter 7 describes CPP variations in response to specific challenges. The variations are designed to address situations in which the parent's mental health impairments overtake the therapeutic focus on the child, in which the child's behavior during the sessions triggers unmanageably damaging responses from the parent, and in which intractable conflicts between an estranged mother and father are persistent pathogenic influences for the child.

Clinical difficulties inherent to the CPP focus on the child-parent relationship are described in Chapter 8 through four cases that illustrate specific challenges to the model, either because the therapist's subjective experience of parent and child is polarized by unilateral attunement to one partner at the expense of the other or because the individual functioning of either the parent or the child is too severely compromised to profit from a therapeutic focus on their relationship. Although the standard child-parent CPP format can be conducive to successful treatment outcome even under these constraints, variations in format and focus are necessary when the initial sessions uncover persistent obstacles to the effectiveness of a joint child-parent focus. Chapter 9 places clinical intervention in the context of the systems of care that must often be

enlisted to collaborate on behalf of the child and the family, including pediatric care, child care, and the child protective system. Chapter 10 offers a reflection on the clinical enterprise in the context of the external constraints and internal pressures experienced by therapists engaged in alleviating the plight of stressed and traumatized young children and their families.

Every chapter makes extensive use of clinical illustrations. The use of case examples invariably raises a conflict between two legitimate but contradictory values: protecting the confidentiality of children and families who entrust the clinician with their most private experiences, and commitment to truthfulness, accuracy, and validity in describing psychological processes and therapeutic intervention. To meet these ethical standards, we thoroughly disguised identifying characteristics of children and parents to make them unrecognizable both to the reader and to themselves. Many of the families received treatment many years ago, further reducing the chances of recognition. In several examples, the circumstances and treatment course of two or more families have been conflated when the themes were clinically consistent. The statements attributed to children and parents are paraphrases rather than verbatim quotes. All the parents showed remarkable willingness to contribute to increased knowledge by signing consent forms allowing us to use their clinical material for teaching purposes.

This book is designed for clinicians with a wide range of experience, from seasoned practitioners to graduate students and interns in psychology and social work and residents in psychiatry. Selma Fraiberg said that working with babies and young children is a little “like having God on your side” because the bonds of love between parent and child and the developmental momentum of the early years constitute powerful incentives toward health. We hope that this book encourages clinicians from different disciplines and theoretical orientations to include the treatment of infants, toddlers, preschoolers, and their families as an integral part of their work.

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Acknowledgments

It takes a village. This is true whether the creative effort involves raising a child or writing a book. A large village surrounded us as we worked on this volume, and at the heart of that village were the children and parents who entrusted us with their ghosts and angels and helped us to understand their needs and hopes.

The treatment of early attachment, stress, and trauma strains the heart and calls for the concerted effort of a close-knit community. We could not have written this book without the collaboration, skill, and hard work of every member of our clinical research team, some of whom have been with the Child Trauma Research Project since its inception in 1996. They form the core of our professional family: Nancy Compton, Chandra Ghosh Ippen, Maria Augusta Torres, Laura Castro, Manuela Diaz, and Griselda Oliver Bucio. Others are no longer with our program but continue to be valued colleagues and friends: Robin Silverman, Donna Davidovitz, Edie Walden, Laura Mayorga, Elizabeth Lujan, and Anyella Clark. Also vital to our mission are the more than 100 psychology, psychiatry, and social work interns, residents, and fellows who have participated in our training programs to date. They are too numerous to name individually, but their impetus to grow as clinicians and researchers kept us learning as they learned with us.

We owe much to the members of the Substance Abuse and Mental Health Services Administration (SAMHSA) National Child Traumatic Stress Network (NCTSN), who created a powerful entity to improve the availability and quality of services for traumatized children and their families across the nation. We thank Malcolm Gordon, our SAMHSA project officer, and the National Center codirectors, Robert Pynoos and John Fairbank, for their readiness to share their prodigious knowledge and their tireless leadership in spearheading this national effort. Lisa Amaya Jackson, Alan Steinberg, Janet Markiewicz, Christine Siegfried, Ellen Gerrity, Susan Ko, and Chris Layne at the National Center work

hand in hand with us to convert plans into concrete action. The Early Trauma Treatment Network—a “network within a network”—enables us to adapt infant and early childhood mental health principles to the systems of care where young children in need are most frequently found, and it is a privilege to join forces with our dedicated partners: Joy Osofsky, Howard Osofsky, and Mindy Kronenberg at Louisiana State University Health Sciences Center; Julie Larrieu and Charles Zeannah at Tulane University; and Betsy McAlister Groves, Michele Acker, and Carmen Naroña at Boston Medical Center. Valued colleagues at other NCTSN centers expand our thinking and help extend the reach of our work. Foremost among them are Judy Cohen, Carrie Epstein, Luis Flores, Julian Ford, Anthony Mannarino, Steven Marans, Frank Putnam, Bessel van der Kolk, and Charles Wilson.

Closer to home, we could not maintain our program without the support and encouragement of a great many people at the University of California, San Francisco. Robert Okin, Chief of Psychiatry at San Francisco General Hospital, and Craig Van Dyke, Chair of the UCSF Department of Psychiatry, are exceptional leaders who foster an institutional environment that is welcoming to families while academically rigorous. Laurel Koepernik and her staff are masters in all that pertains to grants and contracts, and Randolph Siwabessey and Susan Quillen are steadfast administrators. They provide the lifeline for a sound program infrastructure, and their skill is matched only by their goodwill. We are grateful to our program administrator, Dione Johnson, who brings order to everyday life with a warm and ready smile.

The harmful impact of cumulative stress and trauma on children and their families transcends the scope of mental health institutions and calls for sustained collaboration with public systems of care and community programs. We are grateful to Sai-Ling Chan-Sew from the Department of Public Health for many years of committed community leadership on behalf of young children. We also thank Debby Jeter, Elizabeth Crudo, Sharon Bell, Sophia Isom, Susan Arding, and many other Human Service Agency managers, supervisors, and child welfare workers who work with us in looking for solutions to the often intractable problems of children and families in the child protective system. Judge Donna Hitchens has been the leading force in spearheading a groundbreaking collaboration between the legal system, family resource programs, and mental health treatment that includes the perpetrators as well as the victims of violence as integral influences in the child's development. Kathy Black from La Casa de las Madres, Martha Ryan from the Homeless Prenatal Program, and Robert Bennett and Charlene Clemens from the Family Service Agency of San Francisco enable us to bring trauma-focused mental health services to community agencies

serving women and their children victimized by violence. The Jewish Family and Children's Services, with the leadership of Anita Friedman, Amy Weiss and Lesley Sternin, gives us the opportunity to disseminate the principles of child-parent psychotherapy to mental health providers from community agencies throughout the Bay Area. This dissemination is also occurring at the national level thanks to the commitment of key administrators. The Safe Start Initiative and Safe Start Promising Practices Initiative, under the leadership of Kristen Kracke and Elena Cohen, allow us to disseminate child-parent psychotherapy principles to multidisciplinary teams of professionals across the United States. Similarly, the NCTSN is sponsoring a series of learning collaboratives that help us meet the challenges of adapting our treatment model to diverse community settings throughout the country. Bryan Samuels, Tim Gawron, and their colleagues at the Illinois Department of Children and Family Services helped us to systematize our ability to serve children in the child welfare system by including us in a project to bring evidence-based practices to service providers in Illinois. Cheryl Polk has contributed her deep understanding of institution building to the ongoing process of refining the many facets of our work. Phyllis Glink has increased our effectiveness locally and nationally by sharing her extensive experience with program development.

The scientific underpinning for our work has been buttressed by the National Institute of Mental Health (NIMH), which supported our randomized trials of child-parent psychotherapy. We benefited greatly from the knowledge, generosity, and enthusiasm of Victoria Levin, our peerless NIMH scientific review administrator. She manages to bring pleasure to the grant review process with unique grace.

Private foundations and individual donors are the bedrock of support that supplements federal and local public funding and provides the continuity to explore new directions in early treatment. Irving Harris, the visionary philanthropist whose decades of strategic giving transformed the landscape of infant mental health, recognized the urgency as well as the obstacles to addressing trauma in the early years and responded with unstinting financial support and sage advice. The Irving B. Harris Foundation has underwritten our training program since its inception, and we are grateful for the ongoing support of Joan Harris and the board of trustees. Bill Harris and the Coydog Foundation make it possible for us to explore the interface between attachment and trauma by highlighting the beneficial effect of loving experiences in the restoration of healthy emotional bonds. Lisa and John Pritzker and Ingrid Tauber enable us to learn by teaching—one of our most rewarding endeavors. Over the years, the Mimi and Peter Haas Fund, A. L. Mailman Foundation, Nathan Cummings Foundation, Pinewood Foundation, Francis

S. North Foundation, Louis R. Lurie Foundation, and George Sarlo Foundation supported the development, manualization, and testing of intervention strategies geared specifically to the experience of immigrant and minority families facing violence. Our dear friend the late Kathleen Altman, and her husband, Jonathan Altman; Aubrey and Beverly Metcalf; and the Isabel Allende Foundation bestowed gifts that allowed us to respond to unanticipated needs.

This book has undergone several iterations in response to the invaluable feedback of Victor Carrión, Megan Gunnar, Bill Harris, Toni Heineman, Barbara Kalmanson, Julie Larrieu, Joy Osofsky, Judy Silver, Arietta Slade, Vivian Snyder, and Sheree Toth, who read the manuscript with great care and provided their characteristic insight. Our deep thanks to each of them for standing with us in making it a better book, and for many rewarding years of shared thinking and doing to improve the lives of children and families.

At The Guilford Press, we thank our editors, Kitty Moore and Barbara Watkins, whose enthusiasm for the book kept alive our momentum to write amidst the pressures of our daily work life and whose expert suggestions organized our thinking. We also thank Sawitree Somburanakul and Dan Weingarten for their skillful assistance in bringing the book to publication.

At the end of every day, each of us found her way home to partners who were supportive of this project but also insisted on our striving for balance by bringing play and beauty into our lives. As always, we thank David Richman and Verlene Perry for their love, encouragement, and forbearance. We also thank our sons, Michael Lieberman and Alexander Gebala, for giving us a visceral knowledge of the fierceness and tenderness of a parent's love.

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CHAPTER 1



When Development Falters

Putting Relationships First

Three-year-old Elias is watching his father, who is late for work and rushing about the house getting ready to leave. He asks his mother: “Is Daddy angry at me?” His mother answers: “No, sweetheart, why should he be angry at you?” The child answers: “Because he is moving sooo quickly.”

Elias is showing us something adults often overlook: Small children are keen observers of parental behavior, and they constantly draw inferences about how they figure into it. Young children’s inner lives are rich and complex, organized around their primary emotional relationships, and governed by a logic only dimly accessible to adults. The affective tones of their experiences—pleasurable or hurtful, predictable or chaotic, manageable or unbearable—become embodied in who they become, shaping their sense of self, their trust in others, and their confidence in learning about the world. The momentum toward healthy development is built on the foundation of parental protection, which gives children the internal security and external safety they need to acquire the capacities to love and learn that are essential for mental health. Early attachment is the affective child–mother bond that promotes survival through the child’s reliance on the adult for protection (Bowlby, 1969/1982; Ainsworth, Blehar, Waters, & Wall, 1978). Babies and young children thrive when they feel secure in their parents’ care* as they experiment with their bodies, relationships, and physical environment. When the

*We use the terms “parent,” “mother,” and “caregiver” interchangeably to refer to the child’s primary attachment figures. These are defined as the persons to whom the child turns preferentially for safety and protection in situations of need, uncertainty, and fear.

child cannot feel safe because the parent is consistently unavailable, unpredictable, or frightening, the basic conditions that promote early mental health are severely undermined.

This book describes child–parent psychotherapy (CPP), a relationship-based approach to treatment for children ages birth through 5 when their parent’s failure to protect them has derailed their mental health. Freud defined mental health as the capacity to work well and love well. For infants and young children, mental health may be defined as the capacity to *grow* well and love well. Three domains define early mental health: the young child’s capacity to (1) experience, tolerate, and express a range of emotions without lasting emotional collapse; (2) form and maintain mostly trusting intimate relationships; and (3) learn the culturally expected skills considered appropriate for the child’s age. CPP addresses each of these domains through the vehicle of the child’s primary attachment relationships. Treatment efficacy has been empirically documented in randomized trials with high-risk groups of toddlers and preschoolers. The samples include toddlers of depressed mothers, anxiously attached toddlers of impoverished, unacculturated Latina mothers with trauma histories, maltreated preschoolers in the child protection system, and preschoolers exposed to domestic violence (Cicchetti, Rogosch, & Toth, 2000; Cicchetti, Toth, & Rogosch, 1999; Lieberman, Weston, & Pawl, 1991; Lieberman, Van Horn, & Ghosh Ippen, 2005; Lieberman, Ghosh Ippen, & Van Horn, 2006; Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002; Toth, Rogosch, Manly, & Cicchetti, 2006). The findings show that this treatment approach results in reduced child and maternal symptoms; more positive child attributions of parents, themselves, and relationships; improvements in the child–mother relationship and the child’s attachment security; and improvements in child cognitive functioning. Children and their mothers in several of the samples had exposure to diverse and repeated interpersonal violence. Their improvement following treatment is particularly noteworthy because few treatments are designed for children or adults with histories of multiple or chronic trauma. The treatment has ecological validity for different socioeconomic and cultural groups. The randomized trials included parents in poverty as well as predominantly ethnic minority samples, including monolingual Spanish-speaking dyads. This body of research provides strong support for a therapeutic focus on the child–mother relationship for young children whose mental health is impaired by stress, trauma, and the parenting problems associated with these conditions.

Two treatment manuals describe the application of CPP when the child is faced with specific traumatic circumstances. *Don’t Hit My Mommy!: A Manual for Child–Parent Psychotherapy with Young*

Witnesses of Family Violence (Lieberman & Van Horn, 2005) outlines domains of intervention, provides an itemized description of essential therapeutic strategies, and illustrates these strategies with clinical vignettes of infants, toddlers, and preschoolers who witnessed domestic violence between their parents. *Losing a Parent to Death in the Early Years: Guidelines for the Treatment of Traumatic Bereavement in Infancy and Early Childhood* (Lieberman, Compton, Van Horn, & Ghosh Ippen, 2003) addresses the plight of young children who experienced the death of one or both parents. This book offers a developmental framework for understanding early grief and describes a treatment approach designed to help the child accept the physical reality of the parent's death, cope with traumatic and loss reminders, and regain impetus toward healthy development through the formation of new attachments that substitute for the dead parent but do not replace the memory of that unique, loving relationship. The present book expands on the theoretical framework and clinical applications of these manuals. It describes the applications of CPP in the broader range from normative to traumatic stress, illustrating the theoretical premises and intervention modalities with extended case presentations that enable the reader to follow the clinical reasoning that guides the course of treatment.

Why Focus on the Attachment Relationship?

Starting at birth, babies seek out human connections. They are biologically endowed with the capacity to discriminate and respond contingently to different stimuli, turning preferentially to human signals as well as to familiar smells, sights, and sounds. They imitate facial expressions and synchronize their own expressions, gestures, and vocalizations with those performed by other people, engaging in reciprocal exchanges that are the substrates of later empathy and mutuality. These accomplishments are not purely cognitive feats: They are imbued with feeling. Before they are ready to crawl, infants are capable of differentiating between emotions of sadness, anger, and happiness and know what tones of voice match the appropriate facial expression (Gopnik, Meltzoff, & Kuhl, 1999). In fact, infants use emotional experiences—their own and those of others—as guides to interpersonal relationships and exploration of the physical environment. In the course of their first 5 years, they form mental representations of the psychological, social, and physical realms; develop working hypotheses about how the world works; and use their interactions to test and refine these hypotheses.

For babies who are growing well, many different biological, physical, social, and cultural factors operate together to promote the unfold-

ing of development. When different influences coalesce harmoniously, it is usually unnecessary to extricate their individual contributions to the process. An interested observer would report that the baby is gaining weight, length, and head circumference at a reasonable pace; that age-expectable motor, cognitive, emotional, and social milestones are attained roughly within the time frame outlined in child development textbooks; that the mother, father, and other caregivers have the baby's well-being as an organizing focus of loving concern; that the tensions and stresses of life do not overshadow the parents' emotional investment in their baby; and that society provides institutional supports for physical safety and basic needs that buttress the family's ability to raise the child. In summary, things are going well enough for the main players involved in raising the child, and the thriving baby is the result of the confluence of beneficial biological, emotional, social, and cultural processes.

In this example of the interplay of reciprocal effects, factors within one realm may moderate or mediate the influence of other realms, but developmental progress is not derailed by major insufficiencies or distortions in the constellation of protective and risk factors within and around the child and the family (Cicchetti & Lynch, 1993; Sameroff, 1995). Childrearing values and practices have long been considered a deeply private domain, but the recent popularization in the United States of the African adage "it takes a village to raise a child" demonstrates a growing societal awareness that raising a child is also a major public responsibility. The child's innate capacities can only unfold within the nurturing parental sphere, but the parents, in turn, cannot operate alone. They need access to the resources of their community and the society at large in order to fulfill their roles as the child's closest and most immediate protectors.

When the child is not doing well, all bets are off about the specific reasons for this situation. The intricate interconnections among constitutional and environmental influences often defy professional consensus about the source of the child's distress. In these cases, the search for pathogens tends to be informed by the specific discipline and theoretical preferences of the practitioner(s) examining the child (Mayes, 1998). The long-standing dichotomy between nature and nurture in explaining the etiology of mental health problems, while outdated and derided, continues to influence diagnosis and treatment. We are often the prisoners of our mental and disciplinary silos. The proliferation of highly technical advances in genetics, neurodevelopment, developmental psychopathology, clinical theory and practice, and intervention research has enriched current understanding of etiological processes, but narrow areas of specialization also have the countereffect of setting up barri-

ers to interdisciplinary communication. A group of comparably trained assessors with different specialties may highlight different etiological factors (e.g., genetic, constitutional, or environmental) and different domains of functioning (e.g., somatic, emotional, social, or cognitive) as the preferred focus of evaluation and may recommend widely divergent treatments on the basis of their specialized area of expertise. The outcome may be that different practitioners may give primacy either to the child's constitutional vulnerabilities or to the parent's psychological conflicts and ineffective childrearing as the primary contributors to an individual child's emotional problems. As Goethe observed, "We see only what we know" (quoted in Beveridge, 1957).

We propose that the child's attachments, defined as the primary emotional relationships with the parents, should be a unifying theme and should be given a prominent role across different disciplines in assessing and treating early mental health problems. Loving parental care has unmatched transformational powers in restoring the child's developmental momentum in risk situations. The parents constitute the primary agents of the young child's emotional well-being even in the presence of environmental stresses and constitutional child vulnerabilities. For example, newborns with difficult temperamental tendencies such as irritability may have a predisposition toward less optimal development, but this predisposition tends to be actualized primarily when the mother cannot respond to her infant's cues because she is too distraught or depressed (Vaughn & Bost, 1999). An intervention developed by van den Boom (1994) to help mothers identify and respond contingently to their irritable newborn's affective signals resulted in significant and lasting improvements in the child's quality of attachment and competence in exploration. Similarly, two separate randomized studies demonstrated that toddlers of depressed or highly stressed mothers improved significantly in their cognitive and socioemotional functioning as the result of toddler-parent psychotherapy aimed at enhancing reciprocity and partnership between mother and child (Cicchetti et al., 2000; Cicchetti et al., 1999; Lieberman et al., 1991). Focusing on the affective tone of the child-mother relationship also proved effective in improving the mental representations of the self and of caregivers for maltreated preschoolers, who did better in a randomized trial of preschooler-parent psychotherapy than a comparison group receiving a psychoeducational home intervention model (Toth et al., 2002). A study of preschoolers who witnessed domestic violence between their parents demonstrated that CPP led to a significant reduction in the diagnosis and specific symptoms of posttraumatic stress disorder (PTSD) both in the children and in their mothers when they were compared with a group referred to individual psychotherapy and case management. Improvement con-

tinued 6 months after the termination of treatment (Lieberman et al., 2005; Lieberman et al., 2006).

The child–parent relationship remains the most parsimonious vehicle for improvement even when the child has a constitutionally based condition such as autism or pervasive developmental disorder (Green-span & Wieder, 1998). This is not surprising because autistic children, like their normally developing peers, show individual differences in quality of attachment that are influenced by their mothers' sensitivity to their signals (Sigman & Ungerer, 1984). Autistic children also demonstrate better language and communicative skills when their parents synchronize their play with the child's focus of attention, a research finding that remained stable in a follow-up study of the same children 16 years later (Siller & Sigman, 2002). The cumulative empirical evidence confirms the effectiveness of a relationship-based approach to the treatment of mental health disorders of infancy and early childhood across a spectrum of constitutional and environmental risk factors.

Principal Components of Child–Parent Psychotherapy

Child–parent psychotherapy (CPP) has its origins in infant–parent psychotherapy and continues to be strongly influenced by this approach (Fraiberg, 1980; Lieberman & Pawl, 1993; Lieberman, Silverman, & Pawl, 2000). Selma Fraiberg and her colleagues developed infant–parent psychotherapy to address mental health disturbances in the first 3 years of life through the treatment of parental psychological conflicts that are expressed through the parent's attitudes and behaviors toward the infant. While extending its scope for intervention through age 5, CPP is also based on the premise that, in most circumstances, the child's relationship with the primary attachment figures represents the most expeditious route to the child's improvement. CPP is a multitheoretical approach that integrates attachment, psychoanalytic, and trauma theory with intervention strategies derived from cognitive-behavioral and social learning therapies. Attention to the family's cultural values is woven into every facet of the intervention. CPP principal components are briefly outlined below, then described and illustrated with clinical examples throughout the book.

1. CPP employs joint child–parent sessions that are centered on the child's free play and spontaneous child–parent interactions. When the child has been exposed to specific traumatic events, the materials provided include toys selected to evoke the trauma and to facilitate effective coping, such as a doctor's kit, an ambulance, and police officers.

Individual collateral sessions with the parent(s) are flexibly introduced as needed to discuss the content of the joint child–parent sessions, the parents’ experience, the family circumstances, and other factors relevant to treatment.

2. The CPP therapist translates for the parent the developmental and emotional meaning of the child’s behavior in order to increase parental understanding and promote sound parenting practices.

3. Treatment targets include maladaptive child behavior, parenting patterns that are punitive or developmentally inappropriate, and patterns of parent–child interaction that reflect mistrust and misunderstanding of each other’s developmental agendas. Given the wide range of cultural expectations for age-appropriate child behavior, the therapist consistently inquires about the family’s cultural mores and tailors the interventions to these values.

4. CPP actively encourages joint parent–child activities that foster mutual pleasure, positive parental attributions to the child, and the child’s trust in the parent.

5. Intervention is individually tailored to the needs of the child and the parent. Clinical modalities include the use of play, language, physical activity, and physical affection to promote development; developmental guidance; role modeling of protective interventions; addressing traumatic reminders; evoking memories of benevolent and loving past experiences that restore self-esteem and promote hope; insight-oriented interpretation; emotional support; crisis intervention; and concrete assistance with problems of living.

6. Intervention begins with simple and direct strategies. More complex modalities are used only when simpler interventions do not result in improvement.

The term “child–parent psychotherapy” is a unifying descriptor for a treatment approach where parent(s) and child are jointly present during the therapeutic sessions and the focus is on the emotional quality of the child–parent relationship, with simultaneous attention to the individual contributions that each partner makes to the affective tone of the interaction (Lieberman, 2004a). As a generic term, child–parent psychotherapy represents an overarching construct that encompasses the age-specific labels of “infant–parent psychotherapy” (Fraiberg, 1980; Lieberman et al., 2000), “toddler–parent psychotherapy” (Cicchetti et al., 1999; Lieberman, 1992) and “preschooler–parent psychotherapy” (Toth et al., 2002). This inclusive treatment label is needed because relationship-oriented treatments across infancy and early childhood have important commonalities that bridge the adjustments in therapeutic technique that become necessary as the child develops.

CPP is a more accurate description of relationship-based treatment than the widely used term “dyadic therapy” because the participants in relationship-based treatment often include more than one parent and one child. The cast of participants varies depending on clinical and situational factors but may include both parents, biological and foster parents, stepparents, siblings, grandparents, and other important figures in the child’s life. The unifying link across different configurations is the focus on how the relationships affect the child’s functioning. The treatment goal is to enhance the capacity of the child and primary caregiver(s) to create and maintain a growth-promoting partnership in the context of the other relationships in their lives. In this book we focus on environmental risk factors ranging from normative stress to trauma and describe the theoretical and clinical parameters of the therapy. We also describe how CPP changes and how it stays the same across the developmental stages spanned by infancy, toddlerhood, and the preschool years.

A Multitheoretical Rationale

CPP is grounded on three major conceptual frameworks: psychoanalysis/attachment theory, stress and trauma work, and developmental psychopathology. From this foundation, it borrows from cognitive-behavioral therapy (CBT) and social learning theory and is open to new theoretical frameworks and clinical practices that inform and refine clinical effectiveness. This attitude is based on the conviction that clinical work must transcend the confines of theoretical formulations to be responsive to the individual ways in which different children, parents and families can make use of opportunities to change.

Psychoanalytic theory, including attachment theory, object relations, and intersubjective approaches, contributes a point of view that emphasizes the child’s innate motivation to seek human relationships. In attachment theory, emphasis is placed on infants’ biological propensity to develop a hierarchy of preferential emotional relationships with a small number of attachment figures based on the expectation that they will provide reliable protection against external and internal dangers. In psychoanalytic theory, this innate motivation is understood as closely intertwined with and colored by other motivations, including self-assertion, sexuality, and the need for *mutual* recognition: i.e., the baby learns to recognize and accept the legitimacy of the mother’s independent existence while simultaneously depending on being recognized by the mother for the fulfillment of needs and desires (Lichtenberg, 1989; Diamond, Blatt, & Lichtenberg, 2007).

The contributions of psychoanalysis and attachment theory also emphasize that the past matters. The ongoing influence of past experiences is evidenced in the continuity of early perceptions and responses that become internalized into mental representations of the self and others and are transmitted to the next generation through such unconscious processes as imitation, introjection, and identification. The past is also transmitted through the intricate interplay between cultural mores and the individual adaptation to these traditions. Childrearing practices are shaped by the specific demands of the group's ecological niche but also represent an individual compromise solution to universal human conflicts (Bowlby, 1969/1982, 1973, 1980; Erickson, 1950; Freud, 1926/1959c, 1933/1964). The generative influence of psychoanalytic theory and attachment theory is evident in a variety of approaches to infant-parent treatment (Baradon, 2005; Heinicke, Fineman, Ponce, & Guthrie, 2001; Heinicke et al., 1999, 2006; Slade et al., 2005).

CPP also incorporates other theoretical orientations. The field of stress and trauma contributes an understanding of a number of factors: the individual's behavioral responses (ranging from mild alarm to extreme helplessness) to internal threats and external dangers; the neurophysiological profiles of these responses; and the antecedents, correlates, and mediators of PTSD in children and adults (Cicchetti & Walker, 2001; De Bellis, 2001; LeDoux, 1998; Laor, Wolmer, & Cohen, 2001; Osofsky, 2004b; Pynoos, 1993; van der Kolk, 2003). Attention to how the body responds when traumatic events are remembered or reenacted is a major therapeutic contribution to this point of view. Developmental psychopathology provides an interdisciplinary model for understanding the etiology and manifestations of atypical development, its interconnections with normal development, and its changing expression in different domains and at different developmental stages through the course of life (Cicchetti & Cohen, 1995a, 1995b; Cicchetti & Sroufe, 2000). The quick pace of development in the first years of life makes it particularly important for the therapist to keep track of these processes in the course of treatment. The primary contribution of cognitive-behavioral approaches involves introducing deliberate changes in cognition and behavior in order to improve affect and self-defeating attitudes (Cohen, Mannarino, & Deblinger, 2006). Parents are often responsive to concrete recommendations that can lead to prompt behavioral changes in the child. Social learning approaches emphasize the importance of imitation and social role expectations in the organization of behavior (Patterson, 1982). Parents are often motivated to improve their behavior when they realize that their child imitates what they do. Similarly, therapists are aware of the implicit modeling effect of their behavior on parents and children. Encompassing these different orienta-

tions, the family's cultural background and its influence on childrearing values and practices provide an overarching perspective through which parental behavior and the parent-child interaction are examined and understood.

The different theoretical frameworks provide complementary approaches to intervention when the young child's developmental progress is damaged by the parent's failure as a protector at times of uncertainty, stress, fear, or traumatic helplessness (Freud, 1926/1959c; Bowlby, 1969/1982; Lyons-Ruth, Bronfman, & Atwood, 1999; Main & Hesse, 1990; Pynoos, 1993, 1995). A variety of factors affect how this damage is manifested and whether it will be temporary or permanent, pervasive, or circumscribed. Some of these factors are based in the child, such as developmental stage, temperamental style, and constitutional strengths and vulnerabilities. Other factors are environmental, such as the timing, intensity, and chronicity of the stress; the presence of additional risk factors; and the effectiveness of protective influences in reducing the impact of the stressful events. The core damage, however, consists always of a distortion in the child's capacity to trust—namely, to harbor a conviction that the parents are consistently available, able, and willing to intervene effectively in fending off danger to the child's sense of physical and psychological integrity. CPP organizing principles stem from this point of view and are described below.

The Core Concept: Feeling Lovingly Protected Is the Cornerstone of Early Mental Health

Being alive and staying healthy are biological imperatives that guide behavior from the initial moments after birth, when newborns root toward the mother's breast and their sucking sets in motion the maternal physiological processes that trigger lactation. While the newborn needs the mother's assistance in gaining access to the breast, babies' active role in promoting their own survival is already evident in this earliest of exchanges, when the baby needs the mother's milk and the mother needs the infant's participation in order to provide it. This early reciprocity around basic survival needs remains the hallmark of attachment, a biologically based affective bond that becomes increasingly more complex in response to each partner's changing individual agendas, which at times conflict in the course of development (Bowlby, 1969/1982).

The child's growing circle of relationships—with the father, siblings, extended family, substitute caregivers, and friends—introduces a range of interpersonal connections that carry different meanings and expectations in different cultural groups. Indeed, there is lively academic debate

about the precise definition and contextual characteristics of terms such as “protection,” “safety,” and “security.” In particular, it is not always clear whether scholars are using evolutionary theory, a mental health perspective, or idiosyncratic cultural preconceptions when they discuss secure, anxious, and disorganized patterns of attachment in terms of their relative value in maximizing the child’s chances for survival and reproductive fitness (Belsky, 1999).

Developmental Changes in the Perception of Danger

From the perspective of a small child, the major cues to danger consist of uncomfortable or painful physical sensations and fear of external threat. These cues mobilize attachment behaviors that promote proximity and contact with the parent with the goal of attaining safety, which takes the forms of objective protection and internal relief (Bowlby, 1969/1982). An often unrecognized but key element in this process is that *regardless of the objective nature of the danger, it feels exceedingly real to the child*. For this reason, developmentally appropriate parental responses must be geared to the child’s subjective experience of danger and not only to the objective reality of the threat. Parental attunement to the child’s emotional states becomes embedded in children’s sense of self and their perceptions of being safe or endangered (Stern, 1985). The messages of attunement or misattunement are conveyed through synchrony and the construction of shared rhythms between parent and child (Beebe & Lachman, 1988; Feldman, 2007).

The sources of perceived danger change as the child becomes increasingly more capable of self-care. Freud (1926/1959c) outlined an epigenetic unfolding of internal dangers in the first 5 years of life that remains a remarkably useful tool to understand children’s anxieties: being abandoned, losing the parent’s love, body damage, and doing wrong (i.e., transgressing the internalized moral standards of the culture). These internal dangers exist independently of circumstances but are exacerbated by external events, so that the child’s responses to stress and trauma need to be understood in terms of the convergence of internal and external dangers (Freud, 1926/1959c; Pynoos, 1995). Fears of abandonment, loss of love, body damage, and doing wrong always play a role in shaping the child’s response to external threats. For this reason, helpful parental responses to the child’s fears must always include the implicit or explicit message that the child will not be abandoned, will continue to be loved, and will be protected from harm.

In infancy and early childhood, all children have core needs for parental love, protection, and socialization. When these core needs are

consistently met, the child's sense of self is organized around two largely unconscious assumptions: the trust that the parents are capable of raising the child well and the conviction that the child deserves this care (Ainsworth et al., 1978; Bowlby, 1988). Attachment theory has given impetus to three decades of fruitful research documenting the normative course and individual differences in the child's attachment to the mother (and, although less well studied, the father) in the first year of life. The preponderance of evidence shows that the quality of early attachment makes a significant contribution to the child's cognitive and social-emotional competence both concurrently and as a predictor of later development (Weinfeld, Sroufe, Egeland, & Carlson, 1999). In this paradigm, security is defined as "the capacity to engage directly, flexibly, creatively, and actively in the solution of interpersonal and intrapsychic attachment problems as they arise" (Bretherton & Munholland, 1999, p. 99).

This definition raises the question of what constitute "interpersonal and intrapsychic attachment problems." Our answer is that in the first years of life, attachment problems emerge when the child's expectations for protection from external threat and relief from internal danger are violated either by the parent's behavior or by the child's interpretation of it. Attachment problems face parent and child with dilemmas about what is safe and what is dangerous, what is allowed and what is forbidden, that need to be resolved through interpersonal negotiation, internal accommodation, or a combination of both. This is the case regardless of whether the child's interpretation of threat is accurate or distorted by cognitive immaturity, sensory-regulatory constrictions, fantasy fears and wishes, or experiential history. Through repetition and practice, children internalize processes of resolution and make them part of their internal landscape concerning intimacy and its relation to danger and safety. In infancy and early childhood, securely attached children trust their mother's availability for protection and comfort, seek her out when distressed, and are readily calmed by her ministrations or by her reappearance after a separation. In contrast, anxiously attached children cope with their uncertainty about the mother's availability by engaging in avoidant, ambivalent, or disorganized behavior in stressful situations. While securely attached children turn to the parent when the challenges they face are beyond their own coping competencies, anxiously attached children rely prematurely on their own devices because their experience has taught them that the parent is not reliably available for help in situations of need. Avoidant, resistant, or disorganized behaviors demonstrate that the child feels unsupported and is struggling to overcome the innate inclination to turn to the parent for comfort and assistance (Ainsworth et al., 1978; Main & Solomon, 1990).

The convergence of internal and external dangers shapes children's responses to threat. In the first months of life, before the child has learned to predict the reliable satisfaction of need, hunger pangs set off intense crying, a mode of communication that usually has the predictable outcome of meeting the baby's need by prompting the parent to feed the child. In contrast, well-regulated 1-year-olds are able to wait for food even when they are hungry without becoming overly upset. This change signals the progressive maturation of homeostatic mechanisms that enable the child to achieve more predictable internal states based on trusting expectations. The child learns to organize physiological processes by engaging with the outside world and expecting that the parent will be available when needed. The 1-year-old can best tolerate pangs of hunger if the parent promotes a manageable delay of gratification by encouraging the child to watch and perhaps participate in the interesting spectacle of preparing food while providing reassurance that food is coming.

The maturing child is increasingly more competent at biopsychological regulation. Nevertheless, body sensations continue to serve as danger signals all through life. We can become frightened by our own feelings of anger or fear, leading to a cascade of reactions where the initial danger signal is amplified by secondary stress responses. The younger the child, the more overwhelming this experience can be. The child becomes afraid of fear itself because of the painful bodily sensations associated with it. For example, a 4-year-old refused to go to school following a loud and angry argument between his mother and his preschool teacher over their tardiness. After the mother casually dismissed his anxious questions, he whispered in a frightened tone of voice: "My heart wants to jump out of my body when you yell." The child was still gripped by the memory of his heart racing while he watched the confrontation between these two women on whom he depended for his well-being.

In the second half of the first year of life, the onset of locomotion coincides with the child's increased separation distress and fear of strangers, two protective mechanisms that motivate the baby to seek closeness to the mother as a safe haven when feeling frightened or uncertain and to use her as a secure base for exploration when feeling safe. Toddlers become increasingly adept at detecting and responding to natural cues to danger, which include loud noises, strange people and objects, large or unfamiliar animals, rapid approach, darkness, being alone, and other stimuli associated with the increased probability of danger (Ainsworth et al., 1978; Bowlby, 1973).

The socialization process that starts in earnest in the toddler period introduces culturally determined cues to danger in the forms of social disapproval, punishment, and ostracism when the child violates cultural

norms. The resulting fears of losing love and being “bad” provide the foundation of the moral conscience while also becoming enduring sources of anxiety. The self-oriented cognitive stance of young children is coupled with their rich imagination and their urge to make sense of the world, engendering fears that may seem irrational to the adults but reflect the child’s attempts to find meaning in what is happening. From the perspective of the toddler or preschooler, a father’s snoring easily becomes a sign that a tiger is roaring in the next room, the shadowy shapes of objects in a darkened room may look like lurking monsters, and the flushing water in the toilet can evoke fear of being swept away along with the excrements from the child’s body. These developmentally expectable fears become even more intense and pervasive when children are unsure about their own goodness and their parents’ love.

Many of the young child’s initially incomprehensible responses become clearer when the adult adopts the vantage point of what seems safe and what seems dangerous to a small child. By contrast, failing to understand the child’s point of view can lead to emotional estrangement. The following vignette illustrates this point. A father could not understand why his 30-month-old son dissolved in tears at a Mardi Gras celebration where people were dressed as giants with huge heads and long, dangling arms. The father kept asking: “Why are you crying?” Unable to articulate the reason for his fear, the child kept pointing wordlessly at the enormous figures prancing about. Throughout this exchange, the father was frustrated by his son’s failure to join in the fun of this festive occasion. The child, in turn, was befuddled by his father’s failure to take action against the dangers to which he was pointing. Each partner was locked in his own frame of reference and unable to perceive the situation from the perspective of the other. Feeling helpless to solve this impasse, the father picked up the child and left the party, with the child crying loudly as he was taken away. This episode illustrates one of many ordinary breaks in communication that routinely mar the emotional reciprocity between children and their parents.

Attachment, Stress, and Coping with Danger

Manageable mismatches are a routine component of normative development and provide the child with opportunities to practice how to endure and cope with developmentally expectable anxieties. The quality of attachment in which these mismatches are embedded may affect the child’s physiology in response to stress. Anxiously attached infants tend to respond with higher heart rates and higher cortisol levels in potentially threatening situations (Sroufe & Waters, 1977; Tout, de Haan,

Kipp-Campbell, & Gunnar, 1998). On the other hand, securely attached children showed no increases in cortisol production in response to a stressful episode even when their parents reported that they were temperamentally prone to fear (Nachman, Gunnar, Mangelsdorf, Parritz, & Buss, 1996). These findings suggest that secure attachments buffer the impact of stressful situations on children's emotional functioning.

Stress becomes trauma when the intensity of frightening events becomes unmanageable to the point of threatening physical and psychological integrity. Intensity and chronicity of trauma have been linked to significant changes in the child's biological makeup. Children with a diagnosis of PTSD have an increased startle response, suggesting stable changes in brainstem functioning (Ornitz & Pynoos, 1989). Abused children show alterations in the physiology of stress and fear responses, with higher levels and atypical daily patterns of cortisol and adrenaline production that correspond to the duration of the abuse (De Bellis, Baum, et al., 1999). Anatomical brain changes have been found in sexually abused children when compared to children without a history of trauma (De Bellis, Keshavan, et al., 1999). Abused children also show an attenuation of frontal lobe asymmetry in addition to less cerebral volume when compared with children who have not been abused (Carrión et al., 2001). These findings support van der Kolk's dictum that "the body keeps the score" by carrying the imprint of the traumatic experiences long after the actual danger has passed.

Young children can be remarkably articulate in letting their parents know what they need in order to feel safe. For example, 40-month-old Elias's father asked him if he wanted anything to be different in his life. Elias thought for a moment and then answered: "I want you and Mommy to hug me when I am mean to the baby." Elias had been struggling with aggressive impulses toward his little sister, and his parents had been responding with firm messages that he could not hurt her. This boy's fear of losing the parents' love was looming large in his mind as an internal danger, and he was asking for reassurance that he would be loved even when he misbehaved.

Young children can learn to cope with stress and trauma and regain developmental momentum when their caregivers provide them with corrective experiences of safety and predictability. CPP focuses on protection, predictability, and emotional regulation as central organizing constructs in addressing the mental health problems of infancy and early childhood. Therapeutic interventions are informed by the goal of enhancing physical safety and emotional security as cornerstones of the child's emotional health. The CPP therapist helps the parent and the child to understand that dysregulated behaviors, such as tantrums and outbursts of rage, are manifestations of intense and unmanageable

emotions that include fear of harming oneself or one's loved ones. Interventions may take various forms, including containment, redirection, limit setting, skill building, and interpretation. The underlying message informing each of these interventions is that regulating emotions instills well-being by preserving safety both for the self and for others.

Parents as Protectors: Intergenerational Transmission of Relational Patterns

Just as children have an innate predisposition to seek protection from their attachment figure to maximize survival and reproductive fitness, parents have a complementary biological propensity to provide protection to their offspring. The parental caregiving system includes behaviors that are reciprocal to the infant's attachment behaviors and have the goals of retrieving the child from danger and keeping the child close at hand in situations of uncertainty or threat. The same behaviors that in the child signal the activation of the attachment system have a caregiving function when performed by the parent: looking, calling, searching, following, and maintaining proximity and contact. The parent holds; the child needs to be held. Parents maximize their own reproductive fitness when protecting the survival of their child (Bowlby, 1969/1982).

There is a strong gender differentiation among many primate species that allocates to females the protection of the young and to males the protection of the group. Systematic empirical evidence is lacking in humans, but it is plausible to postulate a marked overlap between the sexes, with mothers and fathers behaving similarly when the danger signals are clear and immediate, but showing more gender differences when the danger is not imminent or the cues to danger are ambiguous. In nonthreatening conditions, fathers tend to emphasize affiliation and exploration rather than caregiving (George & Solomon, 1999). A common area of marital conflict is the mother's complaint that the father is not sensitive enough to the child's distress and the father's complaint that the mother is overprotective. These normative frictions may have an adaptive function by offering children a range of alternatives as they work out their own individual solutions to the dilemmas of balancing exploration and attachment (Lieberman, 1995).

Parents provide their offspring with protection from external and internal dangers. They carry the major burden of responsibility for keeping the child safe because they are the more mature partner in the dyad, although security becomes progressively more co-constructed as the child becomes increasingly adept at self-care. Lapses in the parent's ability to protect from external danger are shown, for example, in reports that dog bites and drowning are major causes of morbidity and mortality in

early childhood. Failure to protect from internal dangers occurs when the parents do not respond supportively to the child's distress, misinterpreting the child's behavior as manipulation or another undesirable trait. These negative attributions are commonplace. For example, a mother may dismiss her 9-month-old's frantic crying on watching her leave the house as an example of the child's "being spoiled," or the parents may attribute their 2-year-old's night terrors to her "wanting attention," or a 3-year-old who cries on being left at the day care center may be labeled a "crybaby." When mismatches between the child's internal state and the parent's understanding of it are the norm, the child may internalize the mismatch as a generalized expectation of being emotionally bereft or a conviction that the child is bad and unworthy of care. This does not mean, of course, that parents must always do what their children want them to. Socialization is as important a parental function as emotional attunement. Both parental functions must be integrated in a balance between understanding the child's perspective and implementing the parent's best judgment about what the child needs.

Children's temperaments and personalities contribute to their parents' attributions of who they are and what they need. Similarly, parents' psychological needs color their perceptions of their children's behavior. These two overlapping processes shape the "goodness of fit" in the personality styles of the child and the parent. This compatibility, in turn, influences how the child will develop because it affects the "what" and "how" of child-parent interactions (Thomas, Chess, & Birch, 1968). The concept of "goodness of fit" is far from global: A parent and a child may be exquisitely at ease with each other in some areas but at odds in others. In their role as a secure base, the parents' protective interventions need to be tailored to the child's specific needs for protection. For example, a temperamentally fearful child may stay in close proximity to the parent in mildly unfamiliar situations that more assertive children would explore on their own. The parents are then faced with the challenge of responding to the child's subjective need for reassurance while also promoting the child's more accurate reality testing and age-appropriate autonomy. Conversely, constitutionally active and bold children may rush into potentially dangerous situations, and their parents need to contain and teach without unduly dampening the child's enthusiasm for exploration.

The child's developmental stage plays a role in the parent's mental representation of the child. Although imbued with their own distinct individuality, infants are more likely than older children to serve as "blank screens" for their parents' projections because they are more undifferentiated in their emotional responses. Toddlers and preschoolers become increasingly more articulate, assertive, and at times defiant in expressing their personal preferences. These two developmental stages

usher in major restructurings of the balance among the attachment, exploration, and fear motivational systems as the child endeavors to consolidate an autonomous sense of self while still needing the parent's basic assistance (Bowlby, 1969/1982; Lieberman, 1992, 1993). In response, parents embark on a brave new developmental phase in their role as parents, striving to balance two complementary sets of caregiving behaviors: *protective behaviors* that provide the growing child with age-appropriate nurturance and safety and *letting go* behaviors that encourage exploration without fear. Toddlers and preschoolers use their parents' signals for "social referencing," learning to tailor their behavior to the cues of safety versus risk provided by the parents (Campos & Steinberg, 1980).

Obstacles to Parental Ability to Protect

What interferes with the parent's capacity to provide protection? All parents are influenced by a unique constellation of protective and risk factors that must be taken into account in addressing the child's needs. The parent's caregiving attitudes and behavior should always be a focus of inquiry when the child shows mental health disturbances because in many cases the assessment uncovers important deficiencies or distortions in the parent's ability to provide a protective experience to the child (Bowlby, 1988; Fraiberg, 1980).

Parental behavior is the result of the complex transaction among multiple situational and psychological factors. Many parents remain steadfast in protecting their child in spite of enormous environmental obstacles, as attested by the example of stable and loving families that reside in urban neighborhoods riddled with poverty and violent crime. Some parents can provide adequate care to their child when they have access to environmental supports, but they become neglectful or downright punitive when severe stresses deplete their own personal resources, as when they are faced with unemployment, personal losses, or traumatic events such as domestic violence. An important minority of parents feel routinely overwhelmed by the ordinary hassles of living, to the point of being chronically physically and emotionally unavailable to their child. Another subset of parents would provide safe care for their children in ordinary social and economic conditions, but their capacity to do so is derailed by the extraordinary stresses of living in neighborhoods that are routinely violent and lacking in the minimal infrastructure necessary to sustain social order. Decades ago, the sociologist Jonathan Crane found that when the number of professionals, managers, teachers, and other role models in inner-city neighborhoods decreased below 5%, social

problems such as dropout rates and adolescent pregnancy increased dramatically (Crane, 1989). The concept of epidemics can be applied to the high and sustained levels of health problems, low education, unemployment, depression, anxiety and traumatic stress, and crime in underserved sectors of society where the availability of social institutions falls below what Malcolm Gladwell (2000) calls the tipping point.

Environmental Stresses

Poverty is the common thread underlying many environmental stresses. These stresses include everyday hardships like inadequate housing, unreliable transportation, and lack of access to education, employment, and health care and culminate in increased victimization by crime and community violence. The absence of resources for adults is inevitably translated into the lack of access to basic parenting resources for children. Babies and young children are disproportionately affected, as evidenced by the finding that children under age 7 comprise a disproportionate percentage of children in the foster care system, and homicide is one of the leading causes of death of babies in the first year of life following the perinatal period (Osofsky, 2004b).

The role of severe environmental stressors and traumatic events in derailing parental competence should not be underestimated. Exposure to traumatic situations in infancy and early childhood shatters the developmentally appropriate “protective shield,” engendering traumatic helplessness and prematurely confronting the child with the realization that the parent is unable to protect from danger (Freud, 1926/1959c, Pynoos, 1995). Traumatic events can also damage the preexisting quality of attachment by introducing unmanageable stress in the child–parent relationship. Very young babies show behavioral disorganization in response to a traumatic event, including disruptions in physiological rhythms and inconsolable crying (Gaensbauer, 1982). Parents may react with feelings of grief, guilt, anger, anxiety, and blame, changing the fabric of family relations and prompting deterioration in the marital relationship (Figley, 1989; Gaensbauer & Siegel, 1995; Pynoos, 1990; Terr, 1989). Traumatized infants and young children engage in unpredictable responses that present a challenge even to generally empathic and emotionally attuned parents. The parents may find themselves unable to recognize their traumatized infant as the same baby they knew before the event, leading to fears that the child has been permanently damaged and altering the parent’s emotional attunement to the child.

External disruptions may create emotional alienation between parent and child, but quality of attachment can also buffer the impact of stress and trauma. Securely attached children who endure a traumatic

event may be able to cope effectively by relying on more flexible interpersonal strategies and retaining greater trust in their parents' capacity to help. Conversely, when an anxiously attached child becomes traumatized, the event may serve to confirm and perpetuate negative expectations about the parent's availability and effectiveness as a protector (Lynch & Cicchetti, 1998).

Parental Mental Health Problems

Even in the absence of external dangers, a young child may show mental health disturbances when the parents' psychological functioning interferes with their caregiving abilities. Substance abuse, fueled by hopelessness and despair, is a recurrent factor in child neglect and maltreatment because addiction clouds judgment and because addicted parents often engage in dangerous lifestyles to support their habits, particularly when they live in poverty. As a result, they may be torn between their need to maintain access to their substance of choice and the demands of parenthood. The co-occurrence of substance abuse and mental health problems is often a focus of individual treatment but presents exceptional challenges for parenting interventions because the demands of recovery from substance abuse often interfere with attention to the child's needs. In our experience, parents who are actively abusing substances do not as a rule have the motivation to make use of child-oriented interventions before they have made some progress toward recovery. As one mother said sadly after losing custody of her child: "I loved my crack more than I loved my child." At the same time, many parents show exceptional courage in their efforts to overcome their substance abuse habits and the social stigma associated with them for the sake of their children. Here again, the importance of the child-parent relationship is a core mutative factor, as documented in the relational psychotherapy group treatment developed by Luthar and Suchman (2000). Maternal depression has received the lion's share of research attention as a factor in predicting psychological problems in children, with findings that children of depressed mothers show different brain activity and physiological patterns, more behavior problems such as school difficulties, poorer peer relationships, decreased ability for self-control, increased aggression, and heightened incidence of serious psychopathology when compared with the offspring of nondepressed mothers. Genetic predisposition may be a significant contributor to these problems, but genetic effects are probabilistic rather than deterministic because they increase the likelihood that certain outcomes will happen rather than causing them directly. Environmental factors loom large in light of the increased evidence for gene-environment interaction in

shaping behavior. For example, the research literature shows consistent findings that depressed mothers, who might have a genetic propensity to depression, tend to be less emotionally available to their children and are more likely to respond with either withdrawal or hostility to their child's overtures when compared to nondepressed mothers, setting up an interactional pattern that is conducive to mental health problems in the child (Plomin & Rutter, 1998; National Research Council & Institute of Medicine, 2000). The peripartum period is often the first stage in the manifestation of these intergenerational processes. Mothers and fathers who perceived their own mothers as less caring tend to show more mood fluctuation and dysphoria at 8 months gestation and in the weeks and months immediately following the baby's birth (Mayes & Leckman, 2007).

These maternal behaviors evoke a variety of responses in the baby, including efforts to enliven the mother and entice her to interact through eye contact, smiling, cooing, and reaching. The impact of maternal withdrawal and other misattunements on the baby is powerfully illustrated in the "still face" paradigm, where mothers are asked to stop their playful interaction with their baby and adopt a neutral, unresponsive stance (Tronick et al., 2005). Many depressed mothers are keenly aware of their emotional withdrawal and endeavor to remain available to their babies; others are unaware of the impact of their depression on the baby or are unable to take action to overcome it. Parental mental health problems need to be carefully evaluated both for their etiological role in the child's functioning and as integral components of a realistic treatment plan.

The frequent co-occurrence of psychiatric diagnoses both in adults and in children highlights the importance of looking beyond discrete diagnostic categories in conceptualizing a comprehensive treatment plan. For example, there is extensive literature documenting the overlap between clinical depression and PTSD (Cohen & Work Group on Quality Issues, 1998). Identifying secondary adversities associated with exposure to trauma is particularly important in the treatment of children and families with histories of multiple trauma. The ACE (Adverse Childhood Experiences) study conducted with thousands of Kaiser-Permanente medical patients documented the long-term effects of a handful of childhood traumatic stressors on leading causes of adult morbidity and mortality (Felitti et al., 1998; Anda et al., 2007; Edwards, Dube, Felitti, & Anda, 2007). The researchers found that nine categories of traumatic childhood events—psychological, physical, and sexual abuse; violence against the mother; living as a child with a household member who abused substances, was suicidal or mentally ill, or was ever imprisoned; absence of one or both parents; and physical or emotional

neglect—exhibit a highly statistically significant graded relationship to 10 leading causes of adult death and disability, including ischemic heart disease, liver and lung disease, cancer, and fractures. In the realm of mental health, respondents who had experienced four or more of these adversities had a 4- to 12-fold increased likelihood of alcoholism, drug abuse, depression, and suicide attempts when compared to individuals who had not experienced any of these stressors. The long-term repercussions of childhood trauma and its impact on multiple domains of functioning make it imperative to develop specialized approaches to the treatment of chronic mental health problems (Harris, Lieberman, & Marans, 2007).

Selma Fraiberg coined the phrase “ghosts in the nursery” to describe the intergenerational transmission from parent to infant of unresolved psychological conflicts originating in the parent’s childhood experiences (Fraiberg, 1980). The ghosts symbolize unintegrated early memories that live on outside consciousness and continue to affect the parents’ sense of themselves in the context of their most intimate relationships. In this model, the baby becomes a transference object for the parents, standing in at times for the parent’s unconscious self-image as a forlorn infant and at other times for unloving or tyrannical parents, siblings, or other important figures from the parent’s childhood. The present baby loses his own individuality as he is engulfed in the parents’ conflicts, evoking caregiving responses that are imbued by parental experiences of the past rather than by the baby’s needs in the moment. For example, a crying infant may trigger anger rather than the impulse to comfort if the crying carries for the mother the echoes of her own critical mother scolding her with the message, “You can’t do anything right.” Through her own angry response, whether it involves ignoring the baby’s crying, yelling, jerking, or holding the baby stiffly during feeding, the mother passes on to the baby the same message she heard as a child: “You don’t please me. You are no good.”

The Special Case of Interpersonal Trauma

Many parents show distortions in their ability to cope with stress as the result of their own traumatic experiences. The ability to make realistic appraisals of danger is one of the first casualties of traumatic exposure. Traumatized people of all ages underestimate the magnitude of the danger because of affective numbing and constriction or overestimate danger by responding to relatively mild threats with high physiological arousal (American Psychiatric Association, 1994). Young children lose their emotional compass when their parents’ emotions are consistently

raw and unmodulated. Four-year-old Janice described this state of mind when she told her angry mother: "Mommy, don't yell at me. I forget who I am when you yell at me."

When the parent becomes the agent of the trauma, as in child abuse or domestic violence, the child faces an intractable emotional dilemma because the perpetrator and the protector are one and the same (Main & Hesse, 1990). The child's normative tendency to seek protection from the parent is violated by the stark realization that the parent *is* the source of danger. The child is torn between approach and avoidance, between seeking out comfort and fighting off danger while being simultaneously flooded by the overwhelming sensorimotor stimulation of the trauma inflicted by the parent. Specific aspects of the parent's behavior, and perhaps the parent herself, can become traumatic reminders. The parent's violent behavior also confirms and exacerbates the normative developmental fears of abandonment, loss of love, body integrity and moral transgression (manifested in preschoolers in the fear of "being bad").

Confronted with overwhelming emotions, the child responds by withdrawing, fighting the parent off, becoming excessively solicitous and deferential in efforts at self-protection, or becoming sexualized as a way of discharging the anxiety about being destroyed by pleasing the potential aggressor. These different mechanisms are often deployed in quick succession, leaving the parent confused about how to respond. Because of the self-referential cognitive frame of early childhood, young children tend to believe that only their own behavior or intrinsic badness could explain the parent's punitive or violent behavior. When child maltreatment is followed by foster care placement and marital violence is followed by separation and divorce, children have additional reasons to believe that they are not wanted and to fear that the parents will leave them behind.

Just as the parent can become a traumatic reminder for the child, children can also become traumatic reminders for the parent through their role as a transference object from the past or because they are associated with a traumatic situation in the present. Mothers who have been battered by their spouses often equate their child with the child's father, attributing to the child the same characteristics of unpredictable aggression but also irresistible seductiveness that they experience in their partners. This response is particularly prevalent when the battered mother has also been abused or traumatized by interpersonal violence or sexual abuse as a child. Negative maternal attributions are often manifested in rejection of the child's signals of distress. For example, a mother in a battered women's shelter yelled, "Don't hit me!" when her

18-month-old infant raised his arms toward her in a plea to be picked up after falling down. This traumatized mother misconstrued her child's normative attachment behavior, interpreting it as an aggressive act that mirrored the aggression she had experienced from the child's father. When similar experiences are repeated again and again, children learn to internalize their parents' negative attributions, incorporating them into their sense of self through a process of projective identification (Klein, 1952; Lieberman, 1999; Silverman & Lieberman, 1999).

Questions of power and domination, always at the core of human relationships, become particularly stark when there is violence in the family. Mutuality breaks down when the adults, feeling bereft of recognition, resort to aggression to feel noticed and met by the other. Jessica Benjamin (1988) states that "domination begins with the attempt to deny dependency" (p. 52). It is not surprising that battered women are at great risk of being murdered by their partner when they choose to leave the relationship: Their assertion of autonomy is perceived as the ultimate negation of the partner's very existence. Children, in their dependency, are treated as extensions of the parent when the adults cannot recognize the child's separate subjectivity without feeling that this autonomous existence threatens their own. Parents traumatized by interpersonal violence often convert their relationships with their children into polarized arenas where one is either the master or the oppressed. This unconscious dynamic underlies many mothers' experience that their toddler or preschooler is "out of control," a "tyrant," or a "monster," and who simultaneously respond to the child with physical punishment or other harsh efforts to cower the child into submission.

This process might be at the root of the "frightened/frightening" maternal behaviors postulated as transmission mechanisms for disorganized attachment in infancy (Main & Hesse, 1990; Lyons-Ruth et al., 1999). The relational diathesis model developed by Lyons-Ruth and her colleagues builds on the "ghosts in the nursery" model by placing fear in a relational context both for parents and for children. Parents with unresolved fear dating back to childhood traumatic experiences may be unable to help the infant modulate fear because they ignore the child's distress in order to avoid reevoking their own traumatic response. This constricted pattern of deploying attention generates unbalanced interactions where the mother's needs can only be met at the expense of the child's needs, resulting in attachments characterized by polarized hostile-helpless or controlling-controlled states of mind rather than by mutuality. The internalization of affective dysregulation into disorganized states of mind in relation to attachment is increasingly used as a focus for therapeutic intervention (Slade, 2007).

The intergenerational transmission of psychopathology is countered by an equally powerful but often overlooked process: the transmission of loving, life-affirming interpersonal patterns. “Angels”—in the form of benign and protective influences—routinely do battle with ghosts for control of the metaphorical nursery, and their presence is often the salient force in shaping the baby’s experience (Lieberman, Padrón, Van Horn, & Harris, 2005). Children can make use of their inner resources to establish and maintain protective relationships with caring adults even under very adverse circumstances, as documented by the extensive literature on resilience (Luthar et al., 2000; Masten, 2001; Werner, 2000). As a parallel to ghosts in the nursery, the metaphor of angels in the nursery speaks to moments of intensely positive shared affect that are internalized and become an integral component of the child’s identity. Discovering and acknowledging the impact of these beneficent influences can have far-reaching implications in bolstering the parent’s self-esteem and strengthening a sense of hope in the future. The same person may at times play the role of an angel and at other times the role of a frightening ghost in the parent’s psyche. Learning to integrate these contradictory emotional experiences can lead to greater compassion for the failures and insufficiencies of loved ones and create increased appreciation for the complexity of relationships.

Past and present, external circumstances, and the inner world all matter. Clinical intervention must integrate attention to the psychological effects of external dangers with attention to the transmission of psychopathology from parents to children. The clinician works at the interface between subjective experience and interpersonal behavior. The bifocal lens of stress/trauma and attachment can help to sort out the contributions of present life circumstances from the enduring effects of the parental past on the child–parent relationship. Real-life events have a central role in shaping the building blocks of attachment. Reciprocally, quality of attachment can moderate or exacerbate children’s responses to external events. CPP moves flexibly between reality factors and psychological mechanisms, focusing as needed on each partner’s actions in the moment and on the mental representations that the parent and the child have of themselves, the other, their relationship, and their life situation. Helping the parent and the child remember and cherish positive experiences and health-affirming moments is an integral part of the treatment because these pivotal aspects of life are often overlooked in the midst of suffering. Integrating positive experiences into the mental representations of the self and the other is as essential to mental health as the integration of fended-off conflicts and should be an intrinsic component of the therapeutic endeavor.

The Importance of Context: Ecological Influences on Mental Health

A Brazilian saying states, in rough translation, “The head thinks from where the feet are planted.” The proverb conveys the centrality of our surroundings in shaping how we interpret the world. Cultural groups that value intergenerational continuity uphold different expectations for their children than cultural groups that welcome technological advances and social change. Immigrants who strive to maintain their cultural traditions while adjusting to their adopted country may be in conflict within themselves, with other family members, and with authority figures such as teachers and health providers while they try to reconcile contradictory messages about what kind of adult the child is expected to become.

Socioeconomic factors also have a profound impact on parenting attitudes and practices through their impact on daily routines. For someone living in a shantytown or an inner-city neighborhood, the preoccupations of everyday life are very different from those that fill the mind of a person living in an affluent section of the same city. Both individuals organize their days according to different priorities; are bound by different social expectations; have access to different choices in housing, transportation, and health care; and have different opportunities in education and employment, to name only a few of the salient areas of divergence. These abstract entities manifest themselves in disparate physical experiences: They see different sights, hear different sounds, inhale different smells, touch different kinds of objects and textures, and move through different settings. Their overall sense of safety, comfort, and ease is fundamentally shaped by these different sensations. The Spanish sociologist Jose Ortega y Gasset (1957/1994) coined another eloquent expression to describe the inextricable connection between the self and its context when he declared: *Yo soy yo y mi circunstancia* [I am myself and my circumstances]. The Brazilian and Spanish sayings share a similar appreciation for the “I” as a social and cultural construct that reflects the conditions in which it evolves.

A Tale of Two Neighborhoods

The impact of environmental conditions is particularly pronounced in infancy and early childhood because young children only know what is immediate to them. Although parents are powerful influences on their children, they are not autonomous agents, independent of the situations in which they live. How they raise their children is conditioned not only

by how they were raised and who they have become but also by the everyday circumstances of their lives, the resources they have access to, and the quality of life they can provide. The following two vignettes illustrate this point.

Example

Nancy is 2 years old. She and her parents live in a house in a quiet, safe area of the city, near a well-maintained park with a playground that serves as a gathering place for the children of the neighborhood. Nancy's parents work full time, and she spends the day in a nearby day care center where class size is a close-to-optimal 10 children cared for by two adults—one teacher and one assistant teacher. The center is clean, sunny, and colorful; the toys are varied and age appropriate. The teachers are kind and trained in child development and group care. Their salaries are low but supplemented by their husbands' earnings, and so they are able to choose a job they like and to make a long-term commitment to the children in their care. Weather permitting, Nancy's class goes to the playground for at least 1 hour a day, and the children thoroughly enjoy the sturdy and well-maintained equipment. When Nancy's father picks her up at the end of the day, father and child are eager to spend time together. They talk about what happened during the day, cook dinner together, and wait for Nancy's mom to come home. After dinner, Nancy takes a leisurely bath supervised by either her mom or her dad, whoever is less tired. The nighttime ritual consists of reviewing what happened during the day, singing a song, and saying a prayer. Nancy has no problem falling asleep.

The kinds of scenes described above take place daily, with minor variations, in millions of homes. They constitute the expectable environment for toddlers from middle-class families who rely on having access to resources that support their well-being and their children's healthy development. In contrast, the scenes described next, although also taking place in millions of families, are the source of much distress for the parents and represent major negative influences on the child's development.

Example

Tracy is also 2 years old, and she also has a mother and father. They live quite far from the family described in the previous example, in a public

housing high-rise plagued by drugs and crime. Although the criminals comprise a small percentage of the residents, everybody suffers from their presence and organizes their daily comings and goings around the drug dealers' schedule of operations. People try to do their chores before noon, the time the dealers and addicts take charge of the block. Nobody is out after dark, when street business is at its peak. Tracy's mother works at a fast-food restaurant; her father sells trinkets to tourists on the city's waterfront. Tracy spends her day in a day care center where 30 children are cared for by two women who have no training in child development and whose wages are so low that staff turnover is high, in keeping with the national norm for child care providers. Like many of their colleagues, Tracy's caregivers are not trained to understand their importance in the lives of the children in their care, and they cannot provide reliable relationships to the children because they change every 3 months or so. Toys are meager, cleanliness marginal. The few organized activities are conducted haphazardly and with many loud warnings to these young children to pay attention and to behave themselves. Outside the day care center, drug transactions take place and the addicts freely urinate by the front door in full view of the children. Outings are kept to a minimum because of the danger outside, which compounds the child care providers' lack of motivation. When Tracy's mother picks her up, she dreads the walk home because she never knows what will happen. She is tense and rushed as she urges Tracy, who has not seen her all day, to hurry along. The mother cannot forget that in the last month, Tracy witnessed two frightening street fights. When they finally reach their building, Tracy's mother has become hyperalert. Is shooting going to start unexpectedly? Are any of the regulars on the street more agitated or menacing than usual? The elevator to their fifth-floor apartment is filthy, and the floor is often strewn with needles, which Tracy, at 2, has already learned to avoid. However, the stairs are even worse, as Tracy and her mother know only too well, because the elevator breaks down at least twice a week. When she finally closes the door of their apartment behind her, Tracy's mother's nerves are frazzled. She tries to spend some time playing with her daughter but finds her thoughts drifting as she ponders how to escape from the prison that she sees as her life. When her husband comes home, there is silence and tension; he has just come through the same ordeal Tracy and her mother have braved in reaching home. Dinner conversation is short. So is Tracy's bath, primarily because there is never enough hot water for everybody in the family plus the dinner dishes. The nighttime ritual, as in Nancy's house, also consists of a song and a prayer, a tribute to the parents' pleasure in their child and their emotional investment in building moments of pleasure and intimacy. However, nobody wants to review what happened during the

day, and neither the song nor the prayer holds sway against the terrors of the night. As Tracy falls asleep, the screeching of tires, shouts, and occasional shooting can be heard nearby. Tracy has a hard time falling asleep, needs constant reassurance, and often wakes up crying during the night.

When an audience is shown videotapes of Nancy and Tracy, people know instantly who is who. Although the girls look physically similar because they belong to the same ethnic group and are both dressed similarly, Nancy is full of life, interested in her surroundings, and able to concentrate well. She is self-confident, sociable, and cognitively on target for her age. Tracy, in contrast, is often listless and withdrawn, with occasional outbursts of aggression. She looks around anxiously and is overly responsive to sounds, asking, "What dat?" with an alarmed tone of voice. Her play is often interrupted by her need to monitor what is happening around her. She stays close to her mother and father whenever she can and seems at ease primarily with them and other close relatives. All things remaining equal, Nancy has a very good chance of doing well in school and becoming a competent adult. Tracy, unless the conditions of her life improve significantly, has the odds stacked against her because her parents' loving care and concern cannot redress the emotional erosion caused by the daily stresses they encounter.

Support systems are often conceptualized in human terms: a spouse, a parent, a friend. This is understandable because human relationships are essential to personal well-being. But support systems consist also of community networks that provide supplies and services and keep people safe, able to take daily survival essentially for granted, and therefore free to attend to work and play. These support systems involve sufficient food, decent housing, efficient transportation, safe streets, good schools, reliable employment, and accessible and affordable medical care. When readily available, these resources are "psychologically silent" because people do not notice the enormous contribution they make to their self-worth and capacity to engage in satisfying relationships. Conversely, the feeling of need becomes a salient component of the person's subjective experience when access to resources breaks down. The resulting stress, worry, anger, and self-blame can become permanent backdrops of the sense of self. The intricate transactions between sociological and biopsychological factors in shaping child outcomes highlight the importance of ecological models of development (Bronfenbrenner, 1977; Garbarino, 1990; Sameroff, 1983).

James Garbarino coined the term "social toxicity" to describe sociocultural conditions that deprive children of opportunities to learn and thrive, such as economic inequality, racism, and mass-media legiti-

mization of aggression (Garbarino, 1995). The impact of such social risks cannot be underestimated because these factors affect developmental domains that have traditionally been understood from a biological perspective. For example, the relationship between early developmental delay and later deficits in IQ seems to differ depending on socioeconomic standing. In a classic study, the percentage of developmentally delayed 8-month-olds who showed deficits in IQ at 4 years of age was inversely related to the family's social class: 13% of lower-class, 7% of middle-class, and 2% of upper-class preschoolers (Willerman, Broman, & Fiedler, 1970). A likely explanation for these findings is that the upper-class families had more access than lower-class families to material and educational resources that would promote their delayed babies' development, with the middle-class families somewhere in between. These resources may range from abundant and nutritious food to safe housing, predictable daily routines, high-quality medical care, access to developmentally stimulating child care, and more parental time and leisure to devote to the baby.

The Psychological Effect of Social Risk Factors

There is compelling research evidence that single risk factors do not result in developmental problems or psychiatric disturbances for children. Rather, negative child outcomes are best predicted by the accumulation of risk factors (Rutter, 2000; Sameroff & Fiese, 2000). Several longitudinal studies using "adversity indices" that measure different aspects of neighborhood and family life—including economic disadvantage, low parental education, parental psychiatric status, parental criminality, marital conflict, and maladaptive parenting practices—consistently indicate a steep risk gradient, where the likelihood of negative child and adolescent outcomes is negligible with one risk factor but rises sharply as risk factors accumulate (Fergusson & Lynskey, 1996; Furstenberg, Cook, Eccles, Elder, & Sameroff, 1999; Rutter & Quinton, 1977; Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987).

Risk factors do not as a rule occur in isolation. One risk factor tends to create circumstances that increase the likelihood of other risk factors. For example, prolonged unemployment leads to depleted material resources for basic needs, creating high levels of stress that can trigger marital conflict and decrease warmth and supportiveness and result in compromised parent-child relationships that have a negative impact on child functioning (Conger & Elder, 1994; McLoyd, 1989). This tendency of risk factors to cluster together may explain the consistent association between economic hardship and negative developmental

outcomes in children (Brooks-Gunn & Duncan, 1997). Poverty tends to be associated with “socially toxic” risk factors such as racial and ethnic discrimination, precarious employment, educational disadvantage, inadequate housing, and unsafe neighborhoods, and with a paucity of resources that promote healthy development (Garbarino, 1995). The influence of risk and protective factors on family processes and on the psychological functioning of individuals highlights the continuing relevance of conceptualizing the child’s ecology in terms of the immediate settings in which the individual develops (*microsystems*), the relationships between these microsystems (*mesosystems*), and settings where children are not usually present but which play an important role in their development, such as the parents’ workplace, government agencies, and the headquarters of corporations (*exosystems*) (Bronfenbrenner, 1977). Decisions taken at the level of exosystems may have powerful consequences at the level of microsystems—for example, when offering subsidized prenatal and perinatal services to low-income families leads to a decrease in infant morbidity and mortality.

These considerations have important implications for approaches to intervention, because they suggest that treatments geared at optimizing child outcomes should focus not on a single aspect of the child’s ecology but rather on the variety of risk factors that are likely to act in synchrony to derail the course of development. CPP incorporates active assistance to the parents with problems of living, such as advocacy to secure adequate housing; quality child care; appropriate medical, psychiatric, or substance abuse services; and other needs. However, clinical intervention cannot make up for toxic social conditions. The pathogenic conditions affecting millions of children call for “supraclinical” interventions that include public policies designed to provide adequate income and health, education, and early intervention services to children and families afflicted by the consequences of poverty and marginalization (Harris, Putnam, & Fairbank, 2006; Harris et al., 2007).

Mutative Factors in Treatment

Therapists make implicit, often unconscious assumptions about how improvement occurs when they choose particular strategies to bring about change in the parent–child relationship. There is extensive literature elucidating the relative importance of different mutative factors, including the roles of interpretation and noninterpretive mechanisms in psychoanalytic therapy (see Pine, 1985; Stern, Sander, & Process of Change Study Group, 1998; and Wallerstein, 1986, for helpful overviews and discussion). Although this literature refers to individual treatment of

adults, the issues raised also apply to CPP. At least four recurrent themes can be identified in this body of work: (1) the degree to which insight-oriented interpretation promotes change; (2) the role of intersubjective attunement, empathy, and other forms of “relational knowing” in the therapeutic relationship; (3) the definition and usefulness of emotional support; and (4) the significance of the patient’s real-life experience as a direct focus of the intervention. Reduced to their essence, these mutative factors can be defined as intrapsychic (interpretation), interpersonal (emotional support, intersubjective attunement, empathy), and external (education, advice, assistance with concrete aspects of daily life).

In keeping with these clinical research findings, CPP relies on supportive, interpretive, and reality-oriented interventions. As described in earlier sections, the basic premises of the model are that feeling lovingly protected is the cornerstone of mental health in infancy and early childhood; that the parents’ competence as protectors fosters the transmission to the child of adaptive mechanisms for coping with anxiety, stress, and trauma; and that the family’s ecological context (including cultural values and the cumulative impact of protective or risk factors) is the matrix that facilitates or undermines the parents’ effectiveness as protectors and guides to the child’s development. In this framework, the mutative factors in treatment may differ depending on the specific areas of competence and vulnerability in the parent, the child, their relationship, and the family’s ecology.

The mutative factors may also change as treatment unfolds. For example, when the parents are resistant to treatment, the therapist starts by building a therapeutic alliance that responds to the sources of concern and stresses the collaborative nature of treatment. Here, the therapeutic relationship is the first mutative factor that opens up the possibility of successful treatment. When the parents are so depressed, angry, or self-absorbed that they cannot respond to their child’s needs, the therapist may need to focus first on decreasing the intensity of the parents’ emotional states and on helping them to notice the impact they are having on the child. The initial mutative factors in this approach involve emotional support for the parents’ situation, perhaps including referral to individual psychotherapy coupled with developmental guidance in order to help the parents establish the connections between their own states of mind, their parenting practices, and their child’s emotional difficulties.

A common clinical scenario involves external circumstances that are so dangerous and chaotic that the parent’s capacity to engage in protective action is obliterated by their pervasive helplessness and despair. In this situation, the treatment focuses first on identifying dangers, affirming the importance of safety, and engaging with the parent in effective

action to fend off danger and increase sources of protection. This stance may include concrete steps—for example, changing the locks of the apartment to prevent a violent estranged spouse from breaking in or facilitating the family's move to a less dangerous neighborhood. Such an immediate treatment focus on changing external circumstances derives its mutative potential from at least three elements. First, it introduces a way of being with the parent characterized by responsiveness in giving treatment priority to a need expressed by the parent (intersubjective relationship). Second, it makes available for the parent and the child a more self-affirming way of being in the world by linking talk about the importance of safety to effective action on the environment (external circumstances). Third, it changes the day-to-day affective experience of the parent and the child from uncertainty and fear to greater predictability and control (internal experience).

The temporal sequence in which different mutative factors operate is, of course, largely unknowable. What leads to what in this improvement of internal experience, interpersonal trust, and external circumstances? Regardless of the order in which change might occur (and it may occur simultaneously in the three different domains), tactful concrete assistance can give the parent confidence in the usefulness of treatment and open up new opportunities for therapeutic intervention. The key mutative factor here is not only the concrete action to improve the family's circumstances but also the way in which this concrete action is offered as a collaborative partnership with the parent.

The therapist's capacity to engage in a genuine human connection with the parent is the essential building block that allows other mutative factors to crystallize. The quality of the therapeutic relationship is the oxygen that breathes the possibility of life into every other component of the treatment. The emphasis here is on the therapist–parent relationship rather than on the therapist–child relationship because although the child's mental health is the ultimate goal of the treatment, the parent's cooperation is indispensable in making this goal possible.

In our experience, young children suffering from stress-related mental health problems are uniformly eager for treatment and ready to engage in a therapeutic alliance with the therapist. It is the parent who often presents the more difficult challenge. Parents may consciously want their children to get better, but their ability to cooperate with the treatment is often hampered by obstacles that may include their own mental health problems, unconscious jealousy or resentment of the child, the wish to be the “therapist's favorite” over the child, fear that the therapist may prove to be the “better parent” and become the child's preferred figure, or daily hassles such as unmanageable work schedules or competing priorities.

There is always a potential for competitive struggles between the therapist and the parent for the love of the child. The therapist will invariably lose this struggle because the parent always has the option of terminating treatment, and the child will carry the burden of this loss. For this reason, child–parent psychotherapists need to define themselves as providing corrective attachment experiences for the parent and the child through the vehicle of the therapeutic relationship. By remaining focused on the child–parent relationship while equally empathic to the separate individual experiences of the parent and of the child, the therapist offers the necessary emotional safety to examine rigidly constricted, frightening, or disorganized emotional states and to practice more satisfying ways of relating to oneself and others.

The therapeutic relationship is a necessary but not sufficient ingredient in therapeutic change. The relationship with the therapist can be reduced to serving as a temporary emotional shelter at best, unless the parent and the child can use the protected therapeutic space to reflect on burdensome emotional experiences and to learn, practice, and internalize more adaptive ways of coping and relating. When the therapist does not encourage alternative ways of relating to the child and living in the world, the therapeutic relationship can be misconstrued by the parent as giving tacit support for emotional dysregulation and abusive exchanges.

Treatment improvement should be maintained long after the end of treatment. The combined use of diverse clinical modalities defines CPP as a multitheoretical, cross-disciplinary endeavor designed to promote enduring internal and interpersonal change. Interventions informed by social work blend seamlessly with interventions based on developmental psychology, psychoanalytic/attachment theory, trauma, social learning theory, and CBT. The next chapter describes the impact of the stress–trauma continuum of experiences on individual functioning and on the child–parent relationship and provides the rationale for using CPP to treat the psychological sequelae of exposure to danger and threat.

CHAPTER 2



Coping with Danger

The Stress–Trauma Continuum

Children encounter internal and external dangers as part of everyday life and are stressed by those encounters, making stress intrinsic to development. Although volumes have been written about stress, the term remains imprecisely defined and generally refers to physical or psychological alterations capable of disrupting homeostasis (Cullinan, Herman, Helmreich, & Watson, 1995). Stress may range in intensity from normative strains associated with everyday life to extreme distortions of physiological and emotional balance as the result of catastrophic experiences. This is what we mean by “the stress–trauma continuum.” As discussed in Chapter 1, stress becomes trauma when the intensity of frightening events becomes unmanageable to the point of threatening physical and psychological integrity.

Theorists beginning with Freud and continuing with contemporary cognitive psychologists have formulated a cognitive-affective processing model to explain human reactions to stress ranging from normative to extreme (Freud, 1920/1959b, 1926/1959c; Lazarus & Folkman, 1984; Lazarus, 1991). The model identifies a three-step process: (1) recognition of the potential danger; (2) appraisal of the event in order to identify coping strategies; and (3) deploying the coping strategies identified as most useful. This three-step process may take split seconds to implement and is essential to survival.

Although this model of stress identification, appraisal, and coping is considered to be universal, it does not unfold in identical fashion across individuals or at every age. New stresses loom and new skills are acquired in the course of development. Children appraise and cope with risk differently depending on their individual styles and developmental stage. The capacity to appraise external danger matures with age, but it always intersects with children's perception of dangers emerging from within, reflecting fears and conflicts that also shift with development, such as the basic anxieties about losing the parent, not being loved, body damage, and failing to meet the moral standards of the culture. Parents are intimately bound up with young children's sense of what is dangerous and what is safe, and their own stresses and traumas can have a major role in derailing their ability to protect their children. This chapter examines how external dangers affect children's development and their relationships.

Adaptive and Maladaptive Responses to Danger

Responses to real and perceived danger exist along a continuum that ranges from healthy adaptation to pathological dysregulation, including severe constriction or derailment of the ability to relate to others and to explore and learn from the environment. Responses in the adaptive range involve the child's ability to accurately read cues to danger and to choose effective self-protective strategies that match the level of objective danger. For example, an emotionally healthy toddler may remain in close proximity to the parent in an unfamiliar situation but may insist on being held, may cling to the parent, and may refuse to be put down in the presence of a barking dog or a screaming adult. Maladaptive responses involve inaccurate reading and responding to danger cues. These misconceptions may involve underestimating danger and engaging in risky behaviors (e.g., letting go of the parent's hand and rushing across the street and moving away from the parent in a situation fraught with unfamiliar stimuli) or over-reacting to neutral stimuli as if they involved danger (e.g., clinging anxiously to the parent in familiar and benevolent settings). These two polarities of response—recklessness versus constriction of exploration—are often associated with distortions in secure base behavior and may be indices of disorders of attachment (Lieberman & Zeanah, 1995; Zeanah & Boris, 2000). The example that follows illustrates the coordination of adaptive responses in a child and a parent as they collaborate in devising a strategy to help the child cope with a normative stress.

Example

Ruth Hall, now a grandmother, recalls the week that she began kindergarten. It was customary in her small town for children to walk to and from school on their own. Although she was looking forward to beginning school and to the more grown-up status this would give her, Ruth was also frightened that she would get lost on her way home from school. Many of the houses in her neighborhood looked alike, and she did not believe that she would be able to find her way back from school. One night, a few days before the first day of kindergarten, she burst into tears at bedtime and told her parents that she couldn't go to school. She cried for several minutes before she finally blurted out, "I'll be lost. I won't be able to get home."

Ruth recalls that her parents comforted her and helped her fall asleep. The next day, her father suggested that they take a walk to the school together. As they walked back home, he pointed out familiar landmarks to help his young daughter remember where to turn. Ruth felt better as her father helped her plot the route home. The next evening they repeated their walk, with her father again pointing out the landmarks along the route. Ruth remembers that by the third evening she was pointing out the landmarks to her father as they walked along. She started kindergarten the next day filled with anticipation and excitement, confident that she would find her way home to her parents at the end of the day.

This example shows that developmental milestones may be stressful no matter how eagerly anticipated. It also illustrates how environmental dangers interact with children's constitutional vulnerabilities and developmentally salient anxieties. Ruth may have had a relative vulnerability in visual-spatial processing that made it difficult for her to make use of visual cues in her environment without extra support. Even so, she had a realistic fear of being lost in her neighborhood because there are actual dangers facing children who navigate the streets on their own. She dreaded encountering hurtful strangers, not seeing her parents again, and being cold and hungry if she could not find her way home. These "real" dangers and vulnerabilities interacted for Ruth with two of the normative anxieties of early childhood, fear of losing the parent and fear of bodily injury. Fear about being "bad" might also have been at play if Ruth worried that her parents would be angry with her if she could not find her way home. In the face of all these external and internal dangers, the young girl became anxious and afraid. She communicated her distress to her parents, first through crying and finally through expressing in words her fear that she would be lost.

Ruth's anxiety did not escalate to a severely stressful response because she trusted her parents and they, in turn, responded supportively by helping her appraise and cope with the danger and with the feelings it aroused. Her father took her perspective and assessed the risk from her point of view. He may or may not have understood her visual-spatial processing vulnerabilities or her internal fears, but he certainly understood how threatening her familiar neighborhood suddenly seemed to her when she was expected, for the first time, to navigate it alone. This empathic attunement was sufficient to mobilize his supportive response.

Beyond helping his daughter appraise the situation, Ruth's father taught her to cope. He was emotionally attuned and physically available; he did not attribute her fears to an innate helplessness but understood that she had some coping abilities to bring to the situation. He worked sensitively with Ruth's coping skills and developed a strategy that helped her succeed. Reciprocally, Ruth was not so aroused by her fear as to be unable to use her father's guidance. She could be comforted and soothed and used the information her father offered her to grapple with her fear and successfully meet the challenge she faced.

Had any of these factors changed, the outcome might have been different for Ruth and the child-parent relationship might have been negatively affected. Ruth could have been a more constitutionally anxious child, too panic-stricken to accept her father's reassurance or process the information he gave her to cope with the new situation. For his part, the father might have been unable to suspend his adult perceptions and accept Ruth's appraisal of the situation as dangerous. In this case, he could have dismissed her fears, telling her that she had lived in the neighborhood all her life and that her worries were groundless. In either case, Ruth would have felt all alone while her fears escalated as the first day of school approached. The experience might have put her at risk of becoming a generally more fearful and insecure child. In the most extreme situation, Ruth might have been overcome by anxiety and actually gotten lost on her way home from school, placing her in real danger and confirming for her the validity of her fears as well as her parents' inability or unwillingness to help.

A different damaging process could occur if Ruth's father had overreacted to his daughter's distress and attributed helplessness to her. Consider the outcome if he had taken Ruth to school each day and picked her up when school was over in spite of the fact that children in the community were accustomed to walking home on their own. This overprotectiveness would have undermined Ruth's belief in her ability to learn and would have given her the message that instead of being

increasingly able to rely on her own resources, she would always need a parent nearby in order to be safe.

When children and parents do not manage as well as Ruth and her father, failures of protection and coping in the face of danger may lead to a range of problems in the parent–child relationship and the child’s development. The consequences of stress and trauma for the child involve the intersection of three factors: the nature and severity of the stress, the parent’s capacity to help, and the child’s ability to rely on the parent for reality testing and protection.

The Stresses of Early Childhood

There has been little systematic study of the incidence of stress and trauma exposure among infants, toddlers, and preschoolers. This may be due to the fact that as a culture, we tend to idealize early childhood and imagine infants and very young children as safe and carefree. For example, in a literature review of children’s exposure to community violence, none of the 12 studies included had data about children under age 6 (Jenkins & Bell, 1997).

The available empirical evidence shows that very young children are routinely exposed to a range of stressors. In one study, a pediatric sample of 305 children between ages 2 and 5 showed that 52.5% of the children had experienced a severe traumatic stressor in their lifetime. Although the older children had a higher incidence of these experiences, 42% of the 2-year-olds had suffered from at least one severe stressor. For the group as a whole, 20.9% experienced the loss of a loved adult; 16% had been hospitalized; 9.9% had been in a motor vehicle accident; 9.5% had had a serious fall; and 7.9% had been burned. There was a strong association between the number of stressors experienced by a child and the likelihood of DSM-IV emotional or behavioral disorders, with 17.4% of the children showing such a disorder (Egger & Angold, 2004). Another study found that children under age 5 are hospitalized and die from drowning and submersion, burning, falls, suffocation, choking, and poisoning more frequently than do children in any other age group (Grossman, 2000).

Young children’s exposure to violence is also common. In a sample of children under age 6, 47% percent of the mothers surveyed in the waiting room of the Boston Medical Center pediatric clinic reported that their children had heard gunshots, and 94% of this subset of mothers reported more than one such episode. In addition, 10% of the children had witnessed a knifing or a shooting, and nearly 20% had witnessed

an episode of hitting, kicking, or shoving between adults (Taylor, Zuckerman, Harik, & Groves, 1994). Children under age 5 are more likely than older children to be present in homes in which domestic violence occurs (Fantuzzo, Brouch, Beriama, & Atkins, 1997). Young children are also disproportionately the direct victims of violence. During the first year of life, more children are physically abused and die as the result of the abuse than at any other 1-year period (Zeanah & Scheeringa, 1997). Extrapolating from data from 40 states reported to the National Center on Child Abuse and Neglect in 1995, the National Research Council and Institute of Medicine (2000) found that over one-third of victims of substantiated reports to child protection agencies were under age 5, and 77% of the children killed were under age 3. Some groups of children are at greater risk than others. In one nationally representative sample of children ages 2–9 years, children in single-parent and stepfamily households, ethnic minorities, and children of lower socioeconomic status had greater lifetime exposure to most forms of intentional victimization, including physical abuse, sexual abuse, and witnessing family violence (Turner, Finkelhor, & Ormrod, 2006). Untold numbers of children are exposed to war and to the myriad hardships and traumas intrinsic to it: death of parents, rape and sexual assault, displacement, and starvation. All these events, whether of human or nonhuman agency, whether intended or not, profoundly change children and their relationships.

Children's responses to particular stressors are determined by a variety of factors, including environmental, experiential, and genetic characteristics (Pynoos, Steinberg, & Piacentini, 1999). Children's genetic vulnerabilities, past experiences, present coping resources (including, especially for young children, the resources of parents and caregivers), and secondary stressors all interact to shape the child's developmental pathway after trauma. Early trauma may magnify genetic vulnerabilities, leading to a downward spiral of dysfunction (National Research Council & Institute of Medicine, 2000). Caregiving relationships have a critical role in mediating children's responses to traumatic events. One study of children under age 4 who experienced severe burns demonstrated a direct path linking children's pain as a stressor to parental distress about the child's pain, which was in turn linked to acute stress symptoms in the children (Shalev, Peri, Canetti, & Schreiber, 1966). In another study, maternal psychological functioning and family cohesion predicted the longitudinal adjustment of Israeli preschoolers whose homes were damaged by SCUD missiles during the Gulf War (Laor et al., 2001).

Detrimental effects are not necessarily irreversible. The presence in the child's life of protective factors, particularly in the form of a close emotional relationship with a supportive adult, can ameliorate the impact of adversity and promote a positive developmental outcome

(Lynch & Cicchetti, 1998). Early relationship-focused interventions such as CPP can also promote healthy development outcome by enhancing the child's primary attachment relationships and enabling the adult to be more supportive of the child, thus shifting the dynamic interplay between constitutional strength or vulnerability and environmental stress (Lieberman et al., in press). There is emerging evidence that interventions that strengthen children's primary caregiving relationships also improve their physiological reactivity. The abnormally high cortisol level of infants and toddlers in foster care declined to the normal range after their foster parents took part in a brief intervention designed to help them provide more individually tailored nurturing care (Dozier et al., 2006). The promise that relationship-based interventions may succeed in restoring greater physiological balance has important clinical implications because of the dramatic and enduring impact of traumatic stress on brain development.

The Normal Stress Response

Newborn babies secrete high levels of stress hormones, including cortisol, in response to such noxious stimulation as blood sampling and circumcision, and their cortisol elevations are positively associated with crying. Healthy newborns also have the capacity to self-regulate by withdrawing into quiescent states that are associated with lower levels of stress hormone secretion. The normative pattern in healthy babies is to habituate to stress so that they cry less over time and secrete less stress hormones in response to the same levels of stimulation. Less healthy babies (but still well enough to be cared for in normal nurseries) are less able to regulate their hormone levels and habituate less readily to stress. In these infants, crying is not an accurate index of their stress levels because they continue to have high cortisol levels even after they have been soothed. These findings indicate that individual differences are evident from the days immediately after birth. It is possible that the less healthy babies will remain more physiologically vulnerable to stress as they develop, and that less intense stimulation may trigger a full-blown stress response (Gunnar, 1992).

Healthy newborns' ability to habituate to stress becomes more sophisticated as they develop. By the time infants are 3 months old, their diurnal patterns of cortisol production are related to the sleep-wake cycle, with the highest cortisol level occurring in the morning and declining throughout the day (Bailey & Heitkemper, 1991; Price, Close, & Fielding, 1983; Schmidt-Reinwald et al., 1999; White, Gunnar, Larson, Donzella, & Barr, 2000). The level of cortisol is controlled by

a system of negative feedback loops, with high cortisol levels triggering a shutdown in production (Jacobson & Sopolsky, 1991). Older infants secrete stress hormones on separation from their caregivers or in novel situations, but even temperamentally wary babies are able to habituate quickly to novel situations between 2 and 6 months of age. As this developmental trajectory moves into the school years, children who deploy moderate cortisol levels in response to stress tend to be more competent with peers, more involved in schoolwork, more cooperative, and more realistic in their appraisals of a stressful situation. Elevations in cortisol do not automatically signal stress or anxiety but may index children's active attempts to cope both with the stressor and with their emotional responses to it (Gunnar, 1992; McEwen, 1999). Successful coping with nonoverwhelming stress and supportive care from parents help children be less reactive to later stressors (Gunnar & Quevedo, 2007).

The Body's Response to Extreme Stress and Trauma

Cortisol and other hormones play critical roles in the metabolic and anti-inflammatory responses of healthy children and adults (Tortora & Grabowski, 1993). The body responds to highly stressful stimuli with a dynamic process that involves multiple neurotransmitter systems, including the catecholamine, serotonin, and dopamine systems as well as multiple neuroendocrine axes, including the hypothalamic-pituitary-adrenal (HPA) axis which produces cortisol (Lipschitz, Rasmusson, & Southwick, 1998; McEwen, 1999). Trauma-associated dysregulations have been described in catecholamines, the neurotransmitters that regulate the sympathetic nervous system, as well as in the serotonin system and the metabolism of endogenous opiates, two systems involved in the regulation and modulation of mood (Southwick, Yehuda, & Morgan, 1995). The HPA axis is the most thoroughly studied stress-response system, and it is central both to fear conditioning and to the production of stress hormones in response to fear (Yehuda, Giller, Levengood, Southwick, & Siever, 1995). HPA axis activity over time is complex and variable, with stressors that are uncontrollable, traumatic, and threatening to one's physical integrity eliciting the highest levels of activity (Miller, Chen, & Zhou, 2007).

In the event of a traumatic event, responses to sights, sounds, olfactory, tactile, and kinetic stimuli join with a rapidly accelerating cascade of feelings from within to overwhelm the traumatized person. The external sensory information is filtered by the thalamus and then directed along two separate pathways. One path sends the sensory input to the amygdala, a bilateral structure located in the limbic brain whose

function is to assess the aversive emotional significance of the sensory stimulus and set in motion the fear response. Simultaneously, the sensory information is transmitted along a slower path to the sensory prefrontal cortex, the seat of analysis, planning, and executive function (LeDoux, 1996, 1998). Survival depends on the rapid physiological response to danger that is made possible by the shorter pathway to the amygdala.

The body mobilizes for self-protection when confronting a situation assessed as dangerous from feedback provided by the amygdala and related structures. The sympathetic nervous system discharges as a unit, redirecting the blood supply into active muscle groups and away from functions that are not involved in responding to risk. Simultaneously, there is mobilization of blood glucose to increase energy supply to muscles, acceleration of heart rate and blood pressure to allow for more blood supply to vital organs, and dilation of pupils so that more light enters the eye (Southwick et al., 1995). The brain perceives these physiological changes as part of the global danger situation. In response to both the external and internal stimuli, the amygdala plays a major role in activating the HPA axis via projections to the hypothalamus, which controls adrenocorticotrophic hormone (ACTH) release from the pituitary. Once activated, the adrenal cortex releases high levels of corticosteroids, including cortisol (LeDoux, 1995).

Stimulus evaluation is critical not only to the initiation of the stress response but also to the following stages. Continued interpretation of the event as dangerous results in the continued activation of the sympathetic and HPA systems (LeDoux, 1995). This process interferes with the negative feedback loop that, under conditions of mild or moderate stress, halts the production of cortisol. Prolonged and severe stress leads to chronic activation if cortisol and other stress hormones are secreted for extended periods. In preclinical animal models, the result is cell death and atrophy of specific parts of the brain. One recent study suggests that cell death in the human brain may also be linked to prolonged exposure to cortisol. Baseline cortisol levels and PTSD symptoms predicted decreased hippocampus volume over a 12- to 18-month interval in a group of 7–13-year-olds, with higher levels of cortisol associated with greater decreases in volume (Carrión, Weems, & Reiss, 2007).

Although the nervous system may habituate even to predictably high levels of stress over time, such habituation does not occur if stresses are severe, unpredictable, uncontrollable, or novel. In these conditions, high levels of stress hormones will continue to be secreted even in response to stimuli that are not inherently traumatic. It is as if the switch that controls the production of stress hormones is recalibrated and reset to a position where less frightening stimuli are sufficient to activate it (Yehuda, Giller, Southwick, Lowy, & Mason, 1991).

For decades, the stress response has been described as a fight-or-flight mechanism that allows the organism to fend off the threat or to escape it, depending on which of these two strategies is appraised as most effective (Cannon, 1932). This binary model is currently considered too narrow to encompass the sex differences found in strategies for coping with danger (Taylor et al., 2000, 2006). Although both males and females display the core neuroendocrine stress response described earlier (Allen, Stoney, Owens, & Matthews, 1993), oxytocin and progesterone are involved as well. Oxytocin is a pituitary hormone released by both men and women in response to a broad variety of stressors and found to enhance relaxation, decrease fearfulness, and lower sympathetic activity, but it is related to different coping behaviors in men and women (Uvnas-Moberg, 1997). Oxytocin effects may be more pronounced in women than in men for several reasons. First, females appear to release more oxytocin under stress than males (Jezova, Jurankova, Mosnarova, Kriska, & Skultetyova, 1996). Second, androgens appear to inhibit oxytocin release under conditions of stress (Jezova et al., 1996). Third, oxytocin effects are modulated by estrogen (McCarthy, 1995). The hormone progesterone, also released in times of stress and highly correlated with stress-related cortisone production, is likewise associated with the arousal and affiliation motives, although the sex differences noted in oxytocin release are not observed (Wirth & Schultheiss, 2006).

Oxytocin is also implicated in maternal caregiving behaviors in animal models. High levels of licking and grooming behavior in rats during lactation are associated with higher oxytocin receptor levels in the brain (Francis, Champagne, & Meaney, 2000), and higher levels of maternal care are associated with lower levels of stress reactivity in adult offspring (Leckman, Feldman, Swain, & Mayes, 2007; Weaver et al., 2004). These studies are based on the behavior of animal mothers in the interval immediately following the birth of young. Early caregiving behaviors, associated with higher levels of oxytocin, appear to have enduring consequences for anxiety regulation and stress responsiveness in the offspring (Leckman et al., 2007).

Females are more involved than males in the immediate protection of offspring, and gender differences observed in oxytocin production may be explained by the demands of caregiving (Taylor et al., 2000, 2006). Pregnancy, nursing, and care of young render females particularly vulnerable to attack. Given the female's investment in the protection of the young, neither a fight response that could end in her incapacitation or death nor a flight response that could entail the abandonment of vulnerable offspring would be adaptive. Females may instead adopt behavioral patterns for coping with stress that involve protecting offspring and affiliation, particularly with other females. These behaviors

are labeled “tend or befriend” by Taylor and colleagues as a counterbalance to the fight-or-flight alternatives. One interpretation of the studies that find that animal dams with higher oxytocin levels engage in higher levels of licking and grooming behavior is that these dams are managing the stress of birth and lactation by tending to their young. These tending behaviors may be stress relieving for the dams as well as having a lasting impact on their offspring’s stress responsiveness.

If the model proposed by Taylor and her colleagues holds for humans as well as animals—a hypothesis supported by some human behavioral studies—women’s urge to tend to their children in times of overwhelming stress may work to the advantage of relationship-based treatments such as CPP. An important element of CPP is the co-construction of a trauma narrative by the caregiver (most often the mother) and her young child. Recalling the details that surrounded a traumatic event can be extraordinarily anxiety provoking, giving rise to an attenuated form of the body’s stress response to the original event (Foa, Rothbaum, & Molnar, 1995). Women whose tend-or-befriend stress responses are activated in response to the co-creation of a trauma narrative with their children may be more likely, according to this hypothesis, to nurture and protect their children, and these behaviors may strengthen the children’s trust in their mother’s capacity to provide protection.

Central Nervous System Dysregulation and Structural Change

The human stress response is associated with lasting changes in brain structure, neurotransmitter systems, and the HPA axis, although some of these changes seem to differ in children and adults. The empirical evidence is somewhat mixed, but most studies of adult trauma survivors (including one study of Holocaust survivors with PTSD but without the substance abuse history that is so frequently comorbid with PTSD) point to hyporesponsiveness in the HPA axis with low levels of cortisol (Yehuda et al., 1995). Traumatized children, on the other hand, show higher levels of cortisol than matched nontraumatized controls (De Bellis et al., 1999a; Carrión, 2006). This difference in the child and adult literature has led to the hypothesis that the low cortisol levels in adults reflect a long-term adaptation to trauma because the body cannot sustain the hypersecretion of cortisol that is triggered in childhood by extreme stress and trauma (De Bellis, Baum, et al., 1999; Gunnar & Vazquez, 2001).

There is also empirical evidence of changes in brain structure following trauma, although the findings are inconsistent. Some studies show that maltreated children have smaller frontal lobe volumes

(De Bellis, Keshavan, et al., 1999). Other studies have shown larger frontal cortex volume associated with increased gray matter in the left frontal lobe that attenuates the normal frontal cortex asymmetry (Carrión, 2006; Carrión et al., 2001). In both cases, however, the changes are associated with earlier age of maltreatment, longer duration of maltreatment, and greater severity of PTSD symptoms. Maltreated children also show pronounced asymmetry in left–right volumes of the superior temporal gyrus, a brain center implicated in the cognitive processes of language production (De Bellis et al., 2002). Most studies have not found hippocampal atrophy among maltreated children (De Bellis, Hall, Boring, Frustaci, & Moritz, 2001; Carrión et al., 2001), although this atrophy has been observed in several adult samples, including combat veterans with PTSD (Bremner et al., 1997; Gurvits et al., 1996), PTSD sufferers who experienced childhood physical maltreatment (Bremner et al., 1997), and women with a history of sexual abuse as children (Stein, Koverola, Hanna, Torchia, & McClart, 1997). As noted earlier, hippocampal atrophy has also been observed in a single longitudinal sample of children ages 7–13 years (Carrión et al., 2007).

The evidence of structural brain differences associated with trauma is provocative, but it requires further study with larger sample sizes and longitudinal designs to help explain whether developmental processes or other factors explain the discrepancies between adult and child findings and whether there are accompanying functional changes that appear with maturation (De Bellis, Hooper, & Sapia, 2005). From the current literature, it is clear that the changes in brain structure observed among maltreated children with PTSD are associated with limitations in cognitive functioning that affect children's readiness to learn (Green, Voeller, Gaines, & Kubie, 1991). Maltreated children with PTSD show more deficits in attention and abstract reasoning and executive function than did a group of matched nonmaltreated controls, and their IQ is positively correlated with total brain volume and negatively correlated with duration of maltreatment (Beers & De Bellis, 2002; De Bellis, Keshavan, et al., 1999). Childhood exposure to domestic violence was associated with an 8-point IQ loss among monozygotic and dizygotic twins in a large study that controlled for genetic factors and direct maltreatment but did not measure brain volume (Koenen, Moffit, Caspi, Taylor, & Purcell, 2003). In a sample of 7–14-year-olds, verbal IQ was negatively correlated with the number of traumas experienced, the number of reexperiencing symptoms reported, and the level of functional impairment from symptoms (Saltzman, Weems, & Carrión, 2005). Traumatized adults with stress hormone dysregulation also show deficits in verbal memory and intelligence (Bremner, 1993, 1997).

One reason for the frequently observed decrements in intelligence may be that individuals who have suffered traumatic life experiences tend to attend to cues that may, in their minds, be tied to risk and danger. Findings that lower IQ is linked to higher numbers of reexperiencing symptoms support that hypothesis. In laboratory conditions, traumatized adults and children attended selectively to negative emotions and negative situations (Armony, Corbo, Clément, & Brunet, 2005; McPherson, Newton, Ackerman, Oglesby, & Dykman, 1997; Pollack, Cicchetti, Klorman, & Brumaghim, 1997). Although preferential attention to negative stimuli might be adaptive in chronically dangerous environments, selective attention to danger cues is likely to interfere with the traumatized person's ability to process emotionally neutral information in a learning situation.

Changes in Behavior and Functioning after Trauma

Stresses range from mild stimuli that may enhance performance to daily hassles and hardships that may dampen performance to the overwhelming stress of trauma that derails coping responses. Traumatic stress responses, in turn, are associated with a range of functional changes that depend on whether the trauma was an isolated incident or a pattern of chronic maltreatment or violence exposure. Isolated traumatic events are more likely to produce discrete conditioned biological and behavioral responses to trauma reminders, sometimes reinforcing avoidant strategies that render the traumatized individual fearful and helpless when confronted with traumatic reminders that cannot be avoided (Bremner, 2005; Foa, Steketee, & Olasov-Rothbaum, 1989; Horowitz, 1976). In contrast, chronic or complex trauma interferes more profoundly with the development of children's brains and minds. The factors most consistently associated with later personality problems, including dissociation, are the child's early age when the trauma occurred, trauma chronicity, and the perpetrator having a close emotional relationship with the child (Bremner, 2005; Herman, 1992a, 1992b; van der Kolk, 2005). When parents are the source of danger, young children are unable to turn to them for help and become compromised in their ability to process and make sense of what is happening. As a result, subsequent traumatic reminders evoke globally helpless and fearful states rather than discrete conditioned responses. Children respond to these situations and to the accompanying emotional states as if the original trauma were happening again, resulting in the generalization of the traumatic response to a broadening range of stimuli that the child is unable to process and

integrate. This failure of emotional and cognitive integration is associated with dysfunction in multiple domains of functioning, including attachment security, affective and behavioral regulation, self-concept, and cognition (Cook, Blaustein, Spinazzola, & van der Kolk, 2003). Some scholars believe that a new diagnostic category of developmental trauma disorder is necessary to systematize the conceptualization of these global patterns of dysregulation because of their potentially devastating impact on development (van der Kolk, 2005). This proposed category is described in greater detail in Chapter 4.

Interpersonal trauma is especially destructive to children's attachment relationships. Maltreated children have higher rates of insecure and disorganized attachment and are less able to rely on their caregivers for emotional and behavioral regulation (Cicchetti & Lynch, 1995; Lyons-Ruth & Jacobovitz, 1999; Schore, 1994, 2001). Relationship problems are also associated with dysregulations in children's stress hormone systems (Kaufman et al., 1997). When parents perpetrate the traumatic events, children face a conflict without solution. Their sensory systems are overloaded by terrifyingly intense visual, auditory, kinetic, tactile, and olfactory stimuli that overwhelm their capacity to process and make sense of them, but they cannot turn to the parent for help because that source of protection is simultaneously the agent of terror. This "unsolvable dilemma" (Main & Hesse, 1990) has a profound impact on children's template for close emotional relationships. It is possible that the physiological changes associated with repeated exposure to interpersonal violence may hamper the development of rich networks of connections in the orbital prefrontal cortex, an area of the brain implicated in empathy, concern for others, and the use of language to solve relationship problems (Schore, 1994, 2001). If this is the case, the intergenerational transmission of trauma and disorganized attachment may well happen at the neural level, as children traumatized in their attachment relationships grow into adults whose brain structure is ill-equipped to support an empathic response to their children.

Failures of Protection: Relationship Perturbation, Disturbance, and Disorder

Just as stress ranges along a continuum from mild to traumatic, there is a range of severity in the relationship problems that result from these stresses. Anders (1989) proposed three categories of parent-child relationship problems on the basis of their duration, pervasiveness, and degree of interference with the child's healthy functioning: *Perturbations* are at the milder end of the continuum and are defined as transient

disruptions in one or two areas of functioning that arise in the context of satisfactory overall adjustment while parent and child adjust to new developmental challenges and environmental stresses. *Disturbances* are patterns of inappropriate or insensitive regulation in the interaction between parent and child that are not rigidly fixed although the adaptive qualities of the relationships are beginning to be superseded by their problematic features. *Disorders*, at the more severe end of the continuum, are long-lasting patterns of inappropriate or insensitive regulation in interaction, pervasive across several domains of functioning, and disruptive to the developmental milestones for the child, the parent, or both. The boundaries between the categories are permeable. Duration is used as a formal classification criterion, with perturbations generally lasting less than a month, disturbances lasting between 1 and 3 months, and disorders being of longer duration. This schema about relative duration needs further empirical support, however. For example, we have found that perturbations and disturbances have often been of longer duration by the time the parents seek consultation.

The classification of relationship problems into perturbations, disturbances, and disorders is purely descriptive and does not assume a particular etiology for any of the categories. A broad range of causative factors, including environmental stresses and trauma, constitutional vulnerabilities in the child and/or parent, poor temperamental fit, and psychological conflicts can underlie relationship problems. These causative factors operate in a transactional pattern with one another, making it difficult to predict from a single factor alone whether a relationship disturbance will follow or how severe it will be. The sections that follow give examples of perturbations, disturbances, and disorders and demonstrate that even severe environmental stresses do not necessarily lead to relationship disorders. Chapter 5 describes how CPP is used to treat perturbations, and Chapter 6 focuses on the treatment of disturbances and disorders.

Perturbations

The case of Ruth Hall, described at the beginning of this chapter, is typical of the transient difficulties that characterize perturbations in relationships that are generally supportive and adaptive. As the time for young Ruth to begin kindergarten approached, her anxiety manifested itself in a fear that if she went to school she would be lost and unable to get home to her parents again. This fear had some basis in reality given the similarity of the homes in her neighborhood and the custom in the community that children walk to and from school alone. At first Ruth kept her fears to herself, but ultimately she shared them with her

parents, first in an emotionally unmodulated way and then, with their help, more calmly and in words. Ruth's father was able to hear her concerns, to accept them as valid, and to respond to her in a sensitive way to help Ruth build further capacities that she could use to cope while working from existing strengths. Ruth's attachment to her parents was sufficiently secure that, after a relatively short period of distress, she was able to talk openly with them about her fears. She expected to be protected from the danger that she perceived and to be helped with her fears. Her parents did not disappoint her. Ruth's anxiety did not move beyond her fears around starting school. It resolved in less than a week following her parents' intervention, leaving her feeling more competent than before because she had been able, with their help, to cope with her worries and take the next step in her development. This example illustrates the potential for growth inherent in conflict in the presence of protective factors.

Disturbances

Relationship disturbances have a more pervasive and long-lasting impact because they put the relationship at risk for entrenched dysregulations. Although relationship disturbances are by definition confined to one domain of functioning and are not generally of long duration, they can easily become chronic and expand to additional domains in a self-reinforcing cycle that may escalate to become a disorder.

Example

The mother of Katya, 4 years, 6 months old, sought intervention for her daughter because she was withdrawn and sad at home. Katya's preschool teacher reported that the child was friendly with adults, was generally popular with her classmates, and had several special friends. Academically, she was ahead of her peers and well prepared for kindergarten. The teacher believed that Katya was proud of her ability to do well in school and that this gave her a strong sense of competence. At home, however, Katya lived in the shadow of her older 7-year-old sister, whose emotional problems seemed to take up all of the psychological energy in the family. Although Katya turned to her mother for affection, the mother's efforts to encourage her to talk about her feelings were unsuccessful.

The most salient environmental stress reported by the mother was that Katya and her sister had witnessed a single incident of violence in which their father hit their mother hard enough to break her jaw and several other bones in her face. Katya was 3 years, 9 months old at the

time of the assault. Her father was arrested at the scene, her mother was taken away in an ambulance, and Katya and her sister were placed in emergency foster care for several weeks while their mother was hospitalized for surgery to repair her broken bones.

Following this incident, Katya's sister had a full-blown traumatic stress response, with intrusive thoughts, avoidance of reminders, irritability, anger, difficulty sleeping, and academic failure. Katya, on the other hand, had no symptoms other than her sad withdrawal. She was solicitous of her mother but not seriously overprotective. She quietly accepted her sister's outbursts and pursued her daily activities as if nothing had happened. Her mother tried to draw Katya out but the child said little, although she was affectionate, helpful, and cooperative at home.

Katya was doing well in many realms of her life in spite of having witnessed a severe assault that left her mother seriously injured. She was ready for school, had friends, and had adapted reasonably well at home. However, her affect was seriously overregulated and she was not able to accept her mother's help to become more emotionally open and expressive. Katya's individual emotional constriction had at its source a dysregulation in her relationship with her mother. She did not believe that her mother could take care of herself or her daughters, nor did she believe that her mother could help her contain her feelings. Her withdrawal and blunted expressiveness protected her from being overwhelmed, but it was a brittle protection. Katya and her mother needed intervention to restore Katya's trust that her mother could protect her from danger (including the danger of her own angry, fearful feelings) and to restore her mother to her rightful place as a benevolent authority figure in her daughter's life.

At the time Katya and her mother came for treatment, affect regulation was the only domain in which Katya's functioning was seriously affected. She ate well and slept well. Her cognitive development appeared to be intact, and her intelligence and capacity to take pride in her accomplishments in preschool were significant strengths, as was Katya's general ability to form satisfying relationships. She had friendships among her peers, good relationships with her teachers, and loving, cooperative relationships at home. Katya's constitutional strengths and the fact that her life was not filled with other overwhelming stressors may have protected her from the full force of the frightening assault she had witnessed. Nevertheless, she was emotionally blunted, trusting neither her mother nor herself to contain her strong negative emotions. Unless Katya and her mother can change this pattern, it is likely that this constriction in the capacity for emotional intimacy will affect other domains of functioning in their relationship, placing Katya's emotional health at increased risk.

Disorders

Relationship disorders are entrenched, long-standing patterns of insensitivity and dysregulation in the parent–child relationship that affect many aspects of the dyad’s functioning. The case of Luis and his family illustrates how a single traumatic event can derail every domain of a young child’s functioning and create a parent–child relationship disorder when the reverberations of the trauma and its related adversities are not counterbalanced by strong protective influences.

Example

Luis was 2 years, 6 months old when he witnessed the murder of his aunt, who was his mother’s younger sister. He was referred for treatment because of his sudden and explosive outbursts of anger and his aggression toward his mother, child care providers, and peers. By the time of referral 6 months after the murder, he had been expelled from two child care centers, compromising his mother’s ability to work. His parents feared that he would become a criminal unless his aggression could be brought under control.

The assessment revealed that the circumstances of the murder were overwhelming for Luis and his mother, and the events that followed compounded the initial impact of the event. He had spent the night before the murder in his aunt and uncle’s home. The following morning, his aunt and uncle had brought Luis back to his parents’ home. Luis was in his uncle’s arms outside the door to his parents’ apartment when drive-by shooters, believed to be aiming at the uncle, shot Luis’s aunt instead. Luis’s mother witnessed the shooting from an upstairs window. She called for an ambulance and then helped Luis’s uncle pull the aunt into the living room so that all of them would be sheltered in the event that the attackers came back. Luis was forgotten, cowering in the corner crying, while his mother and uncle, screaming in terror and grief, tried unsuccessfully to stop the bleeding from the bullet wound. Luis watched his mother leave in the ambulance with his aunt and uncle and stayed with a neighbor until his father could leave work and come for him. Luis’s parents talked by telephone and decided that it would be better for Luis not to return to the apartment, which had been the scene of so much terror for him. Instead, the father traveled with Luis to Mexico and stayed with his own parents for 3 weeks. During that time, Luis talked to his mother twice on the telephone. Both times, she was crying and unable to respond in a comforting way to Luis’s cries that he wanted to come home.

After Luis and his father returned home, Luis refused to leave his mother's side. He demanded to sleep with her and could not leave her alone long enough for her to take a shower. He was expelled from two child care centers because of his separation distress and resulting outbursts of anger and aggression, and the mother was forced to quit her job to take care of him. Their relationship became more frayed each day as Luis both clung to her and acted out angrily. He was in a furious frenzy against the living room in which he had watched his beloved aunt bleed to death and where he had been unable to turn to his mother for comfort as she was absorbed in her efforts to save her sister and cope with her own responses. He slashed the sofa and chair with a knife, scribbled on the walls with a red marker, and came close to breaking the screen of the family's television set. When he was not in a destructive rage, Luis seemed terrified. He could not be alone in the dark and refused to be alone in the living room even for a few minutes during daylight.

The conditions of the neighborhood exacerbated the child's pervasive sense of impending internal and external danger. Luis lived with his father and mother in a public housing project in a large city. The area was so plagued with gang violence that it was unsafe for children to play outdoors after school. There was gunfire from warring gang members nearly every night, and the gunshots made Luis jumpy and agitated. He spent the Fourth of July under the kitchen table, crying and screaming for his mother to stay with him. She came to help him in response to his calls, but he pushed her away and turned his back to her when she tried to hold and comfort him, only to scream for her again when she left his side.

Prior to the murder, the family lived in precarious economic circumstances but was doing well emotionally. Both of Luis's parents worked but they earned low wages and could not accumulate enough money to move to a safer neighborhood. Luis was cared for in a small child care center while his parents worked, and he was well adjusted there. His motor and language development were on track. He got along well with the other children and had developed a preference for one teacher over the others. He enjoyed being at the center but was always glad to see his parents when they came to pick him up at the end of the day.

By the time Luis was referred for treatment 6 months after his aunt's death, the parents seemed to have forgotten that the murder had marked the beginning of the child's problems because they were so distressed over his destructive behavior and his alternating clinging dependence and angry rejection of help. His mother said, "It's like the devil got into him. First I lose my sister, and now my child is destroying my home. He won't even let me go to the bathroom without him, but when I try to help him he pushes me away. I think he's trying to destroy me, too."

Luis was not a maltreated child. On the contrary, his parents were both attuned to his emotional states and responsive to his bids, although after the murder they had become unable to make sense of his behavior. The family did, however, live in a stressful environment marked by poverty and community violence, and both Luis and his parents were made more vulnerable by these stresses. The parents were acutely aware of the dangers surrounding them and did their utmost to protect their child. Luis was forbidden to play outdoors because of the violence, and occasionally, when gang warfare was at its height, Luis's parents put him to bed in the bathtub, padding it with sleeping bags and blankets, so that he would be shielded from the possibility of bullets penetrating his bedroom. Before the murder, Luis was developing in an environment that was dangerous, but he was aware of his parents' efforts to protect him and this awareness may have been a protective factor for him.

These conditions were dramatically altered after the murder. Luis was overwhelmed and traumatized by the shooting and its immediate aftermath. His fears were probably intensified because the traumatic event he witnessed made his developmentally expectable internal fears of losing the mother's physical presence and love become terrifyingly real. Although his mother was physically present in the aftermath of the shooting, she could not offer Luis even the most elementary emotional support because she was completely occupied with her own terror and with her ultimately unsuccessful attempts to save her sister's life. The terrifying sights of shooting, injury, and bleeding intensified Luis's developmental fear of bodily injury. Internal and external dangers combined to overwhelm Luis's ability to cope.

Luis endured further threats to his development beyond the traumatic moment. His separation from his mother for 3 weeks following the event constituted a severe secondary adversity that confirmed the fear of losing the mother and her love and rendered him frightened, clingy, and angry when he returned. Moreover, when he came back home, Luis could not escape the memories of the original trauma because his living room was a permanent traumatic reminder, as were the ongoing sounds of gunshots and fireworks in his neighborhood. The secondary adversity of separation from his mother had made Luis more vulnerable and made his recovery from the original trauma more difficult. The continuing trauma reminders in his environment made his recovery without intensive intervention virtually impossible. Luis's behavior swung wildly between terror and aggression because aggression was most likely the only mechanism he could muster to ward off the terror. Throughout all of this, from the traumatic moment itself through the separation from his mother and the difficult weeks after his return, Luis's mother was not able to help him cope with his overwhelming feelings. She did not meet

his expectation that she would help him modulate feelings too strong for him to manage on his own. This led to the nascent expectation that she would never be able to protect him and to his rage at her for this fundamental developmental failure.

Luis's mother, for her part, was suffering from her own trauma response, complicated by grief at the death of her sister. She had also experienced the shooting as an overwhelming event. She had been helpless to protect her sister and was reminded of her terror every time she opened the front door. The noises of shooting in the neighborhood also served as traumatic reminders for her, rearousing her and maintaining her in a dysregulated state. More important for her relationship with Luis, his rejection of her at times when he needed help reawakened the feelings of helplessness she had experienced while she tried in vain to aid her dying sister. She defensively turned the helplessness into active anger at Luis, attributing to him a motivation to reject and hurt her.

Luis and his mother were both caught in the grip of individual responses to the overwhelming stress that they had both experienced. The tend-and-befriend response (Taylor et al., 2000) would predict that caring for her child might have helped to calm her in the period immediately after the shooting. However, their 3-week separation after the murder, intended to allay Luis's fears, might have been as difficult for his mother as it was for him: The child's absence deprived her of an opportunity to calm and reregulate herself by tending to the needs of her son, who was in turn deprived of the opportunity to be calmed by her. On his return, mother and child became increasingly locked in misunderstandings based in fear. They had been unable to process and integrate the overwhelming sensory stimuli and feelings that they experienced at the time of the shooting. After the aunt's death, as they continued to be aroused and traumatized in their home and in one another's company, they were unable to integrate their interactions into working models of one another that would sustain their relationship. The mother began to make globally negative attributions to Luis, believing that "the Devil was in him" and that he was trying to destroy her. What had been a relationship marked by sensitive attunement became one marked by mutual misunderstanding and distrust, with virtually every aspect of Luis's development derailed.

The Power of Context in Shaping Individual Responses to Trauma

Both Luis and Katya had endured traumatic events. The impact of these events on each child's individual development and relationships was, however, dramatically different. Luis lived in poverty and was surrounded by danger even before the trauma; Katya did not. The fact

that Katya internalized her distress may have made it easier for her mother to cope with her child's worrisome behavior. Luis's rejecting and destructive behavior fed his mother's negative attributions to him, while Katya's mother responded to her daughter's withdrawal and stoicism with attempts to understand and comfort. Finally, although both Luis's and Katya's mothers also had their own trauma responses to deal with, Luis's mother's response was complicated by the fact that she was also grieving her sister's death. All of these factors may help explain why Katya's relationship with her mother was disturbed while Luis's relationship became frankly disordered. Twenty-five years ago, Sameroff (1983) highlighted the pivotal importance of the advance of developmental research on the discovery and exploration of context. The power of this observation has been amplified in the ensuing decades. The importance of context is not confined to developmental research but applies to clinical practice as well, perhaps most graphically in the understanding and treatment of the sequelae of trauma.

When the Protective Shield Fails: Understanding Why

Parental caregiving behaviors have evolved as a mechanism to protect the survival of the young, but parents cannot always protect their children in spite of their biological propensities and deeply felt desire to do so. The reasons are multiple. Sometimes the parents' most conscientious efforts may not be sufficient to shield their children from the impact of catastrophe. For other parents, psychological obstacles interfere with their capacity to protect. In most situations, the intricate transactions among external stresses, parental psychological makeup, and young children's constitutional styles and developmental stages create conditions that may protect or damage children's emotional health. In the following sections, we discuss four specific manifestations of parental failure to protect. Understanding the motives underlying parental behavior is often necessary to promote greater parental capacity to provide safety. The following clinical examples illustrate the frequent gap between the conscious wish to care for the child and unconscious parental motivations.

When Parents are Overwhelmed by Catastrophic Events

Helplessness and terror are the inevitable responses to trauma because traumatic events are unpredictable, uncontrollable, and terrifying. Parents can be overtaken by these events as easily as children, often with the result that both members of the dyad suffer harm from dangers

that the parent could not anticipate. Once the traumatic event occurs, the unfolding of secondary traumas creates escalating distress in the parent-child relationship (Pynoos, 1997). Their expectations of one another change as the result of the trauma, and they may perceive one another not only as traumatic reminders but also as sources of danger and victimization.

The case of Luis and his family, described earlier, illustrates this situation. Conscientious and protective as they were, Luis's parents could not predict the drive-by shooting that ended in Luis's aunt's murder. Their best efforts to respond sensitively to Luis and to protect him from returning too soon to the scene of his terror actually had the opposite effect. Almost overnight, a parent-child relationship that had been developmentally enhancing for Luis and a source of pleasure and pride for his mother was undermined in every domain of functioning. The sequelae of trauma, and in particular the insidious nature of traumatic reminders, kept Luis and his family frightened and on edge, making their recovery from the original trauma problematic. This chain of events originated in an overwhelming catastrophe that the parents could not prevent, rather than in parental conflict or psychopathology that undermined their protective function.

Unanticipated Consequences of Conscious Wishes to Protect

In some situations, loving parents may unconsciously expose their children to danger in the process of ostensibly protecting them from a different risk that is given disproportionate importance due to the parents' internal conflicts. These parents are single-minded in their effort to prevent a repetition in their child's life of painful circumstances in their own childhood. The overwhelming psychological salience of unresolved childhood conflicts blinds the parent to the risk entailed in their decisions on behalf of their child.

Example

Ms. Miller's father deserted her mother before Ms. Miller was born. Although Ms. Miller's mother tried to provide loving care to her child, Ms. Miller was haunted by longing for her missing father. Throughout her childhood she comforted herself with the fantasy of walking down the street holding the hand of a strong father who looked down at her with adoring eyes. When Ms. Miller was 12, her mother remarried and the stepfather sexually molested Ms. Miller. She left home at age 15 to escape her mother's husband and moved in with her young boyfriend,

Steven Bernard, and his parents. Soon afterwards, Ms. Miller became pregnant and her boyfriend, feeling trapped, struck her for the first time. The violence continued and increased over time. When Ms. Miller was 19 and her son, Todd, was 3 years old, Mr. Bernard pushed her down a flight of stairs as Todd stood by, terrified. Mr. Bernard's mother called the police and he was arrested. Ms. Miller, with Todd, moved back to her mother's home, obtaining a restraining order against her boyfriend to protect herself and her child. She sought treatment because she feared that Todd would grow up to be violent as the result of witnessing his father's violence.

Mr. Bernard expressed a persistent wish to see his son, and Ms. Miller found herself giving in and allowing him more extensive contact with Todd than permitted by the restraining order. When the therapist asked Ms. Miller what she thought might follow from her decision to allow Mr. Bernard to spend extra time with Todd, she said, "I want him to have a father. I know how I felt without a father, and I don't ever want Todd to feel that way. I want him to be happy."

Ms. Miller was motivated by a strong wish to give her son what she did not have, and she consciously endeavored to protect him from the external and internal dangers of loss that had been the preeminent theme of her own life. For Ms. Miller, being without a father carried very high risk. She attributed much of her unhappiness as a young child and her sexual molestation as an adolescent to her loss of her father. It is little wonder that Ms. Miller gave that risk a very high priority and tried to ensure that Todd would be shielded from an experience that had been very painful for her. In doing so, however, she lost sight of the more immediate danger that his father's violence posed for Todd. Very soon after the session just described, Ms. Miller revealed that Mr. Bernard had been drunk and belligerent during his last visit with Todd. She said, "He hit me and he pushed me. Todd was in the door crying and saying, 'Why do you hit my mommy?'"

In her effort to save Todd from the danger of a life without a father, Ms. Miller exposed him to the danger of a violent father. Even as she described the violence against her and Todd's fearful response to it, Ms. Miller struggled to understand which was the greatest danger: violence or abandonment. Her unresolved conflict about paternal abandonment prevented her from a realistic appraisal of the danger represented by paternal violence. It is possible that she blamed herself for her father's desertion, and that her sense of self as a bad child was reinforced by her stepfather's sexual abuse. If so, Ms. Miller might have felt that she deserved the maltreatment she received from Mr. Bernard. In this scenario, Todd could well be playing a supporting but secondary role in the primary conflict that still took front stage in Ms. Miller's internal world.

Parental Ambivalence: Enacting Maternal Hate

All parents, no matter how loving and protective, have conflicting feelings about their children. Parents may react to the limitations that children place on their freedom with frustration and anger. They may resent their children's interference with their career paths or with the spontaneous romance that they once knew with the child's other parent. They may simply yearn for a good night's sleep, unknown to them since the birth of their otherwise adored baby. Such ambivalent feelings are integral to the parenting role and generally do not interfere with parents' abilities to protect their children (de Marneffe, 2004).

For some parents, however, ambivalence contains a greater prevalence of hate than love leading them to hurt their children, place them in danger, or even kill them or leave them to die (Hrdy, 1999; Winnicott, 1949). This intense ambivalence may arise from painful childhood experiences that the parents coped with by disowning the fear and helplessness associated with them while identifying with their own aggressive parents or other important emotional figures (Fraiberg, Adelson, & Shapiro, 1975). The parents do not see their infants as unique individuals but as transference objects with whom they reenact their painful childhood experiences, alternating the roles of victim and victimizer. Parents caught in these reenactments are trapped in entrenched conflicts with their babies and young children, loving them consciously, but unconsciously engaged with them in a painful repetition of their past that places the child in danger either from the parent or from others.

Example

Martha was an adolescent mother with two children, Samantha, 13 months old, and Lucy, age 3. They were referred by Child Protective Services after Samantha's child care provider discovered a bruise on the child's leg. Martha's mother had schizophrenia and was often randomly cruel to her. At age 15, Martha became pregnant with Lucy and her mother threw her out of the house. Martha went to live with her boyfriend, a 25-year-old man named Jack. Martha continued to see her mother regularly, stayed with her whenever she and Jack fought, and left Lucy and Samantha in her care for a few days at a time whenever "they got to be too much for me."

As Martha recounted, one afternoon Martha and Jack were at home and Martha was changing Samantha's diaper while the child lay on the floor, aimlessly moving her legs. While moving, Samantha accidentally kicked Martha in the shoulder. Martha shrieked, "Stop it!"

and then leaned over and bit Samantha on the leg, leaving red marks. Lucy ran to Jack, crying, "Mommy bit Sam!" Without looking up from what he was doing, Jack said calmly, "Well, bite her back." Wordlessly, Lucy did so, and then cried when Martha responded by laughing and slapping her. Jack did not intervene.

Scenes such as this one were played out over and over again in Martha and Jack's home. Although Martha protested that she loved her children, she treated them with a casual cruelty very similar to the way she was treated by her own mother. She also endangered them by leaving them regularly in her mother's care. Martha's professed love for her children was sincere, but so was her unconscious hatred of them, based on Martha's identification with her own disturbed and sadistic mother. These mixed feelings caused her repeatedly to place her children in harm's way. She seemed blind to these dangers or to her own part in putting her children at risk. When the therapist asked her about her own early childhood, Martha told stories of her mother's cruelty in bloodcurdling detail. Yet her recounting of her early experience was curiously affect free. She repressed her intolerable memory of how it felt to be a child who was hurt and frightened by her mother, but clung fiercely to her unconscious identification with her mother's aggressive behavior, an identification formed in childhood to protect her vulnerable ego from attack by taking on the characteristics of the feared attacker.

When Trauma Derails the Parents' Ability to Assess Danger

Affective numbing is one of the hallmarks of traumatization. Parents may become so removed from their emotional experience that they fail to notice danger and are unable to protect their children adequately. If the trauma is sufficiently extreme, an inability to identify feelings, or alexithymia, may result (Krystal, 1988).

Example

Mrs. Ames and her two children, 3-year-old Tony and her newborn daughter, Crystal, were referred by a court-affiliated mediator who became alarmed by the mother's attitude toward her estranged husband. Mrs. Ames had left her husband shortly after Crystal's birth. It was their first separation, although he had been violent with Mrs. Ames since before their marriage. His violence was extreme and nearly lethal. Mrs. Ames finally left him when he refused to take her to the emergency room after Crystal developed a very high fever. Mrs. Ames

explained: "I was still recovering from my C-section; I knew that she needed to see the doctor, but he wouldn't take us. So I walked there, carrying Crystal, with Tony hanging onto my skirt. I actually broke some of the stitches from my incision, and I just knew that I had to leave him." In contrast with this awareness of the need to protect herself and her children, Mrs. Ames sat calmly next to her husband during the mediation process and said that she did not think there would be any more problems because, as she put it, "I know what to do now. I know how not to make him angry." Mrs. Ames accepted the referral for treatment because she was concerned about the troubles that Tony was having at preschool. He had been asked to leave two preschools, and was having trouble at the third one because of aggression against peers. The first assessment session took place in Mrs. Ames's home because she was still having trouble getting around after her C-section. As Mrs. Ames and the therapist sat talking, the door to the apartment flew open and a large man stormed into the room. He threw a toy on the bed, narrowly missing Crystal, and began asking questions and making demands of Mrs. Ames in a loud, angry voice. The therapist presumed that the man was Mrs. Ames's ex-husband and felt frightened that her presence would make him even angrier and that he might attack her and Mrs. Ames. She sat quietly in the corner of the room, desperately wishing that she could disappear into the woodwork. Then, as suddenly as he had come, the man left, slamming the door behind him. Mrs. Ames turned to the therapist and, with no trace of irony in her voice, said, "See how charming he can be?" The therapist was astounded by this question and asked Mrs. Ames if she had been concerned that the therapist's presence would make him more angry. Mrs. Ames looked honestly surprised and said, "Oh, no. He knows all about you. He knows that Tony needs help."

Mrs. Ames had lost her ability to judge dangerous situations. She had told the therapist that her ex-husband was stalking her and that he waited for her outside the house and outside Tony's preschool. He followed her in his car and once had forced her off the road when both children were in the car with her. Mrs. Ames appeared unmoved by these dangers. She did not call the police, did not change her locks, and did not take any steps to protect herself or her children. She allowed the children's father to take both of them with him whenever he asked for them, although Tony always cried and protested when his father came for him. Mrs. Ames told the therapist, "He's never hurt them. I'm sure that he wouldn't hurt them, that's just the way he was with me, and I know how not to make him mad now." This was far from a realistic appraisal of Mr. Ames. He had a long-standing problem with abuse of alcohol and cocaine, had been arrested for fights in bars, and

had assaulted strangers. Mrs. Ames seemed unable to see that his anger was not directed exclusively at her but that it encompassed everything he did.

After the incident at the initial home visit, the therapist called Mrs. Ames on the phone to explain that she could not go to her home again because of the danger that this would entail to the therapist, Mrs. Ames, and the children if the father had free access to the house. Mrs. Ames pleaded with the therapist to continue the home visits on the grounds that it would be nearly impossible for her to come to the clinic on the bus with an active toddler and a newborn. The therapist held her ground, telling Mrs. Ames that she was not willing to put the safety of Mrs. Ames and her children or her own safety at risk. This intervention proved to be a powerful one in recalibrating Mrs. Ames's sense of what was safe and what was dangerous. Mrs. Ames did bring her children for treatment at the clinic in spite of the hardship involved. More important, however, within a month she had changed the locks to her apartment, asked her employer for a transfer to a different location, and found a different preschool for Tony. Later, she took the important additional steps of reporting her ex-husband's stalking to the police and applying to the court for a change in the visitation orders so that Mr. Ames could see the children only in a supervised visitation center.

Because of the profound impact of repeated traumas on her mind and body, Mrs. Ames had no longer been able to recognize warning signals, and she underestimated danger, putting herself and her children at risk for further traumatization. Although she spent a great deal of time and energy providing for her children and loved them deeply, there were ways in which she seemed unable to care for them. She was desperate to regain some sense of control over the violence that she had endured, and her long-standing self-blame and low self-esteem made it easier for her to believe that she had brought the violence upon herself and that she could stop it by the way she behaved. It was too threatening to acknowledge that she had been the victim of cruelty over which she had no control and that it might strike her or her children again. This conflict took place largely outside her conscious awareness and she enacted it in a way that repeatedly put her and her children in danger.

The Intergenerational Transmission of Traumatic Expectations

As the foregoing cases demonstrate, the emotional, behavioral, and neurophysiological sequelae of childhood trauma are complex and potentially long-lived. Traumatized children experience the failure of their developmentally appropriate expectations that adult caregivers will

appraise danger accurately and take effective action to protect them. Once children experience helplessness in the face of danger, their fear that it will reoccur influences how they respond to future risk situations, leading to the development of traumatic expectations about relationships and about their future well-being (Pynoos, 1997). The child interprets the world in light of these traumatic expectations, anticipating danger and becoming rigidly avoidant of experiences and feelings associated with the trauma. This stance curtails children's spontaneity and interferes with their learning from the full range of experiences that might disconfirm their trauma-based beliefs about danger, safety, trust, and competence in self-protection. The sequelae are deficits in emotional self-regulation, sense of self, ability to rely on others, and attunement to internal emotional states (van der Kolk, 2005).

These expectations are carried into the child's unfolding adulthood. Trauma-based expectations color later relationships, including the experience of parenting. The goal of CPP is to provide, for both parent and child, a model of relationship in which new ways of understanding risk and danger can be talked about and practiced and in which protection becomes possible once again. The next chapter addresses how this can be done.

CHAPTER 3



Practicing Child–Parent Psychotherapy Treatment Targets and Strategies

The child's mental health is the ultimate goal of CPP. The parent–child relationship is used as a parsimonious mechanism for achieving this goal because parents are the primary contributors to children's behavior and development. The basic assumption is that the most immediate and direct threat to the young child's psychological well-being is an explicit or implicit parental message that the child is not good enough, along with childrearing practices that are suffused with the parent's active negative emotions (impatience, irritability, anger, hostility, and punitiveness), passive emotions (sadness, lethargy, and indifference to the child's signals), or a combination of these behaviors and mental states. Children who have constitutional sensorimotor integration problems or regulatory difficulties such as emotional withdrawal; difficulty with transitions; or intense, negative, and unmodulated emotional responses may more readily evoke distancing, rejecting, or punitive reactions in the parents and other caregivers, particularly when the adult also is constitutionally vulnerable or beleaguered by environmental stresses.

CPP endeavors to repair emotionally damaging perceptions and interactions and to create or restore increased levels of affect regulation, mutuality, and developmentally appropriate interactions. The long-term goal is to equip the parent and the child with the psychological resources to maintain a partnership where after the termination of treatment the parents function as effective protectors, advocates, and guides in their children's development. Therapeutic strategies are informed by the

family's developmental issues and culturally determined attitudes and childrearing values. CPP can be used as the primary treatment or as one component in a treatment approach that also incorporates individual treatment with the child, individual treatment with one or both parents, and/or couples therapy with the parents. The initial assessment and treatment sessions yield important information about the etiological role of the child–parent relationship in the child's mental health problems and about the parents' capacity to participate constructively in the child's treatment. This information becomes the basis for clinical decisions about the best configuration of treatment approaches on behalf of the child.

Overarching Developmental Considerations

Development is a process of continuous adaptation to internal change and external circumstances that continues throughout the lifetime and is characterized by stage-specific milestones, interests, and motivations as well as by continuities and discontinuities in achievement and functioning. CPP is guided by a developmental understanding of the child and the parent as they move through this process. The clinical focus is always on supporting parents and children in negotiating their disparate developmental agendas and co-creating solutions to impasses and conflicts.

Treatment in the First Year of Life

CPP originated in Fraiberg's (1980) model for treating preverbal young children with infant–parent psychotherapy, an approach based on the premise that because infants and toddlers have not yet internalized their parents' practices into their personality structure, they will regain their momentum toward health once they are no longer engulfed in the parental conflicts that distort their development. Although infant–parent psychotherapy is usually equated with a therapeutic focus on the parent's past because of its memorable metaphor of “ghosts in the nursery,” Selma Fraiberg advocated developmental guidance as the first choice in efforts to change damaging parental practices. She recommended insight-oriented intervention only when emotionally supportive psychoeducation failed to achieve the intended therapeutic goals.

In joint parent–child sessions, sustained therapeutic exploration of how the parent's problems affect the parent's feelings and behaviors toward the infant is most feasible in the first year of life, while the parent is still navigating the momentous changes involved in the developmental

transition to parenthood and before the growing child becomes increasingly assertive in demanding equal time during the sessions. The baby in arms is easily transportable and containable and can serve as a ready-made blank screen for parental attributions and projections despite (or because of) marked individual characteristics. The parent's response to the baby in the moment can be linked to the feelings evoked by the infant and to associations with past and present experiences. The therapist can draw inferences about how the parent's conflicts, pathogenic beliefs, and distorted cognitions are visited upon the baby and transform the child into a transference object that is bereft of individuality while serving the parent's psychological needs.

In the "ghosts in the nursery" model, history is not destiny: traumatic events and painful experiences in the parents' past need not determine a rigid reenactment of these patterns in the unfolding experience with the new baby. When the parents are able to remember not only the frightening experiences of their childhood but also the affects of terror and helplessness associated with them, they are better able to summon protective impulses toward their child because they are consciously motivated to spare the baby the kinds of experiences that they had to endure. When, conversely, early terror and helplessness are buried under the defense of identification with the aggressor, which endows rage and aggression with the appearance of strength, parents respond punitively to their babies' expressions of need in order to fend off the danger of being flooded by fears from the past.

The primary interpretive mechanisms of classical infant-parent psychotherapy are wrapped up in a dual message: compassion for what the parent endured as a child and forthrightness in helping the parent recognize the damage that the old pain now inflicts on the new baby. This two-pronged message is conveyed through carefully orchestrated statements designed to support the parent in finding new ways of coping with the past and becoming the parent she wants to be. Edna Shapiro, a gifted infant-parent psychotherapist, spoke to an adolescent mother in gentle and protective tones about the interplay of being hurt and hurting others by saying: "I know you don't want to hurt anybody. I know how much you have suffered and how much it hurt. As we talk about your feelings, even though it is painful to remember, it will be possible to find ways to come to terms with some of these things and to be the kind of mother you want to be." Later in the therapy this mother reflected that she sounded just like her own mother when yelling at her toddler. Mrs. Shapiro used this moment of self-awareness to offer a supportive interpretation of the motive for this young woman's identification with her punitive mother: "I could imagine that as a little girl you might be so scared that in order to make yourself less scared, you might start

talking and sounding like your mother” (Fraiberg et al., 1975, pp. 187, 192). The young mother answered: “I don’t want to talk about it right now,” but her behavior following this interpretation changed markedly. Instead of continuing to act defiantly and aggressively, she started speaking about all the things that made her anxious in her current life. This sequence from interpretation to changed maternal behavior supports the hypothesis that parents’ access to childhood pain serves as a deterrent against converting pain into aggression. Remembering fear prevents the consolidation of early anger at the punitive caregivers into a lifelong identification with them.

Treatment of Toddlers and Preschoolers: A Flexible Format

Although treatment guided by linking the present with the parent’s past can be exceedingly powerful in bringing about enduring change in the parent and in the child, changes in therapeutic technique are called for when the child is no longer an infant. Exploring in depth the parent’s individual experience is not possible when a toddler or preschooler has urgent clinical needs, unless collateral individual sessions with the parent can be arranged as part of treatment. There are built-in contradictions between the child’s and the parent’s developmental agendas, complementary as they may be. Toddlers and preschoolers strive to explore, learn, and individuate; parents need to protect, teach, and socialize. The quick acquisition of new emotions in the second and third years of life adds intensity to the struggle between these competing agendas, as the parent faces a child who is newly capable of ever more refined nuances of elation, pride, anxiety, self-consciousness, petulance, defiance, shame, and guilt. The therapist must then switch the focus of inquiry, highlighting the growing child’s subjective experiences and placing lesser emphasis on exploring the link between the parents’ psychological conflicts and their current parenting difficulties.

This change of therapeutic focus is responsive not only to the toddler’s and preschooler’s developmental stage but also to the parent’s. The birth of a baby reevokes early childhood conflicts and stresses for the parents, providing a window of opportunity to find new and more mature patterns of adaptation. During this sensitive developmental period, remembering the past can open up access to feelings associated with old memories, helping the parents understand themselves in new ways while they assume their new roles as caregivers to their infant. As babies develop and become increasingly autonomous and assertive individuals, the parents’ salient emotional issues move to the struggles of the moment because toddlers and preschoolers operate in the present even when they have become carriers of their parents’ past. When young

children begin to internalize their parents' projections and engage in their own processes of imitating the parents' aggression and other damaging behaviors, they unwittingly reinforce and perpetuate the parents' conflicts in ways that are not easily amenable to interpretation because the child's behavior is so concrete that it calls out for containment and redirection through immediate intervention. The inner world of the mother and the father needs to be understood from the perspective of their own and their children's developmental demands.

These developmental considerations call for versatility in the format of treatment. It is customary to have a preverbal baby always present in infant–parent psychotherapy sessions, but modifications of this format may be needed with older children in response to the specific needs of each case. Joint child–parent sessions are complemented by collateral individual sessions with the parent when it is clear that the parent's psychological issues need to be addressed individually in order to achieve the therapeutic goals for the child. Parallel individual child and parent sessions is the format of choice when the child's emotional problems need immediate attention but the parent's own psychiatric problems interfere with her capacity to collaborate on behalf of the child during joint sessions. The format of parallel individual sessions is used until the parent's and the child's psychological functioning is stabilized enough that joint sessions become possible. A variation when separate individual sessions are not feasible is to divide one session into two parts, with the first half devoted to the child and the second half reserved for “grown-up talk” while the child engages in individual play in the presence of the adults. This format conveys to the parent and the child the message that turn taking is emotionally bearable because the therapist has enough to give. The most important ingredient of CPP is less the actual format of the sessions but rather the conviction and creativity of the therapist in setting up a therapeutic climate characterized by emotional responsiveness, a spirit of collaboration, and willingness to work through conflicts.

Overarching Cultural Considerations

The needs of a child suffering from mental health problems must be addressed in the context of the family's cultural background, including the religious and spiritual values, beliefs, and practices of the child's community. When the problems stem from experiences of stress and trauma, these adversities routinely affect not only the child but the family members as well. The stressed or traumatized family may receive input and advice from informal support systems (relatives, friends, neighbors, coworkers) as well as religious institutions, whose representa-

tives may be given great authority by the family. Clinicians' effectiveness is significantly enhanced by their awareness of these influences. The parents will perceive the clinician's behavior through the lens of their preexisting attitudes and relationships, and the treatment recommendations may be accepted, modified, or rejected depending on the goodness of fit between the clinician's clinical practices and the cultural practices of the child's family and community.

Heterogeneity within Cultural Groups

Learning about the cultural values and practices of different groups is a long-term process because of the complexity and changing facets of the endeavor. Cultural groups are not monolithic, even when they are identified by commonalities of race, ethnicity, religion, and/or country of origin. Internal heterogeneity within the group stems from both sociological and individual factors. Sociological sources of variation include socioeconomic status, education, geographical location, country of birth (i.e., U.S.-born or first-generation immigrant), changes in the prevailing social attitudes toward immigration in general and specific immigrant groups in particular, and the pace of social change as some groups acculturate and new immigrant groups arrive in the country. People from the same cultural group also differ along individual factors such as age, family status, acculturation, identification with values of the culture of origin, and secular or religious orientation. Many families in the United States are multicultural due to intermarriage both in the past and in the present generation, introducing additional sources of variability. In addition, individuals often see themselves as belonging simultaneously to different cultural groups (e.g., American by nationality, Korean by ethnicity, and Christian by religion). For these reasons, knowing a person's race or ethnicity does not, by itself, provide reliable information about the types of therapeutic intervention that will be most effective for that individual. The clinician needs to do an individualized assessment of how the child and the family members see themselves in the context of their cultural identifications.

Mainstream clinical attitudes and practices may conflict with the prevailing point of view of a cultural group on issues such as sexuality, gender roles, and expectations for family relationships. In addition, mental health providers value emotional expression and talking about feelings, premises that are not compatible with the outlook of cultural groups that value stoicism and self-restraint, particularly with nonfamily members. Many cultural groups have specific religious beliefs that prescribe some behaviors and proscribe others. For example, a belief in the sanctity of life may preclude a consideration of abortion following rape, a belief in the sanctity of marriage may bar the idea of divorce

even under conditions of family violence, and a belief in female chastity may prescribe women's attire and gender-segregated social gatherings. How to reconcile widely held mental health assumptions with divergent cultural values poses an ongoing challenge to clinicians working with culturally diverse families.

Prevailing attitudes in the field of mental health also diverge from the values of some cultural groups regarding family and community relationships. Collectivistic cultures traditionally uphold hierarchical family structures, giving greater authority to the older generations and enforcing greater role differentiation between the genders. The mental health field, operating in the individualistic cultural milieu of the United States, tends to assume that individuals will be more psychologically healthy within a democratic family structure where the needs and wishes of all members are taken into account and where there is flexible allocation of roles between the genders. Clinicians working with clients holding cultural values different from their own should examine their own assumptions and cultivate an attitude of receptiveness to different cultural goals in raising healthy children.

Socioeconomic status interacts with cultural background in shaping childrearing attitudes, practices, and opportunities. One of the goals of CPP is to improve the mental health of children across the socioeconomic spectrum. The gap in mental health services for children and families from minority cultural groups and economically disadvantaged backgrounds is well documented and needs to be met with a concerted effort to enhance access to quality mental health services (New Freedom Commission on Mental Health, 2003; National Child Traumatic Stress Network, 2001). This goal calls for intervention modalities that are relevant to the parents' perception of family priorities. When the problems of living are urgent and pervasive, the treatment plan must take into account the concrete needs of the family as well as the developmental and emotional needs of the child. If there is a family crisis, even one in which the child is not directly involved, the therapist needs to be available as a source of information, support, and assistance by linking the family with appropriate resources and following up on the resolution of the problem. In many clinical situations, it is not sufficient to provide developmental information or to alleviate external circumstances to bring about substantial improvement in the child's functioning, and these strategies must be supplemented with specific clinical modalities to bring about change in the parents' capacity to raise the child safely and well. In crisis situations, it is particularly important to coordinate clinical interventions with an understanding of the family's cultural background because the sense of urgency generated by emergencies can lead to hasty decisions that may contravene the family's values (Lieberman, 1990).

When Cultures Harm

While cultural considerations should be integrated into clinical practice, the clinician should be aware of the dangers of cultural relativism. There is a widely spread assumption that “the culture heals.” This is not necessarily the case. Not all culturally rooted attitudes and practices promote the mental health of the individual members of the culture. Some culturally sanctioned practices involve the use of power in ways that denigrate or oppress particular subgroups, most often women, children, and ethnic, racial, or religious minorities. Other cultural practices represent painful historical adaptations to sociopolitical conditions that continue to exist in many countries, including racism, discrimination, slavery, political oppression, and economic exploitation. Identification with the aggressor was mentioned earlier in the context of child abuse as a psychological defense mechanism that enables the individual to feel consciously strong by repressing feelings of helplessness in the face of aggression (A. Freud, 1936/1966). “Identification with the oppressor” can be identified as a sociological defense mechanism whereby a down-trodden racial, ethnic, or religious group persecutes, marginalizes, and terrorizes some of its own members or members of other cultural groups that are perceived as inferior. Culturally competent psychotherapy involves the exploration of the “goodness of fit” between the aspirations and wishes of the individual client and those of the cultural group to which the client belongs. When there is friction between the individual and the cultural domains, the clinician should support an exploration of this friction to promote greater flexibility in the strategies the client deploys in attaining personal goals.

These considerations indicate that the areas of functioning targeted for change should be carefully assessed from both a developmental and a cultural perspective. These two points of view provide a normative context for the clinical decisions that guide treatment. Some behaviors can be misinterpreted as indicators of severe psychopathology when they are isolated from their developmental or cultural roots, leading potentially to ineffective, misguided, or damaging clinical interventions. The two examples that follow illustrate how well-intentioned clinicians can inadvertently pursue a pernicious course of action when uninformed about the developmental and cultural meaning of behaviors.

Example: When Lack of Knowledge Leads to Blame

Mrs. Ramirez, a recent immigrant from a remote Indian village in Central America, was asked by the nurse what name she would give to her

newborn baby girl. Mrs. Ramirez demurred and said that she did not know yet. When the nurse commented that the baby was beautiful, Mrs. Ramirez replied: "She is scrawny." The next day, before discharge, the nurse asked again about the baby's name, and again Mrs. Ramirez said she did not know. The nurse became alarmed by what she perceived as the mother's lack of emotional investment and dislike of the baby's physical appearance. When she called the hospital's infant mental health program to make a referral, she was informed about the custom in the mother's ethnic group of not naming newborn babies before they reached a certain age and not praising them for fear of attracting the "evil eye." Further inquiry clarified that Mrs. Ramirez displayed appropriate caregiving behavior in feeding, changing, holding, and responding to the baby's crying. The intake clinician concluded that the most likely explanation for the mother's behavior was that Mrs. Ramirez was following the customs of her cultural group, which were in turn dictated by the high newborn mortality rate they endured. The nurse was very interested in this explanation and her attitude toward the mother during discharge improved markedly.

Example: When Culture Trumps Theory

Mrs. Said, the mother of a 9-year-old girl and a 3-year-old boy, sought treatment for herself and her children after her physically abusive husband left her for another woman. Recently arrived from a Middle Eastern country, Mrs. Said spoke English haltingly and retained many of the values and childrearing practices of her country of origin. She held distinctly different standards for her two children, insisting that the older girl should obey the younger boy because of their gender difference. She believed that the boy, at age 3, was now "the man of the family." At the same time, she bitterly resented the restrictions that her family imposed on her freedom of movement because she was a woman. The therapist assigned to the family initially understood Mrs. Said's unconscious double standard for her daughter and herself as evidence that she was using her son as an emotional replacement for her husband. Predictably, Mrs. Said responded with indignation to the clinician's cautious efforts to promote this view. The course of treatment improved quickly when, following consultation with a more experienced therapist, the clinician started to address the contrast between Mrs. Said's expectations that her older daughter defer to her younger son and her own aspirations for greater personal autonomy as an example of her being torn between the cultural values she acquired from her family and the new attitudes toward gender equality that she was learning in the United States. This

approach allowed Mrs. Said to become aware of her range of attitudes toward gender differences, and she started thinking about the conflicts she felt between her traditional upbringing and her beginning but incomplete adaptation to American values of gender equality. She became less critical of her daughter and more self-confident in asserting her maternal authority over her son as a result.

Core Intervention Competencies

CPP calls for the clinician's familiarity with several bodies of knowledge: emotional, social, and cognitive development in infancy and early childhood, including patterns of attachment; adult development, including parenting as a normative developmental transition and disorders of parenting; developmental psychopathology and diagnostic frameworks from infants, children, adolescents, and adults; and understanding of sociological and cultural influences on individual functioning. The ability to observe behavior is a core competency that allows the therapist to apply this abstract knowledge to specific clinical situations, a feature that CPP shares with other forms of relationship-based treatment, including interaction guidance (McDonough, 2004) and "watch, wait and wonder" (Cohen et al., 1999; Muir, Lojkasek, & Cohen, 1999). In addition, the therapist should have clinical skills in working with both children and adults and the capacity to engage in collaboration with other service systems on behalf of the child and the family. Case management, crisis intervention, and knowledge of relevant community programs are additional skills that are often acquired "on the job" while serving families with multiple needs. This core background knowledge and these clinical skills are common to many intervention modalities. What is unique to CPP is their coalescence into a single but complex core skill: the therapist's ability to serve as a conduit between the child's and the parent's experience. This role involves skill in translating the meaning of the child's behavior for the parent and vice versa in order to promote safety and trust, as described below.

Translating between Parent and Child

The emotional vocabulary of babies, toddlers, and preschoolers can be a foreign language for adults. Parents whose earliest efforts to communicate were not understood or heeded are often cut off from access to the ancient mother tongue of emotions, which consists of visceral sensations manifested through facial expressions, muscular tension and relaxation, approach and avoidance, motor discharge, and preverbal vocalizations

that evolve slowly into expressive speech. The primary task of the CPP clinician is to build bridges between the subjective experiences of the parent and the child by making the language and behavior of each partner more understandable to the other.

In the early years, children cannot articulate in words what they need and want. Instead of talking, they cry, reach out, avert their eyes, beseech, cling, push away, stiffen, scream, throw tantrums, withdraw, and run away. Sometimes they just look on quietly, doing nothing else but expecting that the parent will grasp the silent request embedded in their gaze and respond accordingly. When parents cannot decipher the meaning of their young child's behavior or respond effectively to the child's signals, a cycle of miscommunication and mutual alienation may follow where neither party understands or trusts the intentions of the other. The CPP therapist guides the parent to observe the child's behavior and to reflect on it, offering explanations framed in the context of the child's developmental stage. A specific form of this modality is "speaking for the baby," a technique that involves helping the mother put herself in the baby's place by articulating what the baby would say if he or she could speak (Carter, Osofsky, & Hann, 1991). The following vignette offers an illustration of how translation may occur.

Example: When the Parent Minimizes the Child's Distress

Rowena, age 8 months, bangs her head repeatedly on the floor and against the wall without uttering a sound. Her mother, who recently left Rowena's father after he battered her, looks on but does nothing. The therapist asks what the mother thinks of that behavior. The mother replies: "It doesn't seem to hurt her. She is not crying." The therapist says: "Yes, but it kind of worries me that she is not crying. It's like she is teaching herself not to feel pain." The mother says, with a little smile: "Like me." The therapist says: "Yes, you really needed to protect yourself from feeling pain. Do you want her to be like you in that way?" The mother is silent for a few moments, looking at Rowena, who is continuing to silently bang her head. Without saying a word, she goes over to the child, picks her up, and shows her a toy. The therapist says: "You are showing her that she doesn't need to stop feeling, that you will help her when she needs you."

The primary element in this intervention was the therapist's effort to enable the mother to understand that her child's behavior signified something, and that the behavior was self-damaging. The mother was able to use this intervention to relate the child's behavior to her own personal experiences and to take protective action. The clinician decided

not to raise the possibility that Rowena might be enacting a scene of domestic violence because the mother denied that Rowena was present when her husband tried to choke her. The therapist chose instead to comment on the mother's protective action of stopping Rowena's head banging as a first step in her plan of helping the mother understand Rowena's response to the violence.

Translation becomes increasingly bidirectional starting in the second year of life. The child-parent partnership calls for the child's ability to understand the parent's motives and cooperate (if not necessarily agree) with the parent's goals. Parents cannot articulate their expectations when caught in a power struggle or when unaware of mismatches between their motives and the child's experience. As the child learns receptive and expressive language, the therapist explains the parent's motives and feelings to the child using words that are tailored to the child's level of cognitive and emotional functioning. The therapist's translation serves a dual purpose: It not only tells the child what the parent's intentions are but also clarifies and reframes the parent's motives to the parent. In this sense, translation is not always literal. The therapist introduces elements of empathy and support that may not have been originally present in the parent's behavior in order to expand parental consciousness and self-esteem. One mother responded to the clinician's sympathetic reframing of her intentions toward her daughter by saying: "You mean I really want to protect her? I didn't know I was capable of that!" Her self-perception as mean spirited and destructive was softened when the clinician spoke to the child about her effort to protect. The following vignette illustrates this approach.

Example: Positive Reframing of the Parent's Motives

Two-year-old Maria is refusing to clean up the toys at the end of the session. The therapist starts to help her, but the mother says sharply: "I need you to stay out of this. She leaves her room in a mess, and I cannot be always helping her to clean up her toys. She needs to learn to do that by herself." The therapist, after an inner struggle to contain her own irritation at the mother's demands of her small child, remembers how overwhelmed and exhausted this mother is by the stresses of her life. She watches quietly as mother and child engage in a tug-of-war about cleaning up the toys. She then says to Maria, speaking slowly and quietly, "Your mommy is trying to teach you something very important. She wants you to take good care of the toys so that you can find them when you come back." Maria stops her squealing and listens. The therapist adds: "It's hard to clean up the toys because you don't want to go

home yet, but every toy will be here next time, just where you left it." Feeling supported, the mother says: "Yes, we will be back next week. Now it's time to put the toys away and we'll go home and have dinner." Maria continues whining and resisting. The therapist and the mother repeat their statements again. Maria now starts slowly putting the toys away, and the therapist praises her skill. Maria brightens and quickens the pace of putting the toys away. Therapist and mother clap when she is done, and Maria smiles shyly, a tear still on her cheek. As they are leaving, the mother says to the therapist: "I didn't realize I was teaching her something. I just wanted her to do what I said." The therapist answers lightly: "See? You didn't even know you are a teacher." The mother laughs and says "You're right about that!" but quickly changes her mood and says crossly: "I don't think she really understood what we said. She is still too little for all that talking." The therapist feels the competitive edge in the mother's voice, and deescalates a potential confrontation by saying: "You are probably right. Maybe Maria didn't understand our actual words, but I think she understood that we were trying to help her." Turning to Maria, she says: "You knew that your mommy was teaching you about the toys?" Maria responds by giving the therapist a toy animal, and the therapist says: "That's right, I will keep it for you." She makes the animal say: "Bye, Maria. See you next week. I will be here. I will wait for you." Maria smiles a little and waves "bye-bye." The therapist makes the toy animal wave back both to Maria and to her mother as they walk down the hallway. The therapist defused the mother's defensiveness while reinforcing her message that Maria was responding to the goodwill of the adults, and the session ended on a positive note.

In this sequence, the therapist simultaneously translated and reframed the mother's intention, making mother and child aware of positive elements that had been obscured by the mother's irritation at the child's lack of compliance and by her resistance to the therapist's intervention. The mother became more receptive to the idea that the child's refusal to put away the toys was not simply due to her obstinacy but reflected the difficulty of ending the session and saying goodbye. The child, in turn, was reassured that the toys (and by implication the therapist as well) would be there when she came back. In other words, "out of sight" would not mean "gone forever," as she feared in her 2-year-old conception of the world. What began as a possible clash of wills between mother and therapist over "ownership" of the child ended in a supportive and even playful note. The therapist's struggle within herself to not enact her initial irritation at the mother was the foundation for all the positive exchanges that followed. By translating the mother's and child's motives for each other, the therapist repaired

first the initial tension between herself and then the tension between mother and child. The emotional availability fostered by this intervention sequence had the effect of serving as a reciprocal reward system between mother and child (Emde, 1980).

Theoretical Target, Intervention Modalities, and Ports of Entry

Daniel Stern pointed out that therapeutic approaches differ both in their “theoretical target,” which he defined as the basic element of the parent–child system selected for change, and in the preferred “port of entry” used to bring about the desired results (Stern, 1995). In his analysis and synthesis of the range of approaches to psychotherapy in infancy, Stern noted that although different therapies aim at changing either the parents’ mental representations or the parents’ behaviors, the commonalities among the different approaches hold the best promise for a unified new form of therapy that incorporates the effective strategies used in specific approaches while also integrating them into a clinically versatile approach. CPP adopts this spirit of inclusiveness, selecting as a target for change the configuration of meanings shared or jointly constructed by the parent and child that demeans, threatens, or devalues each other and their relationship. These meanings emerge from the parent’s and the child’s mental representations of themselves and each other, which are expressed in their individual behavior, patterns of interaction, what they say about themselves and each other and how they say it, and the themes and feelings that emerge in the child’s play. The treatment also targets for change those beliefs, affects, and behaviors in the parent, the child, and their interaction that interfere with affect regulation and interpersonal trust and that detract from their ability to engage constructively in developmentally appropriate activities and goals. The treatment legitimizes, reinforces, and expands beliefs, affects, and behaviors that promote safety, regulation of affect, emotional reciprocity, and the mastery of developmentally appropriate goals.

Building from Simplicity

The most direct interventions are often sufficient to bring about lasting change. Well-timed information and advice, offered tactfully and tailored to the parents’ cultural values, have for generations helped parents learn helpful childrearing practices rapidly and well. Parents are usually eager to help their children develop optimally and open themselves to opportunities that will enable them to do so if the methods suggested are compatible with their own psychological makeup.

Separation anxiety is an area in which emotionally supportive developmental information can be very useful. Parents often disclose that they sneak out of the house because they cannot tolerate the child's crying in protest when they leave. Many parents respond with astonished relief when the therapist explains that sneaking out exacerbates the child's fear of being left because young children constantly scan their surroundings to check on their parents' whereabouts in order to anticipate what will happen and maintain a sense of predictability. Once parents understand that their unpredictable absence makes the child cope by becoming overly vigilant, they are more willing to brave the child's tears when saying goodbye and to find workable ways of easing the separation. Other parents are unable or unwilling to stop sneaking out even when they ostensibly understand the clinician's explanation. For such parents, more sustained clinical intervention is usually needed.

Each of the clinical modalities described below has a range from simple to complex, depending on how readily a parent or a child responds to the initial intervention. For example, developmental guidance can consist of giving a simple piece of information that readily changes parental behavior (e.g., telling a receptive parent that putting the baby to sleep in a supine position protects against sudden infant death syndrome) or may involve a complex analysis of the child's sensorimotor coordination problems (e.g., ascertaining that a baby seems to avert gaze because she cannot hold her neck up and turn to face the parent). Insight-oriented interpretation can be relatively simple and direct (e.g., linking a father's refusal to see a psychiatrist for his depression to his early experience of his father calling him "crazy"), or it can involve a progression of carefully timed interpretations over the course of several sessions. Interventions to address problems of living may be straightforward or laborious depending on the availability and quality of community resources and the parent's willingness and skill in making use of them. Sometimes arriving at a simple solution requires long and complex thinking and planning. There is no ready-made dichotomy between simple and complex intervention strategies.

Intervention Modalities

Intervention modalities are deployed differentially depending on clinical considerations. Two common threads guide the intervention within every modality. The first thread is the effort to promote hope by upholding safety, normalizing and legitimizing feelings, and enhancing competence in both the parent and the child. The second thread involves the clinician's linking of interventions with the parent to interventions with the child. This reciprocal translation has the goal of including the parent in whatever is transpiring between the therapist and the child and including

the child in what is transpiring between the therapist and the parent. The effort is to give both the child and the parent a place and a voice and not to leave either of them out of the circles of communication.

The combined use of the clinical modalities below defines CPP as a cross-disciplinary endeavor. Modalities informed by social work blend with modalities based on developmental psychology, psychoanalytic/attachment theory, trauma, social learning theory, and cognitive-behavioral psychotherapy. Several of these modalities were first described by Fraiberg (1980) as components of infant–parent psychotherapy.

Supporting Developmental Momentum

Healthy age-appropriate functioning is the overarching goal of all treatments. In the normal course of development, parents routinely use empathic responsiveness, physical contact, language, and play as means to this goal for their children. Parents who are depressed, traumatized, or overwhelmed by their circumstances may lack the energy, imagination, and resourcefulness to engage with their child in these basic forms of interaction. The systematic support of healthy developmental momentum is particularly crucial for infants, toddlers, and preschoolers whose behavior is dysregulated and whose perception of relationships is damaged following stressful or traumatic circumstances. Play, words, and physical contact serve as vehicles to explore themes of danger and safety, promote interest and learning, and build a behavioral and linguistic repertoire that can replace emotional withdrawal and the use of destructive action to express anger, fear, and anxiety.

Playing. Play is the therapeutic medium of choice because of its centrality in children's lives. Whether the treatment is provided through home visits or in an office-based playroom, the therapist makes toys available that are chosen according to the child's developmental stage and the goals of treatment. The categories of toys available include toys that promote the playing out of interactional themes (a family of dolls that match the child's and family's ethnicity, farm animals, wild animals); toys that promote nurturing and self-care (kitchen and eating utensils, toy food); materials that promote artistic expression (paper and crayon); toys that evoke the specific stressors endured by the child; and toys that promote healing and repair (toy weapons, police cars, ambulance, medical kit). The choice of toys is often a work in progress through the course of treatment, as some themes are outgrown and new themes emerge.

Other activities may co-occur with play or replace it in the moment, but play is the natural form of expression of young children. Much like adult dreams, play may be considered the "royal road" to the child's

unconscious or to otherwise unspeakable fantasies, fears, and wishes. In his book *Playing and Reality*, Winnicott (1971) described psychotherapy as a form of play when he wrote that “psychotherapy has to do with two people playing together” (p. 38). Successful psychotherapy is construed as restoring to the patient the capacity to play. This is particularly relevant to the treatment of young children, who engage in play as their primary mode of symbolic expression. Children use play to repeat an anxiety-provoking situation, change its outcome, or avoid it altogether by modifying all the parameters of the situation or choosing a different play theme.

Psychodynamic approaches to individual child psychotherapy have traditionally emphasized the mutative role of the therapist’s verbal interpretation of the child’s unconscious conflicts as these are expressed through play (Klein, 1932; A. Freud, 1965). These interpretation-driven approaches have in recent years been expanded to include an appreciation for the multiple and overlapping functions of play (Slade & Wolf, 1994). Play does not need to be interpreted by an all-knowing therapist to promote healing. In individual psychotherapy with the child, a form of intervention described as “simply playing” involves a noninterpretive, collaborative enterprise between child and therapist with the goal of helping children build psychological structures and make meaning of their experience (Slade, 1994). While “simply playing,” the therapist builds on what the child is doing to bring narrative coherence to fragmented and disorganized elements of the child’s experience, promote affect regulation, and enhance self-reflection. The therapist must engage fully in playing in order to co-create with the child play themes that evolve from their conscious and unconscious communications and spur psychological transformation (Birch, 1997; Cohen & Solnit, 1993).

CPP encourages play between *the parent and the child* as a way of building on these developmental and therapeutic properties of play. It is not only the therapist but also the parent who needs to fully play with the child as well as to understand the meaning of the child’s play in order to respond to its message of what the child needs. For young children, the joint meaning created with the therapist in individual psychotherapy is incomplete unless this meaning is also available to the parent, who is the most important organizer of the child’s psychological experience. In joint parent–child sessions, the CPP clinician serves as a play translator so that the parent can understand the meaning of the child’s symbolic language.

When the parent and the child play together, the spontaneity and joy of the play may be therapeutic in itself, and the therapist may choose to simply watch or to join in as another player. While interpretation can be a powerful mutative factor, it is also important to help parent

and child develop the joint capacity for spontaneous, un-self-conscious pleasure and intimate communication that emerge when parent and child “just play” together.

At other times, the content of the joint parent–child play carries the individual meanings that each partner gives to it but does not cohere into an enjoyable reciprocal activity. In these cases, the therapist’s role is to facilitate the joint creation of meaning *between the parent and the child* by enabling them to play together and to step out of the play in order to reflect on it.

This process of reflection and interpretation involves at least three simultaneous layers. First, as in traditional play therapy, the clinician needs to understand the internal frame of mind and mental representations that the child is conveying through the play. Second, the clinician helps the parent to become attuned to the child’s play themes. Third, when the parent joins in the child’s play, the clinician uses the joint play to address the relevant themes in the parent–child relationship. The clinician interprets the content of the play to promote insight when either the parent or the child is able to move from enacting his emotional experience to reflecting on it. The clinician may speak primarily to the parent or to the child when making an interpretation, but she is careful to do so in ways that do not exclude any of the participants in the session.

Putting Feelings into Words. The verbal articulation of feeling can help children understand and manage intense emotion. Strong feelings are always felt viscerally, through bodily sensations. Learning to translate these body sensations into words is an important building block in affect regulation. The parents’ own emotional regulation improves when they participate in helping their child to verbalize difficult experiences. Putting feelings into words also builds intimacy because it makes the child and the parent connect with the emotion of the other.

A variety of vehicles adapted to the child’s age are used to put feelings into words. The most common practice is to read the child’s nonverbal signals and to suggest the feelings that the child might be experiencing. Asking the child what is happening also encourages the child’s verbal expression of emotion. When children and their parents need systematic, structured assistance in identifying and articulating feeling, the session can include telling stories or reading books that address emotionally relevant themes, using “feeling charts,” writing letters, and making drawings that narrate and illustrate the child’s experience.

Protective Physical Contact. Bodily sensations are the primary site of emotions and can be conveyed only incompletely through words or play. The innermost experiences of love, intimacy, and safety are felt in

the body and shared through physical contact. At the other extreme, stress and trauma expose the child and the parent to overwhelming horror, helplessness, and bodily sensations that may be reexperienced in the present without any conscious awareness of its roots in the original stressor. These physical sensations are expressed in everyday language through expressions such as “heavy heart,” “racing heart,” “unable to breath,” “a lump in the throat,” “feeling about to die,” and many others. These sensations can override the child’s and parent’s capacity to tolerate them and often lead to self-protective maneuvers where the body shuts down in an effort to prevent emotional collapse. The CPP therapist encourages age-appropriate affection and protective touch between the parent and the child to build a sense of protection and safety and to encourage loving and pleasurable bodily experiences. The clinician speaks about the reassuring power of picking up and holding a frightened child, letting the child sit on the parent’s lap when feeling low, and other demonstrations of easygoing physical contact. Sometimes the child shows physical affection in such subtle ways that the parent does not notice it. Bringing the parent’s attention to the child’s affectionate gesture can reassure a discouraged parent about the child’s love.

Clinicians do not as a rule initiate physical affection to the child because parents can interpret this behavior as an attempt to displace them in the child’s emotional life. Many children, however, spontaneously hug, kiss, or lean against the therapist in the course of a session. In these situations, therapists use their clinical judgment in deciding how to respond. Brief, spontaneous, and casual expressions of affection on the child’s part toward the therapist are quite common and are usually taken in stride by the parents. The therapist responds similarly, unless the child’s behavior creates or reflects a clinically charged issue that calls for exploration. At times, the child seeks physical contact with the therapist in an urgent search for safety and protection. The best therapeutic response in these cases is to respond to the child’s immediate need and then follow up with an effort to build this sense of safety within the child–parent relationship.

Unstructured Reflective Developmental Guidance

This modality offers the parent information about age-appropriate children’s behavior, needs, and feelings as these emerge spontaneously during the sessions. The developmental guidance is unstructured because it does not follow a prescribed curriculum. It is reflective because it encourages the parent to integrate thinking and feeling into a new and more empathic understanding of the child’s developmental processes (Fonagy, Gergely, Jurist, & Target, 2002). During individual collateral sessions, the clinician includes developmental guidance to normalize and

legitimize the parents' feelings when they disclose difficult childhood experiences. These exchanges can serve as the starting point to increase parental understanding of what their child might be going through. Reframing, empathy, and appropriate limit setting are emphasized as part of developmental guidance. Toddlers and preschoolers can also profit from developmental guidance because they are reassured by learning that other children also feel the way they do.

Principles of Early Child Development. Developmental guidance helps parents to appreciate young children's construction of the world and enables them to see things from the child's perspective (Fraiberg, 1959; Lieberman, 1993). Even well-meaning, reasonably well-informed parents are often unaware of the common developmental themes of the first 5 years of life. The principles itemized in Table 3.1 can substantially decrease miscommunication and conflict in the early years and set a healthy blueprint for development.

These common developmental themes come as a surprise to many parents, but most particularly to parents whose upbringing has been characterized by stress, pain, and unpredictability. Parents often find new meaning in their childhood memories while they learn how their children interpret the world, and in this process they can acquire a richer and more compassionate understanding of themselves and their own parents.

TABLE 3.1. Twelve Principles of Early Child Development

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1. Young children cry and cling in order to communicate an immediate need for parental proximity and care.
 2. Separation distress is an expression of the child's fear of losing the parent.
 3. Young children want to please their parents and fear their disapproval.
 4. Young children are afraid of being hurt and fear losing parts of their body.
 5. Young children imitate their parents' behavior because they want to be like them and assume that the parent's behavior is a model to emulate.
 6. Young children feel responsible and blame themselves when the parent is angry or upset for whatever reason.
 7. Young children harbor a conviction that parents know everything and are always right.
 8. Young children need clear and consistent limits to their dangerous or culturally inappropriate behaviors in order to feel safe and protected.
 9. Young children use the word "no" to assert and practice their individuality and autonomy.
 10. Memory starts at birth. Babies and young children remember experiences long before they can speak about them.
 11. Young children need adult support to express strong emotions without hurting themselves or others.
 12. Child-parent conflicts are inevitable due to their different developmental needs, but they can be resolved in ways that promote trust and support development.
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Developmental guidance is not restricted to information about normal development. In the aftermath of stressful or traumatic events, providing psychoeducation about expectable responses can be extremely helpful. The dysregulations of emotion and behavior following severe stress and trauma are frightening in themselves and often lead to fears of being permanently damaged or becoming “crazy.” Normalizing these reactions by describing their universality and pervasiveness enables the parent and the child to feel less self-blame and to tolerate better the quick oscillations from anger to rage and the preoccupation with themes of retribution and revenge that occur in the aftermath of trauma (Pynoos & Steinberg, 2004).

Modeling Appropriate Protective Behavior

In this modality the therapist takes action to stop dangerously escalating behavior, such as retrieving a child who is engaged in self-endangering behavior or stopping a child from hurting others. This modeling needs to be followed by an explanation about the reasons for the action in order to prevent negative consequences, such as the parent feeling upstaged or the child learning to think of the therapist as the main source of safety and authority. The clinician invites the parent and child (if age appropriate) to reflect on what happened so they can appreciate the potential danger and understand the importance of protective action. Sometimes the clinician needs to start by finding out how the parent responded to the intervention in case the parent feels offended or preempted. Emphasis is placed on how much the parent and the child care for each other, how sad they would be if one or the other were hurt, and how important it is to be safe from danger. The child’s safety is not the only focus of attention. When the parent engages in risk behavior, the therapist discusses sources of concern, explores motivations, and suggests alternatives.

Modeling protective action is particularly relevant to traumatized parents and children, who often have distorted perceptions of danger and safety and minimize the factual realness of danger or overestimate the risk of relatively safe situations. Young children’s developmental expectation that the parents will be able to protect them is profoundly damaged by the experience of trauma (Freud, 1926/1956c; Pynoos, 1995). Their ability to develop realistic appraisals of danger is undermined when they use their parent’s misperceptions of danger and safety as barometers for their social monitoring. In this context, the therapist’s confident protective actions are not only important in their own right but also represent a promise to help the parents learn or relearn how to protect the child.

Insight-Oriented Interpretation

Insight-oriented interpretation has the goal of clarifying the preconscious, unconscious, or symbolic meaning of behavior in ways that increase self-understanding. A frequent type of CPP interpretation involves making clarifying links between the parents' sense of self, their feelings for their children, and their parenting practices. For example, parents who were routinely physically punished, criticized, and neglected may unconsciously repeat these patterns in relation to their children (Fraiberg, 1980; Lieberman et al., 2000). In cases of domestic violence, the battered parent often sees an unsettling resemblance between the child and the abusive partner, and makes negative attributions that are internalized by the child and deeply influence the child's sense of self (Lieberman, 1999; Silverman & Lieberman, 1999).

Interpretation can be used with parents who are receptive to introspection and with children who have receptive language. Well-timed interpretations can help parents become aware of the unconscious repetition of their past in the present, correct their distorted perception of the child, and free them to learn developmentally appropriate childrearing practices. Young children routinely blame themselves for causing fights between their parents or for other stressful or traumatic events. Interpretation can help children acquire a more accurate understanding of causality and of their own role in the family, relieving them from the psychological burden of false beliefs and costly defense mechanisms and freeing them to try out less emotionally demanding ways of coping with anxiety.

Interpretation in the joint presence of the parent and the child calls for utmost clinician tactfulness and sense of timing. There are times when the therapist needs to learn more about the parent's history or current circumstances or to interpret the parent's behavior in the presence of the child. In the case of preverbal, presymbolic infants and toddlers, this conversation can routinely take place in the child's presence because the child, not having mastered receptive language, is less likely to be burdened by an understanding of the parent's painful experience. Older toddlers and preschoolers present a greater challenge because they can understand adult dialogue and participate more actively in the treatment, often claiming priority of attention. This presents the clinician with a clinical dilemma. On one hand, speaking in the child's presence about emotionally charged adult topics can encumber the child with developmentally inappropriate information. On the other hand, many children are exposed to these topics in the routine course of events because adults often discuss events as if children were unable to understand the conversation of the adults. The therapist must decide

what strategy will best serve the child's mental health—not to discuss an important adult topic in order to shield the child and to model this attitude for the parent, or, alternatively, to discuss the topic in the child's presence in the hope that the discussion will offer a more balanced framework for difficult situations and emotions that the child witnesses in everyday life.

The answer is usually highly specific to each individual situation. It is preferable to schedule collateral individual sessions with the parent in addition to the joint child–parent sessions to talk about emotionally charged adult topics. If this is not feasible, individual sessions with the parent may substitute for a portion of the joint child–parent sessions depending on clinical need and reality constraints. Alternatively, the dyadic format of the session can be modified by dividing the session into a portion that is child centered and another portion that is adult centered. During home visits, appointments can be scheduled so that the adult portion of the session coincides with the timing of children's television programs, with the arrival of another adult from work, or with other family routines that can be joined by the child while the parent and the therapist talk. When the sessions are office based, an assistant therapist may be engaged to spend time with the child during the adult portion of the session. Telephone sessions are often useful for discussing adult topics, particularly for parents who need to maintain some emotional distance while discussing painful experiences.

Addressing Traumatic Reminders

The experience of trauma, with its overwhelming helplessness, horror, and fear, can leave long-standing sequelae in personality formation and everyday functioning. "Weakened versions" of the traumatic experience stay active in the person's mind, a phenomenon that explains the pervasiveness of behaviors such as "repetition compulsion," "efforts at mastery," and "turning passive into active" following the trauma (Freud, 1926/1959c; Pynoos, 1995). When the child is referred for treatment following a traumatic event, it is important to examine and address traumatic play, traumatic reenactments, traumatic dreams, avoidance of traumatic reminders, dysregulation of biological rhythms, and other manifestations of posttrauma psychological processes and behavior.

Many events traumatize the child and the parent at the same time, such as car accidents or family violence when one parent is battered in front of the child. The parent may also experience vicarious trauma from witnessing what happened to the child, as when the child is abused by the other parent, mauled by a dog, or has a near-drowning experience. The parent's traumatic stress may aggravate the child's response, both

because the child uses the afflicted parent's behavior for the purpose of social monitoring and because the parent's quality of parenting may lose joy, flexibility, and tolerance following the trauma. Treatment in these cases needs to incorporate systematic attention to the impact of the trauma on the parents, both for the purpose of educating them about how their experience affects the child and in order to assess a referral for individual psychotherapy.

Specific aspects of the parent's behavior, such as tone of voice, body movements, and facial expressions, may become traumatic reminders for the child. Intense negative affect can become a traumatic reminder in itself, whether the affect is felt by the child or whether the child witnesses it in the parent (Pynoos et al., 1999). These traumatic reminders can also serve as realistic danger signals. In situations of child abuse and/or marital violence, for example, a traumatic event can happen again at any time, so that these traumatic reminders can signal that another attack is imminent and give the child time to respond. In these cases, hypervigilance can have an adaptive function by alerting the child to take self-protective action. When a child shows fear and hypervigilance toward the parent, it is important to explore and address frightening or abusive aspects of the parent-child relationship.

Trauma Narratives and Story Telling. Much has been written about the importance of enabling children to create a trauma narrative as an essential ingredient of the healing process (Cohen et al., 2006). For very young children, who have limited capacity to express experience through the use of words, play, and symbolic representation, the creation of a narrative is seldom an elegant, circumscribed process with a well-defined product as its final outcome. Preverbal babies provide their narratives through their bodies, in the forms of disruptions in their capacity to regulate body functions, relate to others, and explore their surroundings. Toddlers and preschoolers use fragmented words and play to express their traumatic experiences a piece at a time and often incoherently because of their own cognitive immaturity and because trauma, by definition, shatters coherence. The younger the child, the more difficult it is to differentiate between objectively real events and the role of misunderstanding and fantasy in the ways that the child perceived the event. Memory always involves an updated reinterpretation of the past, and the disjointed nature of creating a trauma narrative increases when the child has been exposed to many traumatic events that may be reexperienced in unpredictable fashion and expressed in unrecognizable form.

The quick pace of development in the first years of life introduces another complication to the creation of a trauma narrative because

young children may use newly acquired verbal skills to describe a traumatic event that occurred much earlier in their lives. In the absence of corroborating evidence, it is difficult to determine whether this description refers to a current situation or to something that happened in the past. It is also difficult to ascertain whether the event happened in real life or whether the child is expressing fear or a misinterpretation of real events. This uncertainty has implications not only for the purposes of reporting to child protective services but also for helping the child process the experience. For all these reasons, the concept of a trauma narrative needs to be understood as a dynamic process that evolves in tandem with the child's development and must be integrated with other aspects of the treatment.

Storytelling can be a powerful tool to enable children to bring coherence to their traumatic experiences. The story can be told by the therapist in steps while observing the child's response to make sure that the affect can be tolerated. Elements of protection can be introduced into the story. For toddlers and children who have not mastered the use of "I" and "you," the child's name can be used. One example of storytelling involves a 3-year-old who was found wondering in a daze very far from her child care center 4 hours after the child care providers first discovered that she was missing. The therapist used a doll to personify the child and enact the story. She said: "Anita was playing with her friend Susan. Then she went out of school, and walked, and walked, and walked. She looked for Susan but Susan wasn't there. She looked for the teacher but teacher wasn't there. She called for mommy but mommy wasn't there." The child was listening with wide eyes until this point. When the mother was mentioned, she went and hid under an armchair, curling up in a fetal position. Her mother spontaneously took over the narrative, saying: "I called you and called you. I was so scared." The mother's voice broke down, and the therapist took on the role of the mother, speaking for her as she called for the child. After about 10 minutes of therapist and mother calling for the child and "looking" for her, Anita put out her hand so it could be seen. This served as the cue for therapist and mother to "find her" with much rejoicing. In subsequent sessions, Anita's first action was to hide under the armchair as a way of signaling that she wanted to enact the narrative of being lost and being found. It is important to end these narratives on a safe and protective note before the end of the session.

Retrieving Benevolent Memories

The perception of oneself as worthy of love and protection can be severely damaged by stress and trauma. In their aftermath, the person

may lose sight of what is loving, positive, and hopeful both in the past and in the present. The importance of identifying traumatic cues to promote mental health is well established. There is less attention to what William Harris (personal communication, May 2004) calls beneficial cues—moments of well-being that bolster self-worth because they serve as reminders for experiences of being supported and cherished.

Early benevolent experiences with caregivers can be protective forces even in the face of extremely difficult conditions. Their emergence in memory can become a powerful mutative factor in the course of treatment. Even brief images of having been unconditionally loved, accepted, or understood evoke visceral sensations of well-being, serving as “angels” that do battle with and counterbalance the hopelessness and despair induced by the “ghosts in the nursery.” Many parents do not remember these positive experiences. Sometimes the memories are banished from consciousness to avoid the pain of remembering something that was lost. Other times the present circumstances are so emotionally overpowering that they drain the parent’s energy to focus on anything but the current challenges. Therapists sometimes unwittingly collude with the unwavering attention to what is painful under the mistaken assumption that working to redress problems is the primary road to improvement. The parents may assume from the therapist’s behavior that talking about things that feel good has no place in treatment, and a mutually reinforcing process of “accentuating the negative” may ensue.

The message that experiences of love and support are important needs to be conveyed from the very beginning of treatment, starting during the assessment period with questions about positive early memories. Linking the past and the present is as important with benevolent experiences as with conflict-laden memories. Remembering episodes of loving care can give parents the impetus to provide such experiences to the child and to create, perhaps for the first time, the intergenerational transmission of a renewed sense of security and self-worth.

Emotional Support

The clinician’s emotional availability is an indispensable component of all effective therapeutic interventions. It takes the forms of conveying, through words and action, a realistic hope that the treatment goals can be achieved; sharing in the satisfaction of achieving personal goals and developmental milestones; helping to maintain effective coping strategies; pointing out progress; encouraging self-expression; and supporting reality testing (Luborsky, 1984; Wallerstein, 1986). Caring and respectful relationships are the goal of the parent–child treatment and also

the means used to pursue this goal through the child–parent–therapist relationships. The clinician not only promotes reciprocity and attunement but also embodies these ways of being by using an emotionally supportive therapeutic stance.

While always valuable, an empathic clinical approach is indispensable when the client's sense of personal worth is under assault because of external or internal circumstances. The transition to parenthood is a developmental stage that often tests the parent's resources, giving rise to profound self-doubts about one's ability to raise children well. Women, in particular, experience in their personal lives the unresolved societal conflicts surrounding mothering. Mothers are routinely considered the main culprits when a child has a problem of whatever kind, whether this involves developmental delays, mental health problems, or simply less than sterling social skills. The undeniable psychological power of mothers has the deplorable dark side of their being presumed, quite wrongly, to have *all* the power. Many mothers mistake this fallacy for the truth, blaming themselves for not providing their children with perfect lives and perfect personalities. When their children internalize the mother's point of view, the new generation becomes yet another link in the mother-blaming chain.

Clinicians need to be adamant about not colluding with the pressure to blame parents, particularly mothers, for their children's problems. Even when there seems to be a clear causal connection between the children's problem and the parent's behavior, it is important to remember that the parent was once a child and that the causal chain, such as it may be, is likely to go back for generations. Personal change is best promoted not by blame but by the conviction that the parent and the child can find intrinsically more satisfying ways of being and relating and that the therapist's role is to help in this endeavor.

The importance of emotional support cannot be overstated in the treatment of parents and children whose sense of self-worth has been eroded by conditions of poverty, discrimination, and powerlessness. In these situations, an empathic stance becomes an affirmation of human dignity as much as a therapeutic tool. When trauma is part of the clinical picture, the therapist's emotional support and empathic understanding constitute an auxiliary source of ego strength that fortifies the individual's functioning and offers hope for the future.

Beneficial parallel processes take place whenever the therapist engages in emotional support and empathic communication. The child learns and benefits from observing the caring way in which the clinician treats the parent. The parent learns and benefits as well from observing how the therapist behaves toward the child. The therapist's influence as

a role model is particularly valuable when there is a dearth of benevolent, protective influences in the family's environment.

Attention to Reality: Crisis Intervention, Case Management, Concrete Assistance

Reality matters, and the clinician must address it whenever possible by taking appropriate action to prevent or remedy the consequences of a family crisis or stressful circumstances. Although listed last, crisis intervention, case management, and concrete assistance with problems of living are often among the first interventions to be used by clinicians working with families from stressful socioeconomic or environmental circumstances. Parents facing acute problems of living are more receptive to mental health services when they perceive the therapist as actively involved and receptive to their plight. These modalities of intervention might involve a range of activities, including advocacy on behalf of the family with different agencies, consultation with the child care provider to prevent expulsion of the child for inappropriate behavior, mediation between the parent and Child Protective Services if questions of abuse or neglect arise, or referral to other needed services.

Crisis intervention is often the first intervention modality when the child is referred following a traumatic situation, such as an accident, maltreatment, witnessing family or community violence, or the death of a parent. The first order of business in these circumstances is to ensure that the child is safe, in the care of the most appropriate and familiar adults available, and amidst conditions that afford the best continuity and predictability of care. In the chaos that routinely accompanies a crisis, it is easy to overlook the child's need for an explanation and to forget that confusion and not knowing compound the impact of the traumatic stressor for the child. The therapist needs to find the time and the opportunity to probe for what the child knows, elicit the child's understanding of what happened, correct misperceptions and distortions, and provide age-appropriate explanations. Appropriate toys and drawing are helpful tools in enabling the child to demonstrate events that he cannot verbalize due to immature language skills or to the shock of the events.

The inclusion of crisis intervention, case management, and concrete assistance as treatment modalities has far-reaching implications for time allocation. Although in regular circumstances CPP sessions take place weekly and last 1 hour, this schedule becomes irrelevant at times of crisis or immediate need. Selma Fraiberg established a programmatic culture where therapists did whatever needed to be done to protect a

baby and assist a family without looking at the clock. This tradition continues among CPP practitioners. For program administrators, the practice sets a high standard because it means that case loads cannot be so demanding that the therapist has no flexibility to respond to emergencies. Yet constraints of time and energy are real, and limitations in one's availability should be explained in an emotionally supportive way. Jeree Pawl provided a model for the necessary balance between the therapist's availability to a family and availability to other demands. One of her clients had a long history of brutal abuse as a child and was struggling not to repeat her history with her baby. This young mother often dropped unannounced by Dr. Pawl's office when she was on the brink of despair, and left after a brief exchange feeling much better. At the same time, the mother felt profoundly ashamed for "intruding" into her therapist's daily routine. Jeree Pawl said to her: "If I cannot see you because I have to do something else, I will tell you so. But when I am available, I am available" (Pawl, 1995). The wisdom of this message resided in its making clear that the therapist's "boundaries" were not determined by an impersonal and arbitrary schedule but were guided by human considerations that made room for both the client's and the therapist's needs.

Ports of Entry: Choosing What to Treat

How does the clinician choose where to intervene, given the quick succession of exchanges and themes that takes place during a therapeutic session? Daniel Stern, in his exposition of a unified view of different forms of relationship-based interventions in infancy, offers the concept of "ports of entry," which he defines as the component of the parent-child system that is the immediate object of clinical attention (Stern, 1995, p. 119). The port of entry is, in other words, the road that leads to the theoretical target of the intervention. While Stern defined ports of entry rather narrowly as consisting of either parent-child interactions or parental mental representations, we see a broader range of possible ports of entry as an integral component of the effort to promote a unified approach to relationship-based therapy in infancy and early childhood. Skilled therapists working within one or the other approach to relationship-based intervention may be indistinguishable from one another when observed clinically even if they use different theoretical terms to describe their work.

CPP therapists cultivate a conscious versatility in choosing their ports of entry because humans express meaning in a variety of ways, ranging from facial expressions to motor discharges, somatic symptoms, concrete actions, verbal exchanges, and symbolic representations.

The initial choice of a port of entry is sometimes determined by the therapist's clinical judgment of what needs attention in the moment, either because it is charged with emotional meaning or because it has important long-term implications for the child's or the parent's mental health. Other times, it is the parent or the child who often decides for the therapist what the most productive port of entry is likely to be. For example, a parent who cannot speak about inner experience, either in herself or in the child, is not a good candidate for an initial therapeutic focus on mental representation, although this situation may change later in treatment. A 3-year-old who greets a therapist with the announcement "I hit my baby brother" is practically begging the therapist to use this interaction as the road to inner change. In other words, instead of an *a priori* theoretical commitment to either interactions or mental representations as the port of entry for therapeutic interventions, the CPP clinician is receptive to the port of entry that is most promising for positive change in the child.

Once an initial port of entry is chosen, there is no way of knowing where it will lead. New potential points of entry can open up in quick succession or, just as likely, every effort to pursue a port of entry may seem to lead nowhere. Treatment approaches that aim to change the parent-child interaction and approaches that aim to change the parent's mental representations have much in common because interactions are usually the external manifestation of mental representations and mental representations, in turn, result in interactions. Moreover, the mental representations of infants and young children need to be incorporated into the treatment because the early years are the time when children are actively engaged in responding to their parents' mental representations, internalizing them, and creating their own. Ports of entry, in this sense, are nothing more (although also nothing less) than useful constructs to systematize what is by definition a highly fluid process of communication that unfolds at several levels simultaneously and includes both conscious and unconscious, verbal and nonverbal components. Examples of different ports of entry as opportunities for intervention are provided below.

*Child and/or Parent Individual Behavior:
A Baby's Cry, a Mother's Failure to Respond*

A 3-month-old baby girl is crying loudly as her mother listens listlessly without responding to it. Using the child's behavior as an initial port of entry, the therapist asks the mother: "What do you think is bothering her?" The mother shrugs her shoulders and responds: "I don't know. She always cries like that." Sensing the mother's resistance to identify

empathically with the baby, the therapist turns her attention to the mother's experience and asks: "How do you feel when she is crying so loud?" The mother answers angrily: "Something is always bothering her. It makes me tired." The therapist allies herself with the mother's experience as a bridge to help her attend to the baby, and answers sympathetically: "It is so much work to take care of a baby. Do you mind if I try to find out what is bothering her right now?" The mother nods her head, and the therapist lifts the baby up and rocks her, saying to her: "Your mom knows you are not happy, but she is very tired. She did not sleep very well." She looks at the mother and smiles. The baby continues to cry. Searching for the meaning of the cry as an expression of need, the therapist says to the mother: "I think she is having trouble calming down. Do you think she might be hungry?" The mother looks at the clock and says: "I lost track of the time. I think she is due for her bottle." Still immersed in her lethargy and fatigue, which stem from her depression, she takes a bottle from her bag but hands it to the therapist, who puts it in the baby's mouth. The baby quiets immediately. The therapist hands the baby back to the mother, saying "She sure is persistent. Her crying was like an alarm clock saying 'time to feed me.'" The mother cradles the baby in her arms. The therapist says lightly: "It's amazing how quickly she calmed down once she got her bottle, isn't it?" The mother nods in agreement. After a silence, the therapist adds: "You know, I think we just learned something. There are times that you feel so low that you forget what time it is, and then it's hard for you to know why the baby is crying."

In this example, the therapist used the child's and the mother's individual behavior as ports of entry into the meaning of their respective experiences and as an opportunity to translate the meaning of the baby's cry for the mother. She sympathized with both the mother's and the child's predicament, found words to convey to the mother how the baby felt, and acted in response to the baby's immediate need while preserving the mother's primacy as a caregiver by initially asking permission to tend to the baby and later giving the baby back to her. It is noteworthy that the mother stirred herself enough to check the time and produce a bottle in response to the suggestion that the baby might be hungry, although she delegated to the therapist the job of feeding the baby. The therapist accepted this task for just long enough not to make the mother feel rejected and then gave the baby back to the mother while commenting on the baby's crying as a meaningful communication that indicated the baby's competence in bringing attention to her needs. The successful end of the baby's crying, in turn, served as a platform to reflect on the entire sequence and to link the mother's depression to her inability to understand and respond to the baby's crying.

*Interactive Exchanges between the Parent and Child:
Positive Reframing of Maternal Perception*

A 10-month-old baby is sitting on his high chair, systematically dropping slices of peach on the floor, one by one, and leaning over to watch where they land. The mother comes in from the kitchen and sees the floor strewn with fruit. She yells: "Bad boy! See what you did!" She picks up the pieces of fruit. Unfazed, the baby strains toward her, trying to reach the peach slices and saying, "eh! eh!" The therapist speaks for the baby, saying: "Mom, mom, you don't understand me! I am not a bad boy! I was trying to see what happens when the peach lands on the floor!" The mother softens and says to the therapist: "You are always trying to give him the benefit of the doubt!" The therapist replies, playfully: "Sometimes I give him the benefit of the doubt, and sometimes I see things the way you do. It's just that at this age babies are obsessed with things appearing and disappearing. That's why he likes to play peek-a-boo with you so much." The mother says, in mock exasperation: "So what am I expected to do? Pick up things from the floor for him all day?" The therapist laughs and says: "That is up to you. It's a tough decision." The mother washes the peach slides and sits down next to the baby, feeding them to him one by one while the baby tries to grab them from her squealing with pleasure. The therapist comments: "He knows how to feed himself, but he still loves it when you feed him."

In this intervention, the therapist focused on the interactive sequence of the mother's scolding of the baby and the baby's persistent effort to reach the fruit in the mother's hand as an example of the different developmental agendas between the mother and the child. Instead of assuming that the mother's description of the child as a "bad boy" reflected an entrenched negative attribution, the therapist chose to start out by offering developmental information couched in terms of the baby's motivation in the moment. This is one successful example of "starting with simplicity." The mother was receptive to the therapist's positive reframing of her perception of her child, from his being a bad boy to his being a baby trying to learn about cause and effect in making things appear and disappear. The therapist pointed to the baby's pleasure in being fed by the mother as a way of upholding the mother's self-confidence about her primacy in the baby's life.

*Interactive Exchanges between the Parents:
Creating Parental Awareness of the Child's Experience*

The mother and the father of an 18-month-old girl blame each other in front of the child for their failures to live up to each other's expecta-

tions of how they should parent their baby. As their voices escalate, the child looks on with a worried expression and starts pulling her hair. The therapist listens to the parents and says: "I know that the two of you are trying to figure out what is not working in your relationship. I just worry that the way you are doing it is scaring your child." The father asks: "Why are you saying that? We are not fighting." The therapist replies: "I know you are not, but she doesn't. Look at how worried she looks, and how she is pulling her hair. It's like she is punishing herself for your not getting along." The father seems skeptical, but the mother says, "She looks so sad," and picks the child up. There is a tense silence as the mother holds the child on her lap and rocks her.

The therapist's intervention in this instance uses the emotionally charged exchanges between the parents as a port of entry into the child's internal representation of the parents' relationship as a source of fear. In the process, the therapist also ventures the possibility that the child is blaming herself, setting the stage for a mental representation of herself as the source of her parents' marital distress.

*Child Mental Representations of the Self or the Parent:
Child Behavior as a Window into the Self*

A 3-year, 6-month-old boy is trying unsuccessfully to solve a puzzle. He suddenly bites himself. The mother asks him: "Why are you doing that?" The child replies: "Because I am bad." The mother goes on to ask: "Why are you bad?" The child shrugs his shoulders and does not reply. There is a silence. The therapist addresses the following comment both to the child and to the mother: "I think you are worried that we will be angry with you because you can't solve the puzzle." The child does not answer. The mother picks up on the therapist's remark and says to the child: "We are not angry. It's OK not to know something." The child answers, in a very soft voice: "You hit me when I lost a piece."

This poignant exchange revealed the intricate connection between this child's mental representation of himself and his perception of how his mother saw him. In order not to appear as if he were blaming the mother, the therapist couched the interpretation of the child's conviction of being bad in terms of the worry that both the mother and the therapist would be angry at him. The mother responded with remarkable perceptiveness by reassuring the child of her love even when he made mistakes. The child, however, was not so easily reassured. He reminded the mother that she had hit him when he lost a piece of the puzzle. His present difficulty in solving the puzzle reminded him of that scene, and he showed that he had internalized the mother's disapproval by now biting himself as she had hit him then.

*Parental Mental Representations of the Self or the Child:
Projection of a Father's Motives to the Child*

A father says of his 2-year-old daughter: "She is very sexy." The therapist asks: "How do you mean?" The father replies: "She looks at me like she is flirting with me, and she moves around swaying her hips like she's 25 or something." Taken aback but determined to understand better the father's sexualized perception of his child, the therapist asks: "Does that remind you of anything?" The father thinks of a moment and then answers: "Yes. It reminds me of my older sister." The therapist pursues this opening by asking whether the sister was sexy. The father laughs and answers: "You bet! We shared a room together and I pretended to be asleep when she got undressed to go to sleep."

In this exchange, the therapist was able to overcome her embarrassment to pursue the origins of the father's developmentally inappropriate perception of his daughter. The father's candor in responding to the therapist's questions opened up a profitable area of exploration, which eventually led to the father's confession of his worry that he might become aroused by his child.

*Child or Parent Perceptions of the Therapeutic Relationship:
Child Behavior as Trigger for Negative Maternal Attributions*

Toward the end of a home visit, a 3-year-old says to the therapist: "I want to go home with you." The mother snaps at him: "Sure you do. She is only nice with you because she sees you for 1 hour." The therapist is too unsettled by this exchange to respond in the moment. After a while, she composes her thoughts and addresses herself to the mother, saying: "I think he hurt your feelings when he said that he wanted to go home with me." The mother does not look at the therapist or answer her. The therapist continues saying: "Maybe you are also a little mad at me that he wants to go home with me. You are right, visiting for 1 hour each week is not the same as living with someone." The mother answers testily: "You are damn right. He wants to be everywhere but in his own house. He wants to go be with his daddy, he wants to go home with you, but I am the one who is raising him day in and day out. I am like an old shoe to him." The therapist turns to the child and says: "Your mommy wants you to stay with her. She does not want you to come home with me because she will miss you too much." The child busies himself with a toy and does not respond. The therapist says to the mother: "I actually think that he wishes you could always be with him the way you are when I come here—playing and talking about feelings and just paying attention to him." The mother does not answer. The

therapist turns again to the child and says: "You like it when we all play together and your mom can spend time with you."

In this intervention, the therapist managed to recover from the guilt she felt at the idea that this child wanted her more than he wanted his mother. She realized that she was playing into an idealized transference on the child's part which made the mother feel left out and unwanted. This dynamic mirrored the child's longing for his father, with whom he was spending one weekend a month since the parents' divorce. The child constantly asked to go to the father's house, but once he was there he actually missed his mother and wanted to return to her after a few hours. The therapist's intervention was aimed at putting the mother's feelings of rejection and her reactive anger at the child in the broader context of the child's enduring connection with his mother while also fantasizing about the therapist. The translation back and forth between mother and child was aimed at facilitating communication between mother and child about this important issue.

Each of the foregoing examples illustrates a particular way in which the parents and/or the child are conveying a point of view that detracts from pleasurable interpersonal involvement and safe intimacy. The configuration of treatment gives primacy to interventions that will best serve the child's mental health, a goal that involves a constant effort to balance the parent's and the child's individual needs because parents cannot be receptive to their child when they themselves feel in urgent need of help.

The choice of ports of entry is extensive because relationships affect relationships, and these influences are expressed in a multiplicity of ways that open up many possibilities for intervention (Emde, Everhart, & Wise, 2004; Lieberman & Van Horn, 2005; Sameroff & Emde, 1989). The specific port of entry may be determined by factors such as the child-parent psychotherapist's theoretical preferences; the parent's cultural mores, personality structure, and educational level; the child's developmental stage and ability to make use of receptive and expressive language; and the quality of the therapeutic alliance between the parent and the therapist. Some parents are receptive to a focus on their children's thoughts and feelings but become deeply offended when the therapist addresses their parenting practices. Other parents want to talk primarily about themselves and seem uninterested in the child's individual experience. For still other parents, there is deep meaning in exploring how their childhood experiences are influencing their feelings toward the child, a topic that needs to be integrated with the importance of protecting the child from inappropriate exposure to the parent's clinical material. For all these reasons, there are no typical

CPP cases but only a range of clinical presentations that respond well to this relationship-based treatment approach.

When the treatment involves a progressive deepening of the therapeutic relationship, domains that were off limits at the beginning of treatment often become increasingly amenable to exploration, and new ports of entry are opened up as legitimate foci of inquiry. In general, the specific port of entry is less relevant to treatment outcome than the match between the therapist's therapeutic strategies and the parent's and the child's receptiveness to these approaches. The timing of questions, suggestions, and interpretations is a crucial element in fostering this receptiveness. The therapist needs to cultivate a careful balance between addressing the relevant clinical issues and remaining tactfully alert to the parent's and child's ability to tolerate and make use of these interventions.

Conclusion

Trauma in the parent-child relationship lies at the extreme end of the continuum of etiologies in relationship disturbance. When young children have traumatic life experiences, they are at risk across all of the developmental domains. Children's symptoms may manifest themselves in a variety of settings, but it is inevitable that they will be intimately bound up with disturbances in their caregiving relationships, and these disturbances can change the course of the child's development in ways that are difficult to overcome. Caring for children is an immensely complex task that calls upon all of the parent's emotional resources. Even where there is no traumatic experience, parent-child relationships can become dysregulated in ways that place children at developmental risk. These dysregulations can be long-lasting or short-lived and can vary in intensity. Sometimes one can find the root of the problem in a traumatic experience in the parent's own childhood; sometimes the cause is not so clear or dramatic. Whatever the cause, one must understand the etiology of the problem in order to intervene effectively in a distressed parent-child relationship. Being able to describe the presentation of the behavioral problem is necessary but not sufficient. Formulating the problem based on an understanding of the forces that caused it, the ecology that maintains it, and the strengths that one can use to battle against it presents a complex problem in assessment. It is to that issue that we turn in the next chapter.

CHAPTER 4



The Assessment Process

A comprehensive initial assessment facilitates the creation of a treatment plan by identifying etiological factors, risks, and strengths in the child, the parents, and their ecological context (Lieberman & Van Horn, 2004). The assessment should optimally gather information from a variety of sources, including observation of the child in interaction with the parents and other primary caregivers, structured cognitive and sensorimotor assessments, and parental report of the child's developmental history, parenting practices, and perception of the child, environmental circumstances, and cultural niche. Gilliam and Mayes (2004) point out that the word “assessment” originates in the Greek *assidere*, which literally means to “sit beside” and hence to get to know someone. This attitude of open-ended inquiry is an ideal that should be cultivated even in the midst of the pressures for quick answers endemic in the current climate of mental health services.

Assessment Principles

Four overarching principles apply to every assessment. First, the assessment must be geared to the child's developmental stage and encompass the major domains of child functioning (physical, emotional, social, and cognitive) rather than focus exclusively on the presenting problem. Second, the assessment should be conceptualized not only as a time to gather information but also as an opportunity for preliminary interventions that may yield valuable clues about etiology and prognosis. A good assessment can often become the best brief treatment, particularly when the family circumstances do not allow for extended intervention and when the communication process established during the assessment transforms

the parents' understanding of the child's predicament. Third, parents and caregivers are indispensable partners in the assessment, both as sources of objective information and as agents in shaping the child's mental health. The parents are often the primary information providers because young children's cognitive immaturity limits their ability to self-report. In addition, the parents' functioning should be a focus of the assessment because their personality structure; prevailing motivations; social, emotional, and cognitive functioning; perceptions of the child; and quality of caregiving profoundly shape the child's sense of self, capacity for relationships, and readiness to learn. Fourth, conducting an assessment calls for a frame of mind that remains receptive to new information and open to alternative conceptualizations. While a sound initial assessment forms the cornerstone of effective treatment, the clinical formulation and treatment plan emerging from it should be open to revision as the treatment unfolds because more extensive knowledge of the child and his circumstances may lead to new understandings and modifications of the treatment plan.

A Developmental Perspective

A developmental perspective is important because responses to stress and trauma are shaped by the child's stage-appropriate cognitive appraisal of risk and danger and salient anxieties. The role of the normative anxieties of infancy and early childhood—fear of separation, loss of love, body damage, and superego condemnation—should be included in the assessor's efforts to understand how the child is responding to challenging external circumstances. Behaviors that seem incomprehensible without a developmental perspective may become understandable and even self-evident within their developmental context. For example, a 3-year-old boy whose mother had abruptly disappeared a year earlier and whose foster mother was planning to adopt him became uncontrollably aggressive in the mid-afternoon after he started child care about 6 months after his foster care placement. Based on the child's age and history of abandonment, the assessor hypothesized that the child might be trying to gain mastery over a profound fear that his foster mother would not come to pick him up at the end of the day. As part of the assessment, she suggested that the foster mother call him on the telephone before naptime to tell him that she was thinking of him and would pick him up later in the afternoon. The aggressive afternoon outbursts disappeared soon after this intervention. This sequence of events provided valuable information about the etiology of the child's aggression and, together with other information, helped to persuade the foster mother and the child care provider that the child was not organically damaged and that his aggressive behavior was not irreversible.

It is not only children who develop. Development continues across the lifespan and parents are also engaged in a developmental process, albeit more slowly than their children. Stanley Greenspan (1997, 1999) developed a model of intrapsychic functioning that includes presymbolic mental structures and is organized around six basic developmental themes: self-regulation; engagement in interpersonal relations; intentionality; comprehending the intentions and expectations of others; creating and elaborating emotional ideas; and emotional thinking. The presymbolic structures of the self involve issues of regulation and security; the depth, range, and stability of relationships; affective patterns; and the negotiation of the basic emotional themes of safety, approval, acceptance, assertiveness, anger, separation, and loss. Symbols and words, which are acquired later, allow for an expansion of these domains and enable the creation of links between this inner world and the world of interpersonal relations. In symbolic thinking, ideas are used to express a full range of emotions, fantasy is well differentiated from reality, and thinking, as an ideal, is logical, abstract, flexible, and informed by an emotional awareness of the perspective of others but not derailed by the impact of strong emotions.

Parents differ widely along these dimensions, and their capacity to foster their child's development is influenced by their own developmental capacities. The task of the assessor can be greatly facilitated by an understanding of the developmental stage at which the child and the parents operate in the areas of self-regulation, capacity for intimacy, intentionality, ability to understand the intentions and expectations of others, forming emotional ideas, and engaging in flexible symbolic thinking. Focusing not only on the content but also on the affect of the communications expands the assessor's understanding of the child's and parent's developmental stages.

Assessments must encompass as much of the child's and parents' individual and contextual circumstances as relevant and feasible because development unfolds within an interpersonal and ecological context. Even if the assessment referral is prompted by a circumscribed traumatic event, the assessor must cast an information-gathering net that goes far beyond the trauma itself. It is important to understand how the child-parent relationship was functioning prior to discrete stressful or traumatic events because the attachment relationship provides the matrix from which young children develop the basic competencies of self-regulation, trust in relationships, and exploration. A traumatic event may affect the quality of attachment because it represents a violation of young children's developmentally appropriate expectation that their parents will protect them from danger. Even within this basic violation of trust, however, a secure attachment may help the child recover more

readily from the impact of the trauma. Using the dual lens of attachment and traumatic response allows the assessor to appreciate the transactional influences between these two processes and devise an intervention plan that takes into account the intricate connection between the two (Lieberman, 2004b; Lieberman & Amaya-Jackson, 2005).

Assessment as an Opportunity for Intervention

The initial assessment is not purely a time for gathering information toward a case formulation. Starting with the first encounter, clinicians can make important therapeutic alliances and establish themselves as collaborative partners engaged from the very beginning in an effort to improve the situation as promptly as possible. The infant or young child may be referred for treatment in the midst of a family crisis, particularly if the referral follows a traumatic event or loss. In such cases, therapeutic interventions must be implemented without delay even if the therapist does not yet have all the information she might wish. For example, children may be referred for treatment immediately after witnessing incidents of extreme domestic violence. The nonoffending parent may be in such a disorganized or numb emotional state that he cannot participate in a child-centered assessment. A flexible format that combines gathering information with initial intervention by incorporating individual sessions focused on the parent's emotional needs is recommended in these situations because enhanced parental well-being extends also to the child and helps build a therapeutic alliance with the parent on behalf of the child. "Psychological first aid" may be offered in the form of developmentally appropriate interventions that can provide some immediate emotional relief (Pynoos & Nader, 1993). Assessors can also use the information emerging from crisis-oriented interventions to guide their case conceptualization and initial diagnostic formulations. The family's response to these initial interventions provides rich information about areas of strength and vulnerability, presence or absence of support systems, ability to collaborate in the treatment, and improvement versus worsening or absence of change in response to different therapeutic strategies.

Involving the Parents

Perhaps the single most important element in a useful assessment is the assessor's ability to form an early collaborative relationship with the parents in order to elicit accurate, timely, and complete information. Attaining this goal often requires considerable tact and a recognition that parents may be consciously or unconsciously motivated to withhold

or distort information for a variety of reasons. Parents' own painful childhood experiences may make it difficult to focus on their child's distress for fear that acknowledging it may reawaken or exacerbate their own. When the child has become a focus for the projection of the parents' negative emotions, parental report is systematically distorted by their conflicted feelings about the child. Parents may also fear that the information they provide could implicate them in the child's problem, either because of their lapses in caregiving or, in more dangerous situations, because they failed to protect or actually hurt the child. In such cases, parents may withhold important information or give inaccurate accounts due to feelings of guilt, shame, or anger; to avoid legal action; or for fear that the child will be removed from their care. These scenarios highlight the importance of attending to the parents' range of motives as an integral element of the assessment.

The assessor can foster the parents' motivation to collaborate by stating from the outset that a primary goal of the assessment is to protect and strengthen the child-parent relationship as a vehicle for helping the child. For stressed or traumatized parents in particular, the assessor's explicit interest in the parents' personal experiences and experiences of the child promotes cooperation because it gives the parents the message that they are valued as individuals and not only as providers of information about the child. When child maltreatment may be an issue, the assessor should strive for an empathic balance between acknowledging clearly and explicitly the legal duty to report child abuse and neglect while couching this obligation within the larger context of a willingness to work with the parent in improving the conditions leading to the report.

Assessment as an Ongoing Process

Although the formal initial assessment is usually completed in a few sessions, the assessment process continues throughout the intervention. Young children develop at a rapid pace, acquiring new competencies and perhaps also new vulnerabilities that must be encompassed in the treatment. Their development influences the quality of their relationships and vice versa. For example, parents who responded well to treatment with their infant may relapse when their toddler's new ability to walk away makes them feel rejected. Reciprocally, the parent's childrearing practices may constrict the child's developmental progress in a specific domain. A baby who is not spoken to, for example, may develop delays in expressive and receptive language development. Beneficial changes or new hardships in the family's environment are often reflected in changes in the parent-child relationship as well. For example, a parent who loses

her job may become neglecting or punitive toward her children. For these reasons, the clinician needs to maintain a lively curiosity about changing conditions throughout the intervention in order to change course or incorporate new treatment goals as new competencies or challenges emerge. This is particularly applicable when the parent was motivated to withhold or distort information early in the assessment and treatment. As trust grows and a working alliance develops, new information is likely to emerge, and this new information should be incorporated into the case formulation and treatment plan.

Clinical flexibility during the assessment is particularly important when the child has suffered a trauma or a loss. The child's functioning can fluctuate markedly after such an event due to the emotional dysregulation that follows traumatic experiences and because the child and the caregivers respond variably to situational reminders and to the secondary stressors deriving from the event (Pynoos et al., 1999). For example, a child may be moved to a different house, neighborhood, and child care setting following family or community violence or the death of a parent. In extreme cases, the child may be removed from the parent's care and placed in foster care. All these changes compound the impact of the original trauma and must be carefully monitored during the assessment and in the course of treatment.

Assessment Domains and Modalities

A combination of clinical and structured assessment modalities provides the opportunity to learn about the different domains of the child and family functioning.

Presenting Problem

The presenting problem serves to organize the assessment process because it is the ostensible reason for the referral and an important index of how the referral source and the parents perceive the child. While the focus of appropriate attention, the presenting problem should not dominate the course of the assessment at the expense of a sustained exploration of the constitutional, interpersonal, and environmental factors that may contribute to the child's difficulties.

When specific stressors or traumatic events are the primary reason for the referral, the assessor should examine specifically what the child saw, heard, and felt during the event (Pynoos, Steinberg, & Aaronson, 1997; Pynoos et al., 1999). This information should be elicited directly from children who are able to speak about what they experienced or

to enact it in play. However, children's description or reenactment of events is not always factually accurate because it is influenced by their frame of mind and developmental stage, including their wishes, fears, and representational and verbal limitations as well as their conceptions of their parents' omnipotence and omnipresence. As a result, children may misconstrue the meaning and significance of an event. For example, a 4-year-old boy who saw his father attempting to resuscitate his mother after she collapsed reported later that his father had hit his mother over and over again and had hurt her. A 2-year, 6-month-old who had a cut on his finger from grabbing his mother's scissors answered, when asked what happened: "My mommy did it." Children may also place themselves at the center of the action. For example, a 5-year-old whose father was killed in a car accident while he was in the back seat said: "I could not undo my seat belt to go help him and then he died." The omission of key facts is also frequent, as in the case of a 4-year-old whose teenage sister was robbed at gunpoint while they walked down the street together, but who reported only that the sister was talking on her cell phone with her boyfriend and another man took her cell phone away because she was talking too loud. In spite of possible distortions and omissions, children's statements are important as communications about their mental representations of what occurred and their understanding of their role in it (Gaensbauer, 1995).

Young children's limitations as reporters are countered by asking other informants about the child's experiences. In the case of stressful or traumatic events, key questions include what the child and others saw, heard, and felt; whether parents or other attachment figures were close by to help the child; and what happened in the immediate aftermath of the event. Traumatic events can happen with breathtaking swiftness and everyone involved may have different perspectives on what happened, what was most dangerous, and what was most frightening. The assessor should attend to all the narratives and weigh the impact on the child in the context of the different informants' representations of what happened. Each one of the perspectives is important, and all of them help to understand the meaning the child gave to the event and the sensory and affective responses that serve as traumatic reminders for the child.

The assessment of traumatic exposure should also include what the child was told and what the child might have overheard. Adults often underestimate the child's knowledge of what happened or the child's listening to adult conversations, which can give rise to frightening mental images. A savvy assessor will ask, "What has the child been told?" and "What do family members say when they talk with each other about what happened?" in order to evaluate what the child might have overheard. Whenever possible, the assessor should confirm what the

child was reported to see or hear by examining reports to police, child protective services, medical personnel, or the media. Taken together, these will give the assessor the fullest possible basis for understanding the child's exposure.

The Parents as Informants

Unstructured clinical interviews of the parents are perhaps the most frequent sources of information about infants and young children. Some parents are good informants and can speak spontaneously about the different facets of the child's behavior, developmental history, and emotional experience. Other parents have difficulty articulating their knowledge of the child. Sally Provence recommended asking parents to describe the course of a child's day as a productive strategy to help parents anchor their descriptions of the child in specific exchanges and events rather than generalizations (Provence, 1977). While the parents speak, the assessor observes the parents' affect as they recount different parts of the day and compares similarities and discrepancies in how different parents and caregivers perceive and respond to the child.

Structured clinical interviews and self-report instruments can help parents recall and describe important aspects of their child's functioning and also help provide useful adjunct information, particularly if the assessor wants quantifiable methods to measure the effectiveness of the intervention. It is beyond the scope of this book to provide descriptions and psychometric data on these measures, which are reviewed in an excellent volume by DelCarmen-Wiggins and Carter (2004). Some examples of useful instruments include the widely used *Child Behavior Checklist for Ages 1½ to 5* (Achenbach & Rescorla, 2000) and the *Infant-Toddler Social and Emotional Assessment* (Carter & Briggs-Gowan, 2000), both of which allow the clinician to compare the child to other children of comparable age. These instruments have broadband scales for Internalizing and Externalizing behavior problems and narrower content scales that are subsumed within the broadband scales.

Parental input is not limited to providing information about the child. The parents' emotional experience is an integral component of the child's functioning and should be incorporated into the assessment. The parents' life history should be elicited in some detail in order to ascertain the contribution of parental early experiences and current circumstances to the child's mental health difficulties. The child may have become for the parents a reminder of their own painful childhood experiences and a trigger for maladaptive responses. The parents may also suffer from psychiatric problems that interfere with their appropriate care for the child. The parents' emotional functioning may be

assessed through clinical interviews, structured self-report instruments, or a combination of both.

The ecological context of the family yields important cues about the sources of risk and support for the child's healthy development. Poverty, discrimination, unemployment, lack of education, isolation from social supports, and ongoing community violence can be a backdrop of continuing and self-reinforcing adversity. Unless these risk factors are ascertained and their impact thoroughly understood, the assessor may reach faulty conclusions about the etiology of the child's problems and about effective treatment strategies.

The parents' interpretation of the family's circumstances and of the child's situation needs to be understood in the context of their cultural background. Culture pervades the meanings that individuals ascribe to adversity and to stressful and traumatic events and informs beliefs and traditions about the most effective ways to help children through the recovery process (Lewis & Ghosh Ippen, 2004). A family may invoke rituals such as prayer, invocations, exorcisms, and body-based interventions to help a suffering child when these rituals are rooted in cultural beliefs about childrearing values, child development, and the role of children in the family. Assessors who engage in active efforts to ask and learn about the full range of the family's beliefs and practices will be better able to integrate traditional and modern interventions in ways that feel respectful and effective to the family.

Child–Parent Relationship

Infants and young children display their strengths and vulnerabilities as they interact with their caregivers even when they do not have the representational and verbal skills to describe their experience. Depending on the referral question, the clinician may observe the child with each parent separately, with only one parent, or with both parents together. Home observations are especially valuable because they yield information about the quality of the everyday environment, including the nature and severity of environmental stresses and the family's coping strategies. The choice of structured or unstructured observation formats is usually guided by the assessor's theoretical and clinical preferences as well as by research and funding considerations. Regardless of the choice, the assessor should remain attentive to unscripted parent–child exchanges because spontaneous interactions and body language often provide the most penetrating insights into the emotional quality of the relationship.

Semistructured observational procedures allow for systematic comparison of the child–parent interaction before and after treatment and

for standardized group comparisons in treatment outcome research. There is a wide variety of specific formats developed by researchers and clinicians for this purpose. One parent–child interaction procedure that skillfully combines free play, structured tasks, and a separation–reunion episode originated in the work of Judith A. Crowell and her colleagues (Crowell & Feldman, 1989) and was modified by Charles Zeanah and his colleagues (Heller, Aoki, & Schoffner, 1998; Zeanah et al., 1997). The procedure involves a series of episodes, including free play, a clean-up task, blowing bubbles together, four teaching tasks (one of which is chosen to be sufficiently difficult that the child will probably not be able to perform the task), and a brief separation and reunion. The procedure allows the clinician to observe the child's predominant mood and affective range, affect regulation, level of symbolic representation, use of the parent for emotional support and assistance with difficult tasks, coping strategies in response to the age-appropriate stress of brief separation, and ability to reestablish an emotional connection with the parent after reunion. As the child and parent move from one episode to another, the clinician can observe how the child seeks and uses support and how the parent–child relationship functions under a variety of circumstances, including the parent and child level of comfort and affection with one another, ability to cooperate and manage disagreements, and whether the parent is able to set limits and how well the child responds to the parent's guidelines.

Individual Child Functioning: Emotional, Social, and Cognitive Domains

The assessment should encompass the child's developmental history as well as current functioning. The child's emotional, social, and cognitive functioning often reflect the quality of the child's relationships and can be expected to be disturbed if the caregiving relationship is disturbed. Traumatic experiences disrupt the areas of functioning that are most developmentally salient at the time of the trauma (Marans & Adelman, 1997). For example, one of the prominent developmental tasks of the first year of life is the establishment of neurophysiological regulation. Stress and trauma during this stage are frequently manifested in new difficulties eating and sleeping, irritability, inconsolable crying, and difficulty being soothed. Infants who were well regulated before the adverse event become dysregulated by external circumstances that strain their coping resources. For that reason, it is important to ascertain the child's developmental course and the presence of disruptive stressors. Development unfolds in predictable sequences, although there is broad variation in capacity among typically developing children. There are numerous resources describing the course and milestones of early develop-

ment, including Brazelton (1992), Leach (1989), and Greenspan (1999). Learning about development is an ongoing endeavor, and the clinician's professional identity as an assessor and as a therapist is enriched by an ongoing effort at expanding and deepening his or her understanding of this fundamental human process.

The child's quality of relatedness with the clinician, both when they are alone and when the parent is present, provides information about the child's self-regulation, capacity for engagement, and representational capacities. Toys or other props should be carefully selected to facilitate the assessment of the different domains of functioning. When the child was referred as the result of traumatic events, the child's behavior and play should be evaluated for the presence of traumatic triggers and other reenactments of the trauma. Toddlers and preschoolers reenact traumatic events using evocative props, including a family of dolls, medical kit, ambulance and emergency vehicles, animal family groups, puppets, and other toys that allude to the specific stressors in the child's life (Gaensbauer, 1995; Pruett, 1979; Scheeringa & Gaensbauer, 2000).

Structured cognitive assessment is advised when there are questions about the child's achievement of age-appropriate milestones in language, reasoning, and performance. A thorough assessment should include at least a screen for cognitive and developmental problems. One useful instrument for this purpose is the Ages and Stages Questionnaires (ASQ; Squires, Potter, & Bricker, 1999), which includes 19 different questionnaires for children ages 4–60 months. Each questionnaire contains 30 items that assess the child's development across five domains: communication, gross motor, fine motor, problem solving, and personal-social. Cutoff scores are used to determine whether the child is at risk for delay. If children score below the cutoff, they should receive further assessment using a more comprehensive instrument such as the Bayley Scales of Infant Development (Bayley, 1993) or the Mullen Scales of Early Learning (Mullen, 1991).

Collateral sources help to understand the child's functioning in a variety of settings. Parental rights to confidentiality should be addressed by obtaining written permission to contact these collateral sources, couching the request with a clinically informed explanation of what information is requested and how it will be used. Routine requests for pediatric information during the assessment is strongly recommended because medical problems can lead to developmental delays and behavioral anomalies. The child's pediatrician can be an ally in the assessment process by providing input about the child's growth history, physical development and symptoms, health status, and regularity and appropriateness of health care. A medical perspective is particularly important when the child has been exposed to intrauterine and envi-

ronmental conditions that may have a negative impact on the child's health, including gestational problems and postnatal malnutrition. Child care providers and preschool teachers can provide information about the child's relationships with peers and adults, level of functioning in a group setting, and quality of relationships outside the family. Classroom observation of the child is useful to augment this collateral information. Child welfare workers are indispensable informants about child protection and legal issues.

Traumatic Reminders

Trauma reminders are related to the specific features of the traumatic experience, evoke somatic and often presymbolic memories of the trauma, and flood the child with intrusive images, intense feelings, and other sensory experiences that bring the traumatic moment back to life (Pynoos et al., 1999). Children gripped by traumatic reminders behave as if the trauma were happening again in the moment, freezing helplessly or fighting in response to stimuli that are unnoticed by others and engaging in behavior that seems inexplicable to caregivers, teachers, and friends. Whenever the child seems to behave irrationally, the assessor should explore the possibility that the child is linking what is happening in the present with some aspect of an adverse experience or traumatic event. An important reason for collecting an exhaustive factual report of the events in the child's life is to identify potential stressful or traumatic reminders and to help the child cope with the affective and physiological dysregulation they arouse.

Parents are often exposed to the same adverse events as their young children and they may respond by becoming dysregulated much as their children do. Indeed, parents and children may engage in behaviors that serve as traumatic reminders for one another if they were both present at the scene of the event. Identifying stimuli that arouse both the child and the parent is an important part of the assessment.

The Question of Diagnosis

The assessment information enables the assessor to determine whether the child has a diagnosable clinical condition. Even when formal diagnostic criteria for a mental health disorder are met, however, giving a psychiatric diagnosis to a very young child entails conceptual and ethical dilemmas. The rapid pace of development in infancy and early childhood casts doubt on the stability of behaviors that may disappear, become less intense, or be transformed as children reorganize their

emotional, social, and cognitive performance in response to psychobiological maturation and changes in circumstances and relationships (Emde, Bingham, & Harmon, 1993). In addition, young children's limited behavioral repertoire means that the same behavior may have different meanings for different children and in different circumstances. Depending on the context, irritability and aggressive behavior in a toddler may signal a developmentally appropriate struggle for autonomy, depression, generalized anxiety, or a traumatic stress reaction. As it is in adults, comorbidity of disorders is prevalent among children. Last but not least, existing diagnostic manuals suffer from methodological problems that raise questions about the validity and reliability of the categories they present (Greenspan & Wieder, 1998). The ethics of making a diagnosis under these circumstances gives pause to many clinicians as well as parents, who are concerned that a diagnostic label may become a self-fulfilling prophesy by supplying a filter through which the child is perceived by others and which may affect the long-term trajectory of the child's development.

In spite of these challenges, there are clinical as well as practical reasons to assign a diagnosis when appropriate. An accurate diagnostic picture provides the basis for a concrete treatment plan and facilitates communication among different professionals. It also facilitates reimbursement for treatment from insurance companies and federal and state programs.

Three different diagnostic manuals provide classifications of developmental and mental health disorders for young children: the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV and DSM-IV-TR; American Psychiatric Association, 1994, 2000), the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood Revised* (DC:0-3R; Zero to Three: National Center for Infants, Toddlers, and Families, 2005), and the *ICDL Clinical Practice Guidelines* (Interdisciplinary Council on Developmental and Learning Disorders, 2000). The latter nosology focuses on functional developmental and processing challenges in early childhood. While it does not specify traumatic life experiences as etiological, it is helpful in identifying and planning interventions for the sensory motor dysregulation and processing difficulties that can follow trauma.

The descriptions of diagnostic categories in DSM-IV-TR do not include developmentally informed descriptions of how each condition is manifested in infants, toddlers, and preschoolers. In contrast, DC:0-3R was specifically designed for use with infants and young children. The contributions of both manuals have been integrated and expanded in the PAPA (Preschool Age Psychiatric Assessment; Egger, Ascher, & Angold,

1999), a structured interview that collects symptom and impairment information from a parent and is designed to ground the diagnostic process in an empirically derived picture of preschool psychiatric symptoms and disorders. The PAPA is currently used primarily as a research instrument, but it can be used in clinical settings because its modules allow the assessor to choose the sections that are relevant to the specific disorders under consideration.

PTSD is usually the preferred diagnosis if the symptoms emerged after the child witnessed or experienced a traumatic event. The DSM-IV-TR and DC:0–3R descriptions of PTSD differ in another important way. For a person to be diagnosed with PTSD using DSM-IV-TR, that person must have “experienced, witnessed, or been confronted with an event or series of events that involved actual or threatened death or serious injury, or danger to the physical integrity of self or others” (American Psychiatric Association, 2000, p. 427). In DC:0–3R, on the other hand, the PTSD diagnosis can be made following the experience of an event or series of events that involve actual or threatened death or serious injury or danger to the *psychological* or physical integrity of the child or others (*italics added*). The difference is a critical one. Infants and young children consolidate their sense of self around the rhythms and patterns of their parents’ caregiving. A threat to the parent’s psychological well-being constitutes a genuine threat to the young child’s sense of safety and survival (Scheeringa & Zeanah, 1995). The omission in DSM-IV-TR of this psychological reality of early childhood and its failure to include traumatic stress responses that are common in the first 5 years of life mean that traumatized young children may be underdiagnosed with PTSD using this classification system, as has been reported in research comparing the use of the two manuals with preschoolers exposed to trauma (Scheeringa, Zeanah, Drell, & Larrieu, 1995).

Are Current Conceptualizations of PTSD Adequate?

While existing PTSD diagnoses reflect the changes in functioning that follow exposure to a single traumatic event, there is increasing awareness of their limitations when traumatic experiences are repeated, chronic, pervasive, and severe and when they are perpetrated by a person with a caregiving role in relation to the child. Researchers and clinicians have noted that when such a pattern of chronic trauma begins early in life, the child’s developmental trajectory can change across many domains of functioning in ways that transcend the narrowly circumscribed symptoms associated with PTSD. The alternative diagnostic category of disorders of extreme stress not otherwise specified (DESNOS) was first conceptualized for adults who suffered complex and chronic traumas

and is supported by data from over 30 clinical trials (Herman, 1992a; van der Kolk & Courtois, 2005). DESNOS involves alterations in seven domains of functioning: (1) ability to modulate emotions, (2) identity and sense of self, (3) ongoing consciousness and memory, (4) relations with the perpetrator, (5) relations with others, (6) physical and medical status, and (7) systems of meaning (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

This conceptualization has informed the growing understanding of how child development is affected by chronic maltreatment in the child–parent relationship, leading to the development of a new diagnostic category called developmental trauma disorder (van der Kolk, 2005). While isolated traumatic incidents may lead to a discrete symptom pattern as reflected in the PTSD diagnosis, chronic maltreatment has a pervasive adverse effect on the *development* of the mind and brain and on the capacity to process and integrate sensory, emotional, and cognitive information. van der Kolk et al. (2005) propose that the mechanisms leading to developmental disorganization in cases of repeated early trauma are disturbed attachment, parental failure to help the child with affect regulation, and failures in the reliability and predictability of protective experiences. The symptoms of developmental trauma disorder cluster around four criteria.

1. Exposure to multiple or chronic forms of developmentally adverse interpersonal traumas such as abandonment, betrayal, physical assault, sexual assault, threats to bodily integrity, coercive practices, emotional abuse, and witnessing violence or death, which are accompanied by subjective experiences of rage, betrayal, fear, resignation, defeat, or shame.
2. Triggered patterns of repeated dysregulation in response to trauma cues which are experienced in the affective, somatic, behavioral, cognitive, relational, and self-attribution domains.
3. Persistently altered attributions and expectancies, including negative self-attributions, distrust of protective caregivers, loss of the expectation of protection by others, loss of trust in the capacity of social agencies to protect self and others, lack of recourse to social justice, and conviction about the inevitability of future victimization.
4. Functional impairment in the educational, familial, peer, legal, and vocational spheres.

The notion that pervasive early trauma leads to a disorder of development is supported by the growing empirical evidence documenting

the long-term and pervasive impact that adverse childhood experiences have on mental and physical health in adulthood (Felitti et al., 1998) as well as by evidence showing that people who suffered chronic maltreatment in childhood make increased use of medical, correctional, social, and mental health services (Drossman, Leserman, Nachman, Gluck, & Tooney, 1990; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Windom & Maxfield, 1996). Neither DESNOS nor developmental trauma disorder has been included to date in established diagnostic classifications. Both diagnostic categories, however, may be more useful than the PTSD diagnosis to organize the myriad symptoms and problems with which young children can present after experiencing repeated traumas and the secondary adversities associated with them. These newer descriptions cannot be offered at present as formal diagnoses for the purposes of reimbursement, but they can assist in understanding and formulating the child's functioning.

Diagnosing Relationships

There is an inherent contradiction in the fact that while it is widely accepted that children's functioning should be understood in the context of their emotional relationships, diagnostic categories invariably focus only on the individual child. This anomaly is redressed in the DC:0-3R manual through an Axis II that focuses on the quality of the child-parent relationship (Zero to Three: National Center for Infants, Toddlers, and Families, 2005). The premise of Axis II is that "the clinician should consider and conceptualize primary relationships as entities to be assessed and, when indicated, diagnosed" (p. 41), including the overall functional level, level of distress, and adaptive flexibility in both the child and the parent, the level of conflict and resolution between them, and the effect of the quality of the relationship on the child's developmental progress (p. 41). Axis II offers two tools for a relationship classification. The first tool is the 100-point Parent-Infant Relationship Global Assessment Scale (PIR-GAS), which includes a range starting from the highest anchor of good adaptation through progressively less adaptive relationship configurations involving perturbation, disturbance, and disorder to the most severe anchor of the scale that consists of documented maltreatment. The second tool is the Relationship Problems Checklist (RPCL), which classifies the descriptive features of relationship qualities as overinvolved, underinvolved, anxious/tense, angry/hostile, verbally abusive, physically abusive, and sexually abusive. Each one of these qualities is described in terms of three domains: the behavioral quality of the interaction, the affective tone, and the level of

psychological involvement. The criteria for Axis II classification make clear that a relationship disorder is specific to a relationship. The implication is that the child's relationship with each primary caregiver should be evaluated separately in the course of the assessment. It is important to highlight also that the child's triadic relationship with both parents is a significant predictor of functioning and should be included as an integral part of the assessment whenever possible (McHale, 2007).

Identifying Disturbances and Disorders of Attachment

The child–parent relationship has multiple facets. Depending on the characteristics of the particular situation, the parent may play for the child the role of playmate, teacher, disciplinarian, or provider of physical and emotional security. Fluid role boundaries are the rule rather than the exception in the parent–child relationship, and become a frequent source of confusion because parents are often in the position of having to switch abruptly from one role to another. This happens, for example, when an overexcited young toddler bites the parent in the course of a lively game of rough and tumble, and the parent needs to move quickly from a playful exchange to the job of socializing the child by teaching what is allowed and what is forbidden. At the core of the mutually reinforcing parental roles, however, is the overriding responsibility of protecting and ensuring the child's survival in the perilous first years of life. The concept of attachment was developed by Bowlby (1969/82) to describe the specific component of the child–parent relationship involving protection and security regulation. Based on this premise, disturbances and disorders of attachment can be defined as disruptions in the child's readiness and capacity to seek protection and to derive security from access and interaction with the parent figure. Although attachment problems ordinarily stem from pathogenic caregiving conditions, the child engages in a costly psychological adaptation to these situations that becomes internalized as an integral component of the sense of self and affects the capacity for intimate relationships.

Major disruptions in attachment stem from three circumstances: (1) the child cannot become attached because he or she does not have access to a consistent caregiver; (2) the child's attachment is marked by anxiety and fear due to the parent's inconsistency, unpredictability, emotional withdrawal, or punitiveness; and (3) the child has lost the attachment figure due to separation or death, giving rise to grief and mourning. Emotional disturbances in response to each of these situations have been identified, respectively, as *disorders of nonattachment*, *secure-base distortions*, and *disrupted attachment disorder* (Lieberman & Zeanah, 1995; Zeanah & Boris, 2000).

Disorders of Nonattachment

Infants and young children who do not have the opportunity to form a primary emotional relationship with a consistently available caregiver tend to engage in two distinct patterns of behavior: emotional withdrawal or indiscriminate sociability. Emotionally withdrawn children tend not to seek proximity and contact with a caregiver and rarely show affection or pleasure in relationships. This pattern has been extensively documented in institutionalized children (Tizard & Rees, 1975; Smyke, Dumitrescu, & Zeanah, 2002). Indiscriminate sociability, on the other hand, is manifested in the lack of age-appropriate stranger wariness, with children showing little selectivity in seeking comfort, support, and nurturance, and appearing overly comfortable and affectionate with strangers. This pattern has been observed in maltreated children who have been recently placed in foster care (Zeanah et al., 2004), institutionalized young children (Chisholm, Carter, Ames, & Morison, 1995), and children adopted from institutions, who often continue to show shallow and indiscriminate social behavior even after the formation of selective attachments to their adoptive parents (O'Connor, Marvin, Rutter, Olrick, & Brittner, 2002).

The DSM-IV-TR (American Psychiatric Association, 2000) addresses disorders of nonattachment in the category of Reactive Attachment Disorder (RAD), which includes two subtypes: Inhibited type and Disinhibited type. There is considerable consensus about the basic features of this diagnostic category, although there is debate about measurement, differentiation of RAD-related emotional withdrawal from depressive disorder, and the accuracy of considering indiscriminate sociability as an inherent characteristic of nonattachment given its persistence after attachments are formed (Luby, 2006; O'Connor & Zeanah, 2003; Stafford & Zeanah, 2006).

Secure-Base Distortions

This phenomenon is observed in young children who have formed a preferential emotional bond to their primary caregivers but cannot depend on the caregiver's physical and emotional availability. Attachment-related anxiety is frequently shown in the early years through distortions in the balance between attachment behaviors and exploratory behaviors that defines secure-base behavior. The child might explore at the expense of safety, consistently running off and staying away from the caregiver in unfamiliar situations that, for most children, will elicit efforts to seek proximity and maintain contact. Alternatively, the child may favor proximity and contact at the expense of exploration, persistently staying

close, holding on, and clinging to the caregiver in situations that are safe, familiar, and conducive to exploration. A third distortion of secure-base behavior involves role reversal of caregiving between child and parent, with the child showing precocious competence in self-care and excessive attentiveness to the parent's well-being. Each of these patterns represents the child's effort to adapt to the parent's unresponsiveness by maximizing the chances that the parent will notice and respond to the child's signals of need (Lieberman & Zeanah, 1995).

Descriptions of secure-base distortions have gone through several iterations as the formal categories undergo repeated revision. The most recent nomenclature was developed by Zeanah & Boris (2000), who recommend that the pattern be considered an attachment disturbance if it is present sometimes, whereas it becomes an attachment disorder if it is usually or often present. Although presented as distinct categories, the behavioral patterns described below may coexist in the same child in response to different situations. For that reason, it is useful to consider the categories as guidelines for observation rather than as absolute conceptual entities.

Attachment Disorder with Self-Endangerment. The child persistently engages in exploration away from the parent in unfamiliar or dangerous situations, and this behavior is not kept in check by the countervailing tendency to seek proximity and contact in unfamiliar or potentially dangerous situations. Examples include repeatedly darting off in crowded settings or running out into traffic, as if the child is pleading for the parent to show care by taking decisive action to protect. Aggression directed at the self or at the caregiver, especially when the child is frightened or upset, is a frequent associated feature. In toddlers and preschoolers, it is important to differentiate between these behavioral patterns as manifestations of disordered attachment rather than expressions of high activity level, impulsivity, and lack of awareness of potential threat due to cognitive immaturity.

Attachment Disorder with Clinging/Inhibited Exploration. This pattern involves children's prevailing insistence to stay close to the parent rather than explore and play in familiar and safe situations. High levels of anxiety about moving off are often observed in the presence of the parent but recede when the parent is absent, only to reappear again upon the parent's return. Inhibition from exploration is particularly notable when the child is in the presence of the parent and an unfamiliar adult. It is important to determine whether the child is shy and easily cowered by stimulation or whether an attachment problem is at stake in ascertaining whether this pattern is applicable. Temperamen-

tally inhibited children tend to warm up after becoming familiar with the environment, whereas children who are consistently anxious about their parent's availability tend to stay close and monitor the parent's whereabouts even in familiar situations.

Attachment Disorder with Role Reversal. Children showing this pattern are preoccupied with the parent's well-being and show excessive concern and solicitousness, as manifested in monitoring and making precocious efforts to improve the parent's moods. Children may become artificially cheerful in efforts to liven up the affect of a depressed parent, or may ask insistently whether the parent is feeling all right in situations that do not involve cause for alarm. It is important to ascertain whether the child is showing an adaptive capacity for empathy or responding to cultural expectations before considering this pattern as an attachment problem.

The identification of these distortions of secure-base behavior calls for extensive observations in naturalistic settings, and need to be carefully distinguished from age-appropriate or temperamentally based individual propensities. All children are at times reckless, inhibited, or overly concerned about their parent's welfare. Problems arise only when these tendencies are rigid, anxiety-provoking, and interfere with developmentally appropriate activities. It has proven difficult to identify secure-base distortions reliably in time-limited, structured assessment situations, and this is a reason for their not being included in formal diagnostic classification schema. However, the patterns provide useful observational guidelines that can be used as the basis for conceptualizations about the psychodynamics of the child-parent relationship.

Disrupted Attachment Disorder

This category is applicable when the child experiences the sudden loss of the attachment figure as the result of separation or death. Loss of an attachment figure in the first years of life has devastating repercussions due to the young child's physical and emotional reliance on the parent for a basic sense of well-being. This is particularly the case in the absence of other attachment figures that can console the child and serve as partial substitutes for the emotional place occupied by the lost parent. The DC:0-3R includes a category labeled prolonged bereavement/grief reaction, characterized by at least three of the following symptoms: persistent distress and search for the absent parent; refusal to accept others' efforts to provide comfort; emotional withdrawal, sadness, and lethargy; disruptions in eating or sleeping; regressions in developmental milestones; diminished range of affect; and strong reactions to remind-

ers of the loss. Guidelines for the assessment and treatment of grief and bereavement have been developed by Lieberman et al. (2003).

Case Formulation

Case formulation involves synthesizing the findings from different modalities and instruments into a conceptualization that integrates them into a cohesive picture of the child's functioning in the context of her relationship with parents and significant others and environmental circumstances. It seeks to organize information about the child in a biopsychosocial framework that integrates predisposing vulnerabilities, precipitating stressors, maintaining circumstances, and protective strengths in the biological, psychological, interpersonal, and sociocultural domains. The meaning of behaviors and symptoms in terms of the child's efforts to make sense of the world is an organizing thread in the case formulation and treatment plan.

Although an accurate diagnosis can serve as an organizing construct, assigning a diagnosis is, at best, only the first step in case formulation and is only marginally helpful in many cases. The diagnostic category that at first glance seems most obvious to the assessor may not be the one that best fits the child's symptoms. For example, although the assessor might expect that a child referred following a traumatic life event is most likely to have PTSD, this is not necessarily the most frequent diagnosis given to children with histories of abuse and neglect. One study of 364 abused children found that the most common diagnoses were, in order of frequency, separation anxiety disorder, opposition defiant disorder, phobic disorder, PTSD, and attention-deficit/hyperactivity disorder (Ackerman, Newton, McPherson, Jones, & Dykman, 1998). Exclusive focus on diagnosis also overlooks repeated findings that subclinical syndromes are associated with considerable distress and functional impairment. Moreover, multiple diagnoses are often needed to describe the child's difficulties even for young children because of the definitional narrowness of current nosologies (Brown, 2005; Kendell & Jablensky, 2003).

The role of case formulation in designing the treatment plan reiterates the point made at the beginning of this chapter. To understand the child and make good recommendations for intervention, the assessor must understand the range of strengths and vulnerabilities both in the child and in the child's environment. Although diagnosis can be important and useful, assessors should cast a broader net when they formulate a case, using all the information at their disposal, fitting it into diag-

nostic categories when appropriate, but also acknowledging that some of the problems that need most immediate clinical attention may not fit neatly within an existing nosology. The case formulation is always a work in progress, open to revision in light of new developments.

A key component of case formulation is deciding whether the child's mental health needs will be best served by individual psychotherapy or by child–parent treatment. We take the position that with children under age 6, child–parent interventions are likely to do the most lasting good because young children's ego development is inextricably linked to their relationships with their parents and the quality of care they receive. It is critical that the parent, not only the therapist, understands the child's fears and anxieties and how to best respond to them. When, however, parents have disabling mental health problems or are developmentally impaired and unable to fulfill their role as parents, it may be in children's best interest to have individual treatment at least for a time. Child–parent psychotherapy under these circumstances could undermine the child's reality testing to the serious detriment of the child's mental health. In later chapters, we consider cases in which separate sessions for parents and/or children were conducted to avoid such results.

Sharing the Formulation: Giving Feedback

As with the assessment itself, giving feedback is a collaborative effort between the assessor and the parents. A feedback session is most effective when the assessor begins by asking the parents whether they learned anything new about themselves or their child in the process of the assessment. This question makes clear that the parents' impressions are as relevant and useful as the assessor's point of view. It also sets the stage for the expectation that the goals of treatment will be based on the joint understanding of the parents and the assessor.

When the assessor describes his views of the assessment findings, it is usually better to start with the good news. Parents are as a rule anxious and worried about their child and about their competence as parents. Describing the strengths of the child, the parent, and the family relationships helps to alleviate anxiety and enhances the parent's capacity to listen to the rest of the feedback. Reflecting on her work with blind babies and their parents, Selma Fraiberg commented that parents often responded with astonishment to the assessor's positive descriptions of the baby as cute or strong. They were so absorbed in their grief about the baby's blindness that they could not think of the baby as a whole individual with many attributes other than blindness. Praising the baby

was often the first step in building a more hopeful and proactive attitude for the parents (Fraiberg, 1977).

It is equally important to be candid about the difficult aspects of the assessment results. The assessor cannot downplay or shy away from conveying findings that will be unwelcome and painful for the parents, although the emotional impact of the information must be taken into account in deciding how to state it. This can be done by weaving the information into the parents' description of what they learned about their child and themselves during the assessment and by balancing out the worrisome findings with references to the positive aspects that were reported earlier.

The assessment findings should also be presented in the context of a treatment plan and other recommendations geared at giving the parents hope that improvement is possible, including referrals for specific services or additional evaluations, such as vision, hearing, or speech and language evaluation. Many times these recommendations do not take parents by surprise because they have been harboring unspoken worries about their children and may be relieved that a professional confirms the appropriateness of these concerns. For example, one assessor was afraid to tell a mother that her 5-year-old son had significant language delays and cognitive impairments that would require special education services. When asked whether she had learned anything new about herself or her son during the assessment, she answered softly, "No. Everything is just about what I thought it would be." The assessor interpreted this response as meaning that in the mother's view all was well with the child because the mother had given no indication of any worries about her child and had actually seemed irritated by the pediatrician's referral for an assessment. The assessor feared that the mother would become defensive when told about her son's cognitive delays, but when she heard the findings, the mother responded: "I'm glad you see what I've been seeing at home. I was afraid to say anything until now." The assessor's thoughtful but candid description of the child's difficulties allowed the mother to reveal her own concerns. If the mother had responded defensively, as the assessor had feared, the focus of the feedback would have shifted to an exploration of her fears, including emotional support and concrete information about promising intervention strategies to help the child.

Whenever possible, feedback about the formal assessment results should be blended with the parents' stated concerns. Using diagnostic labels is as a rule less helpful to parents than discussing concrete problems in child or parent functioning and stresses in the parent-child relationship. Separate problems may be clustered together when such a grouping helps the parent understand the child's problems better.

Example

Four-year-old Sara had witnessed many fights between her parents. Her mother, Ms. Birch, reported that Sara played with her dolls aggressively, constantly making them hit one another. Ms. Birch said, “I get so upset when she does that. I’m afraid she’ll turn out just as mean as her father.” The assessment revealed that both Sara and her mother met diagnostic criteria for PTSD. During the feedback session, the assessor asked Ms. Birch to tell her more about how she felt when she watched Sara play aggressively with her dolls. Ms. Birch responded that she felt worried that Sara would grow up to be mean to other people. The assessor said, “It sounds like that is what you are thinking about when you watch her play. I’m wondering how it feels in your body at those times? Do you notice anything about how you respond?” Ms. Birch replied that her heart raced and sometimes she found herself sweaty and clenching her fists. The assessor asked, “What do you do when you feel that way?” Ms. Birch said that she didn’t do anything, she just stood there feeling helpless and afraid. The assessor said, “You and Sara have both been through a lot of violence and fighting that left both of you afraid. The two of you have some problems that it’s not too unusual to have after experiences like that. When Sara plays with her dolls, she’s telling us that she thinks about the fighting all the time. She can’t get it out of her mind. The way you describe her play, it sounds like it never changes. So I’m thinking that maybe just playing that way makes her even more anxious. She’s kind of caught in a trap. She has these scary thoughts that she can’t get rid of, but when she plays about them, she gets even more worried so she can’t stop. You have a different problem. It sounds like you would like to put the thoughts out of your mind, but Sara’s playing forces you to remember all the fighting, and then you get some of the same feelings that you had back then. Does that sound right?” Ms. Birch agreed that watching Sara play did make her feel frightened and helpless, just as she did during the fights with her husband. The assessor went on to explain that Sara and her mother were caught in a trap together. Sara needed her mother to help make sense of her experience and feel calm again because she was too little to do that by herself, but Sara’s play made Ms. Birch so anxious that she was frozen and couldn’t help. This case formulation gave an explanation of Sara’s aggressive doll play that differed from Ms. Birch’s attribution of “meanness” to the child. By anchoring the explanation for Sara’s play in Ms. Birch’s recognition of the feelings it evoked in her, the assessor could alleviate the mother’s fears that Sarah would grow up to be violent like her father. Together, Ms. Birch and the assessor agreed that one goal of treatment would be to help Ms. Birch process the feelings she experienced during

Sara's aggressive doll play. Once she felt calmer, she would speak with Sara about the frightening memories of the fights and reassure her that the fights had stopped and Sara and her mother were now safe. While providing this feedback, the assessor frequently checked with Mrs. Birch to learn how she was responding to it.

Another feedback strategy is to ask the parents what they have done in the past that was successful in addressing the problem. This approach actively enlists the parents' strengths and allows the assessor to learn about the problem-solving strategies valued by the parent. The assessment usually reveals that there is more than one problem that needs to be addressed. In such cases parents are asked to collaborate with the assessor in selecting the problems they want to address first in the course of treatment.

Giving Feedback to Other Professionals

Intrinsic to the CPP model is the belief that the family's circumstances are intrinsic to the progress of treatment and that the clinician's role includes engagement with the network of service providers involved with the child and the family. Other service providers often request information about the child and the family to guide their work. How to respond to these requests is at the discretion of the parents unless mandated reporting is involved. The assessor should discuss the potential risks and benefits of revealing information with the parent. For example, giving feedback to legal professionals when the family is involved in litigation carries a high degree of risk because information can be taken out of context and used in a damaging manner during contentious court proceedings. On the other hand, if a referral is made to an occupational therapist for sensory integration treatment, this therapist's work will be enhanced by knowing the child's trauma history in order to evaluate its role as an etiological factor in the child's sensory integration difficulties. Sometimes clinicians can offer valuable guidance to other professionals to help them support the child's functioning in school or day care when these settings are stressful or overstimulating.

Example

Becca learned that her father had been murdered 5 days before her fourth birthday and 3 weeks before Thanksgiving. Her mother brought her for treatment the following October because Becca was having a difficult time making the transition to kindergarten. Her mother said

that in the year following her father's death Becca was sad and tearful, asked frequently where her father was, and did not seem to understand that he could not come home. She had never, however, been angry or aggressive until she started kindergarten. Now, Becca's mother complained, she received frequent calls from the school because of Becca's angry fighting.

The assessor observed Becca in the classroom and talked to the teacher about Becca's behavior. The teacher reported that Becca taunted and bullied her classmates and said that her behavior was getting worse as the school year progressed. Although she was clearly making an effort to maintain a professional demeanor, it was clear that she found Becca to be a drain on her energies and that she had not found a way to connect positively with the child.

The clinician discussed this information with Becca's mother. They reflected together on the fact that the anniversary of her father's murder was rapidly approaching and discussed how common it was for both children and adults to experience heightened distress around anniversaries. Becca's mother disclosed that she was having a hard time herself and this was making it difficult for her to deal with Becca's sadness and to keep from losing her temper when the school called. She was afraid that she would lose her job because she had to go to school so often.

The clinician asked if the teacher knew about the murder. Becca's mother reported that she had not told the teacher about it because she did not want Becca to be labeled "troubled" so early in her school career. The clinician suggested that the teacher might be more understanding of Becca's behavior if she knew about the reasons for it. Becca's mother agreed, adding that in light of the fact that Becca was in trouble anyway, it might be best to explain the situation. She signed a release so that the clinician could give this feedback to the teacher.

The teacher was grateful for the information and said that it helped her understand some of Becca's aggressive responses to her classmates. She told the clinician that fathers were actively involved in her classroom. They came, as did mothers, to pick up their children and to talk to the class about their work. The teacher speculated that in addition to the approaching anniversary of the father's death and the holidays, the constant presence of so many fathers might serve as a traumatic trigger for Becca. She decided to give Becca additional attention and support when there were fathers in the room. This information was also useful to the clinician and to Becca's mother, who used it to help Becca express her feelings about her school experiences.

Once she understood the situation, Becca's teacher became a valuable participant in the child's recovery. She found ways to help Becca

engage in activities that stimulated and soothed her, offering her relief from her anxiety in the presence of her classmates' fathers and promoting a more successful school experience. The clinician's involvement in the reality of Becca's school difficulties served multiple purposes. It gave Becca's mother tangible evidence of the clinician's ability to bring about tangible improvement; it gave the clinician and Becca's mother valuable insight into the factors contributing to Becca's distress in the classroom; it enabled the mother to feel more empathy for Becca's plight and to rally in support of the child; and it provided information that the teacher could use to help Becca feel less anxious and distressed in school. The collaboration between the clinician and the teacher proved to be a turning point in the child's improvement, and it illustrates the therapeutic value of expanding the therapist's professional self-perception to include activities that promote the child's welfare outside the treatment sessions.

Putting It All Together: A Clinical Example

The case of Gabriel and his mother provides an overview of the assessment process. Gabriel, 3 years, 6 months old, was referred by his child protection worker following a hotline report from a neighbor saying that he was often dirty and uncared for and that he was sometimes found on the street with nobody watching after him. Gabriel's 19-year-old mother, Ms. Tanner, agreed to voluntary services with Child Protective Services (CPS) and said that she would participate in the assessment.

Ms. Tanner was initially difficult to engage and broke two appointments before finally confirming a third one. At Ms. Tanner's request, the assessor went to the family's home for the first meeting. The assessor observed that the apartment was dirty and cluttered, although large enough to comfortably accommodate mother and child. Ms. Tanner was reserved and quiet as the assessor explained the assessment process and stressed that participation was voluntary. She agreed to proceed and also agreed to consider treatment if recommended at the completion of the assessment. She commented: "The child welfare worker told me I should get some help for Gabriel, but I guess I don't really have to if I don't want to. It's voluntary, so they can't make me do anything." At first, she gave one-word answers to the assessor's questions but became progressively more forthcoming. By the end of the 5-week assessment, some of which was conducted in the home, Ms. Tanner was answering questions and volunteering information quite freely.

Family Background

Gabriel lived with his mother in a public housing apartment. Ms. Tanner was born in the United States to European American parents. She had been involved with Gabriel's father since she was 14 years old but had never lived with him. By her report, Gabriel's father had spent "more time in juvenile hall than outside" since before Gabriel's birth. He used and sold crack cocaine, and all of his arrests were drug related. Ms. Tanner denied using cocaine or other illegal substance but said that she drank beer "occasionally." When asked how much she drank, she answered, "You know, I party with my friends sometimes. I leave Gabriel with my auntie. I might do that every couple of months. Sometimes I get drunk, but not every time." She denied drinking while she was pregnant with Gabriel.

Ms. Tanner's own childhood had been bleak. Her father left before she was born and she had no siblings. She and her mother lived in a public housing development that was known for gang violence. Ms. Tanner said proudly that her mom had supported her without welfare; what that meant, though, was that Ms. Tanner stayed by herself while her mother worked long hours. Her mother's instructions to her were plain: While the mother was at work, Ms. Tanner was to go straight home from school, was not to let anyone in the apartment, and was to keep the door locked and the lights turned off so that no one would be able to see her. To comply with these instructions, Ms. Tanner sat alone and in the dark every night until her mother got home from work at 7 P.M. Then there was just enough time for supper and homework before she went to bed.

Ms. Tanner was 16 years old when Gabriel was born, and she continued to live with her mother and to attend school. Gabriel stayed with Ms. Tanner's aunt in another neighborhood during the week and was brought to stay with his mother and grandmother during the weekends. Ms. Tanner started living on her own when she was 17 because her mother moved to a different state. When Gabriel was almost 2 years old Ms. Tanner brought him to live with her full time. By then Ms. Tanner had dropped out of high school, although later she passed two of the four tests she needed to obtain a GED (general equivalency diploma). After her mother left, Ms. Tanner felt more isolated. She was an only child, had never met her father, and her only relative in the area was her aunt, with whom she often fought. She had few social supports, did not attend a religious institution, and did not have stable friendships or other relationships other than the on-again, off-again relationship with Gabriel's father.

Child Functioning

Ms. Tanner, the child welfare worker, and Gabriel's preschool teacher all agreed that Gabriel's behavior was out of control. Ms. Tanner reported behavior problems far above the norm for children Gabriel's age on standardized instruments. In unstructured interviews, she described Gabriel as a "sweet child with a big heart" but also defiant and unwilling to listen to her. The teacher said that he could not sit still, refused to participate in any organized activities such as circle time, and could not walk across the schoolyard without starting at least one fight. On the positive side, the teacher reported that Gabriel was very smart, had rich expressive language, and could be affectionate with adults.

Ms. Tanner was unable to provide reliable information about Gabriel's emotional and behavioral patterns as an infant because she cared for him only on weekends, but she reported that he did not mind leaving the aunt to stay with her. She also said that when Gabriel was in her care on weekends he didn't cry much, ate well, and slept through the night reliably sometime before his first birthday, although she could not remember when that happened. She said that he was walking before his first birthday. She described him as a "happy little kid" and added, "I always looked forward to the weekends because I liked having him with me." Ms. Tanner also said that when she brought Gabriel to stay with her shortly before his second birthday he did not protest and did not seem to miss the aunt, something that she did not find concerning because she presented it as evidence that Gabriel "knew I was his mom."

Ms. Tanner was a good reporter of Gabriel's exposure to traumatic events. She said that she and her family lived in a dangerous neighborhood, and that at least once a week there was a shooting that made Gabriel jumpy and nervous. Generally these shootings happened at night and often woke Gabriel from his sleep. There were, however, some shootings during the day as well. When he was almost 2 years old, Gabriel saw a dead man lying in the street in front of the neighborhood store. Gabriel had twice seen his father hit and choke his mother. The first and most serious of these incidents happened about a year before the referral, when Gabriel was about 2 years, 6 months old. He had been in the park with his parents, and Gabriel's father became angry because Ms. Tanner did not bring enough food to the outing. He called her a "lazy slut" and slapped her face. She said, "I reached out to hit him back, but he grabbed my neck and pinned me to a tree. I thought I was gonna die. When he let go, I just fell to the ground." Gabriel watched all of this crying and screaming, but without words. After Ms. Tanner fell to the ground, Gabriel's father stalked away. No one called

the police. The second incident happened at home, about 3 months before the referral. Ms. Tanner said, "It wasn't so bad. He just pushed me, but Gabriel cried and cried. I told him to quiet down, that nothing happened. But he just kept crying." She denied that Gabriel's father had ever hurt Gabriel, and said that most of Gabriel's problems had emerged after the fight in the park. "Before that he was a real sweet child. Now he's just wild all the time."

Ms. Tanner had endorsed a worrisome number of externalizing behavior problems for Gabriel, but she did not report symptoms consistent with a PTSD diagnosis in spite of the fact that she saw his behavior problems as having begun after his exposure to a traumatic event. She endorsed one reexperiencing symptom: intrusive thoughts, manifested in Gabriel's habit of walking up to strangers on the bus and saying things like "My daddy's mean" or "My daddy hit my momma." She also endorsed hyperarousal symptoms, including a strong startle response, irritability, and difficulty concentrating. She did not, however, endorse any symptoms of avoidance or numbing.

Gabriel came to the clinic for two assessment sessions. The first session consisted of a cognitive assessment, followed by a brief period of free play with the assessor and then a period of free play with his mother. In the second session, he participated in a storytelling task in which the assessor began a series of eight story stems about ordinary family conflicts in which the assessor lays out the initial conflict and then turns the story over to the child saying, "Show me and tell me, what happens next?" (Bretherton, Ridgeway, & Cassidy, 1990; Emde, Wolf, & Oppenheim, 2003).

Gabriel could not tolerate the demands of the cognitive assessment. He refused to answer questions and threw the testing material across the room. He was unable to complete enough subtests for his scores to be prorated. On the other hand, Gabriel was a joy to be with when the assessor gave up control of the situation and followed Gabriel's lead in free play. He blossomed in the company of a responsive adult who was focused exclusively on him and gave him a sense of control. He played in an organized way with trucks and action figures, even telling a rudimentary story, albeit one with exclusively aggressive themes.

In the second assessment session, Gabriel was able to choose a doll family to use in the story stem procedure. Strikingly, he chose an adult-size doll to represent himself and child-size dolls to represent his parents, suggesting his Herculean efforts to see himself as self-sufficient and his perception of his parents as unable to help. He was so overwhelmed by intense emotions in response to the story stems that he was unable to tell any stories. He threw a chair across the room and followed it with a piece of fruit pie that he had brought to the session in his pocket. The

assessor had no choice but to end the session because she found no way of containing his aggression.

Maternal Functioning

Although Ms. Tanner had big dreams for herself, when she and Gabriel first came to the clinic she was mired in depression and had no realistic plans to make her dreams come true. At 19, she was pregnant with her second child. She doubted her ability to care for two young children and, encouraged by the child welfare worker, planned to turn her new baby over to her mother “for a year or so, till I get through with college.” When the assessor asked whether “a year or so” was really enough time to finish college given that she did not have her GED, Ms. Tanner replied that once the baby was born she would have more energy and would be able to take “lots of classes” while Gabriel was at preschool. Nor was she any better able to reflect empathically on her unborn baby’s likely experience of her plans. When the assessor asked her what she thought it would be like for the baby to leave Ms. Tanner’s mother after being in her care for over a year, Ms. Tanner answered, “It won’t bother him. He’s going to know I’m his momma.”

Ms. Tanner endorsed symptoms of severe depression on the structured instruments. She also met PTSD diagnostic criteria. She had intrusive images of being assaulted by Gabriel’s father as well as nightmares. She avoided reminders of the assault and had never returned to the park where it had happened. She said that she did not let herself think very much about anything of what had happened to her. She reported having happy feelings only occasionally and fleetingly, and she said that she did not think that she would live long enough to raise Gabriel and the baby. She reported trouble sleeping, could not concentrate, and was irritable most of the time. Some of these symptoms had been with her as long as she could remember (unhappiness and irritability, trouble concentrating, and her sleeping difficulties), and some had gotten worse after Gabriel’s father assaulted her in the park.

Child–Mother Relationship

Although Gabriel had shown well-developed capacities for joyful reciprocal play in interaction with the assessor, the situation changed when Ms. Tanner joined Gabriel for their free-play session. Gabriel had enjoyed playing with the assessor, but his experiences with his mother made him anticipate that she would not want to play with him. As the assessor prepared to leave the room, he pleaded for her to stay and continue playing with him. In response, the assessor encouraged

him to show his mother the toys they had been playing with and to tell her what they had been doing. Gabriel cried quietly as the assessor walked out and closed the door behind her. His tears clearly hurt Ms. Tanner's feelings, and she responded with anger to her son's distress. No sooner had the door closed behind the assessor than Ms. Tanner's voice boomed out, "Get it together!" Gabriel's crying increased and took on a feverish, sobbing quality. Ms. Tanner shifted in her chair so that she was facing away from Gabriel as she said, "You better stop. You just better. I'll tell you one thing. There will be no zoo for you today. We're going straight home. And I can't wait till we get there. I just can't wait." She then fell silent and sat, her back to Gabriel and her arms folded across her chest, for nearly 2 minutes as he stood by her chair and sobbed.

Gabriel then broke the impasse. He sniffed, stopped crying, and began to talk in a babyish voice (quite a different voice than he had used with the assessor). He asked Ms. Tanner to pick up a toy for him. She said sarcastically, "Oh, now you want to play with me!" Gabriel asked again for the toy, still speaking in a babyish tone and in poorly articulated words. Ms. Tanner reached across the floor with her foot and pulled the box of toys nearer, even as she continued to tell Gabriel to get the toys himself.

Slowly, over the next 10 minutes, Ms. Tanner and Gabriel approached each other and sorted together through the box of toy dishes that was left on the floor. Ms. Tanner noticed that Gabriel's nose was runny and sent him to the table for a box of tissues. When he came back, she blew his nose, tenderly supporting his chin in her hand. He pulled an apple out of his pocket and offered her a bite. She asked him to show her the other toys and together they walked across the room and explored the toys in a cabinet.

After several minutes, they returned to the dishes. Ms. Tanner said, "What are you going to cook for dinner?" Gabriel said he would cook chicken and pretended to cook at a toy stove while Ms. Tanner set the table with plastic dishes. They ate their pretend meal and then, working together, cleared the dishes and carried them to a toy sink where they pretended to wash them. Ms. Tanner dropped a dish on the floor and when they both leaned over to pick it up they smacked their heads together with a loud crack. Then they straightened up, looked each other in the eye, and laughed together with genuine joy and pleasure. The assessor hoped that the reasonably successful ending to this free-play session offered a cautiously optimistic prognosis for improvement in Gabriel's and Ms. Tanner's individual functioning and for a more harmonious and developmentally appropriate child-mother relationship as the result of treatment.

Case Formulation

The assessor considered a number of factors in formulating the case. First, both Gabriel and his mother were surrounded by danger. Most obviously, the danger came from Gabriel's father's assaults and from the violence in their neighborhood. Gabriel and his mother had both been terrorized by violence at home and in the community. Ms. Tanner and Gabriel also endured a number of other stressors. They were poor, and Ms. Tanner was uneducated and unemployed. Her mother lived in a distant state and her children's father was absent much of the time and an agent of her distress when he was home. Because Ms. Tanner was herself overaroused by the violence, she was handicapped in her capacity to help Gabriel meet one of the major developmental challenges of the preschool years: affect regulation. Gabriel was unable to soothe himself, a self-regulatory skill that is generally in place in a rudimentary form by age 3 but that Gabriel totally lacked, probably because he had no help in learning it from his mother. His arousal was further exacerbated by fear. Gabriel's development of affect regulation was derailed at a very early developmental level (Greenspan, 1997, 1999). When experiencing intense negative feelings, he lost his otherwise robust capacity to use language and play. He could not modulate and regulate intense feelings by expressing them symbolically and forming links between his emotions, his thoughts, and his interpersonal experiences.

The strong feelings he experienced and was unable to modulate became another source of danger for Gabriel. He became aggressive to protect himself from feeling vulnerable in the face of his fear. His behavior compounded his developmental risk because it made it difficult for his mother, his teacher, or his peers to relate to him without anger. Although Ms. Tanner asserted that she had never hit Gabriel, her wounded anger and her threats at the beginning of the free-play assessment session made it clear that at the very least she sometimes came perilously close.

Gabriel was having a great deal of trouble navigating the developmental tasks of early childhood, and Ms. Tanner was unable to reflect on his needs and to provide him with empathic support and guidance. In addition to his difficulties with affect regulation, he had an extremely anxious and disorganized relationship with his mother. When there were rifts in the child-mother relationship, it was up to Gabriel to repair them. It was symbolic of this aspect of their relationship that Gabriel had reversed the roles in the storytelling task and selected an adult doll to represent himself and child dolls to represent his parents. Because his father was a frequent source of danger and his mother was unable to protect herself or Gabriel from that danger, he felt uncertain that anyone

would protect him and was too insecure and unsure to explore the world in a confident way, placing his cognitive development at risk.

There was also an intergenerational dimension to the struggles that Ms. Tanner had with Gabriel. Although her mother had provided her with adequate food and shelter, Ms. Tanner's memories of her mother lacked feelings of intimacy, tenderness, and understanding. Ms. Tanner's nursery, and now Gabriel's, were filled with "ghosts" and bereft of "angels." Ms. Tanner's childhood was characterized by an abject loneliness that had left her simultaneously defensively dismissive of intimacy in relationships and needy in her relationship with the children's father, a relationship to which she clung in spite of his violence and drug abuse. Because she had not been comforted, she had little capacity to comfort Gabriel or even to notice when he was distressed. She was unable to reflect on what it might mean for a child to lose his main attachment figure, placing her faith instead in the belief that the child would long for and turn to an abstract and almost archetypal mother, whether that mother had been intimately involved in his care or not. Deprived of her own mother's care, she seemed unable to care for her child.

Diagnostically, Ms. Tanner met criteria for both PTSD and major depression. She also met many of the descriptive criteria of a complex or developmental trauma response. She had minimal capacity to regulate affect, very unstable relationships, and impaired judgment. She was distrustful of others, felt victimized in most of her relationships (including her relationship with Gabriel), and had no faith that there was anyone who could really help her. Ms. Tanner's emotional development was disconcertingly close to Gabriel's. Although she had some capacity to use symbolization to regulate affect and to elaborate ideas about her own and other's feelings, this capacity was vulnerable to regression in times of stress. Gabriel's outbursts, her own intense feelings, and the stresses of her everyday life consistently unraveled her ability to create links between her internal affective states and her interpersonal relationships.

The assessor was also mildly concerned about Ms. Tanner's drinking. The mother might use alcohol as a means to avoid her intense feelings, but it was also possible that at age 19, Ms. Tanner was engaging in reasonably typical adolescent behavior and was doing no more than partying with her friends. In the case formulation, the assessor included among possible strengths the possibility that Ms. Tanner was telling the truth when she asserted that she left Gabriel with her aunt when she partied and was able to be somewhat responsible as a parent in spite of her youth. There was another evidence of strength: Ms. Tanner had been fully engaged during the assessment process and seemed open to intervention. She was strongly motivated to be a good mother to

Gabriel, and proud of the things that she did well with him. She clearly yearned for relationships, and had become less guarded as the assessment progressed. It seemed possible that she would be able to accept the clinician's empathy and understanding and internalize them, thus making her better able to understand Gabriel.

Translating the Case Formulation into Goals

As the assessor reviewed the totality of assessment data, she formulated several treatment goals. Although she planned to work collaboratively with Ms. Tanner to formulate more goals, her own conceptualization of treatment goals would guide that conversation.

The first goal was *safety, both physical and emotional*. Ms. Tanner's continuing relationship with Gabriel's father put both of them at risk. While the assessor could not advocate for an end to the relationship, she could advocate for safety. Treatment would include helping Ms. Tanner to reflect on what she wanted from the relationship both for herself and for Gabriel and to consider whether the relationship was providing those things. She also planned to work with Ms. Tanner on a concrete plan for protection in the event that Gabriel's father became violent again.

Emotional safety is a complex goal. Children feel safe when they can rely on their parents to protect them, and the assessor hoped that Gabriel would come to feel safer as he witnessed his mother working out a safety plan for their protection from the father's violence. Emotional safety also involves protection from the internal danger of unmodulated feelings. Both Gabriel and Ms. Tanner suffered from intrusive thoughts that distressed and dysregulated them. Learning to calm themselves when they felt distressed, angry, and overwhelmed would be a pivotal goal for both mother and child.

Another goal was *increased reciprocity* in Gabriel's relationship with his mother. Just as Gabriel needed to depend on his mother for protection, he needed to rely on her to be an adult so that he could be a child. He needed her to take the lead, at least some of the time, in repairing breaks and misattunements in their relationship. Ms. Tanner, who had been a mother since she was only 16 and was raising her young son with little help and support, needed guidance in managing the daily care of herself and her child and setting realistic goals. She also needed guidance in understanding what children as young as Gabriel and the new baby could realistically be expected to do.

The assessor also believed that both Gabriel and Ms. Tanner would benefit from having time together that was devoted to mutual pleasure. Such moments would strengthen their relationship and *increase their ability to be engaged in developmentally appropriate activities and to plan for the future* rather than being mired in the distress of the past.

Finally, the assessor set the goal of helping Ms. Tanner and Gabriel to *co-construct a narrative* that could help Gabriel understand and cope with the traumatic experiences he had endured. This would be a distal goal rather than an immediate one because both Gabriel and his mother were presently too easily overaroused to manage the complicated and painful feelings that would be triggered in the development of the narrative.

Feedback and Collaborative Goal Setting

In the feedback session, the assessor asked Ms. Tanner what she had learned about Gabriel and herself during the assessment. She looked at her lap and said, "I guess I've had a pretty hard life." The assessor asked her what she was thinking of. Ms. Tanner said, "I was alone a lot as a kid. I hadn't thought about that much until I told you about it. I guess I was lonely. And then the kids' dad leaves me alone all the time." She smiled ruefully and continued, "When he isn't hitting me." The assessor continued with this theme, saying that she agreed that Ms. Tanner had been too lonely. She said that she remembered that Ms. Tanner had told her that she had had sad feelings and trouble sleeping and concentrating for as long as she could remember. She added that Ms. Tanner might have felt sad and depressed for a very long time, and that those feelings might make it hard for her to be with her kids and hard for her to meet her goals, like getting her GED and going on to college.

Ms. Tanner had asked if she could see the videotape of Gabriel's storytelling task, and the assessor used the feedback session to view the tape with her. The assessor was concerned about this, unsure of how Ms. Tanner might feel about Gabriel's selection of dolls. When Ms. Tanner saw him choose the adult doll to represent himself, she burst out laughing and kept laughing as she watched him choose the child doll to represent her. The assessor commented on the laughter, and Ms. Tanner said, "My mom always said that Gabriel was the grownup in our family. She said that me and his dad are just a couple of kids. I guess he knows it, too."

Ms. Tanner became more concerned as she saw Gabriel fall apart during the stories. Clearly angered and humiliated by what she saw on the videotape, Ms. Tanner said bitterly that the assessor had gotten a perfect picture of Gabriel. "He's impossible. He won't listen to anyone. He can't control himself. He gets in trouble wherever he goes." The assessor said, "It sounds like you're at your wit's end with him." Ms. Tanner agreed that she was. The assessor continued, "I think you put your finger on the problem when you said that he couldn't control himself. Self-control is something that children learn and they need their parents' help to learn it. The problem is that you have just been too

sad and depressed to really help him learn. And you've both been too frightened by the violence you've experienced from the kids' dad and in your neighborhood. That means that he has even bigger feelings to try to control. But you're frightened, too, so that makes it harder for you to help him." Ms. Tanner sadly nodded her head as she listened. The assessor chose not to highlight at this time the contradiction between Ms. Tanner's perception of Gabriel as the "grownup in the family" and Gabriel's self-protective internalization of this perception on one hand and the child's inability to live up to this larger-than-life image on the other hand because she feared that underlining this contradiction would humiliate Ms. Tanner and make her defensive and unwilling to collaborate in creating a treatment plan. This decision illustrates the importance of omitting from the feedback interpretations that may be clinically accurate but therapeutically premature.

Together, Ms. Tanner and the assessor set three goals for the treatment. The first goal was to help Ms. Tanner with her depression and with the strong feelings she had when she remembered the violence she had experienced. The second was to help Gabriel find ways to be calmer and more in control of himself. The assessor said that at first she would teach both the mother and the child some things they could do to become better able to help themselves. As she began to feel better, the goal would be for Ms. Tanner to take a more active role in helping Gabriel. The third goal, although ostensibly the simplest, was also the one that Ms. Tanner was most skeptical about: to find things that Ms. Tanner and Gabriel could do together that gave them both pleasure. When the assessor suggested this goal, Ms. Tanner replied, "I don't play with him. I take care of him. He plays." The assessor said that she could understand that playing might be hard because it was too child-like and asked whether Ms. Tanner would be willing to think about things that she and Gabriel would both enjoy. Ms. Tanner agreed to this reframe.

The assessor asked Ms. Tanner if she could agree to a fourth goal: making a safety plan to protect Gabriel and herself in the event that Gabriel's dad became violent again. Ms. Tanner minimized the need for that goal. She said that Gabriel's dad was still in jail and that she didn't know if she would let him come back when he got out. But she agreed that she and the assessor could continue talking about safety.

Treatment Goals Become Intervention Strategies

Once Ms. Tanner and the assessor agreed to the treatment goals, the assessor—now the CPP therapist—began to conceptualize the approach to treatment. The strategies would emerge from the clinical material that Gabriel and his mother brought to each session, but the clinician

would chose interventions and select ports of entry most likely to accomplish the treatment goals. The treatment would involve home visits to maximize attendance and continuity of treatment. Because Gabriel was easily overwhelmed, the clinician chose to bring toys selected to teach frustration tolerance (a simple board game and blocks), calming activities (bubbles, a mat for relaxing, simple storybooks, and a large ball that could be rolled on the floor), and toys that would allow Gabriel and Ms. Tanner to find pleasure playing out scenes of their life together (dishes, doll figures, and animal families). She knew that drawing connections between their frightening experiences and their unmodulated feelings would be an essential facet of treatment, but she wanted to make play a centerpiece of the treatment from the beginning to support Gabriel and his mother in pleasurable interactions and to use the rhythms of play to help Gabriel find ways to slow down and to move from a state of agitation to a state of greater calm. She also planned to use developmental guidance and emotional support starting from the first sessions to help Ms. Tanner understand Gabriel's and her own need for safety.

Beginning Treatment

After the feedback session, the clinician found a piece of paper that Ms. Tanner had been doodling on throughout the session and had left behind. On the top of the page, Ms. Tanner had written, "People I love." Underneath she had made a neat list down one side that named Gabriel, his father, and Ms. Tanner's mother. And then, all over the rest of the page, she had written Gabriel's name, over and over again. The clinician took that piece of paper to the first home visit and showed it to Ms. Tanner, who blushed and smiled when she saw it. The therapist said, "I think you were telling me something important when you left this behind. You were telling me that even though Gabriel has many problems and he sometimes drives you crazy, you love him very, very much. It's important for both of us to keep that in our minds." In fact, that knowledge sustained both the mother and the clinician throughout the upheavals of a complex and demanding treatment course.

CHAPTER 5



“Not Quite Good Enough”

Perturbations in Early Relationships

This chapter illustrates treatment when the duration and intensity of the child's problems shake up the parents' confidence in their ability to manage those problems without professional assistance. Sometimes the situation involves a circumscribed difficulty that can be managed relatively quickly through developmental guidance and emotional support. Other times, the presenting problems are sufficiently entrenched that improvement calls for additional intervention strategies, including attention to how the parents' personalities and parenting strategies are involved in the etiology or continuation of the child's problems. By definition, however, perturbations involve developmental strains that are superseded by the overall healthy thrust of the child's development and the positive features of the parent-child relationship. A careful assessment is important to lend perspective on the scope and severity of the problem and tailor the treatment accordingly.

We all wish we had had a perfect childhood. This wish is manifested in a profound human longing for a state of harmony where pain does not exist and every wish is fulfilled. The ubiquitous belief that this ideal state actually existed and the lingering mourning over its disappearance find expression in the cultural myths of a paradise lost. The wistful wish for perfect communion with another person is embodied in the archetype of the perfect mother, who has the power to protect us from harm and satisfy all our desires. The realization that we never had such a mother is the interpersonal equivalent of paradise lost and takes

the form of a disillusionment that can be experienced viscerally again and again. Erik Erikson (1950) articulated this frame of mind when he wrote about the inevitability of feeling incompletely cared for and the psychological struggle involved in achieving a state of basic trust:

But, even under the most favourable circumstances, this stage seems to introduce into psychic life (and become prototypical for) a sense of inner division and universal nostalgia for a paradise forfeited. It is against this powerful combination of a sense of having been deprived, of having been divided, and of having been abandoned that basic trust must maintain itself throughout life. (p. 250)

The “Good-Enough” Mother

D. W. Winnicott attempted to rescue us from the tyranny of pining for the impossibly perfect mother by pointing out that we can make do with what he sensibly called “the good-enough” mother. Also known as the ordinary devoted mother, she is preoccupied during the first weeks of her baby’s life with learning about and responding to his all-encompassing needs, and becoming progressively less completely absorbed in her mothering as the child matures and learns to tolerate delays of gratification (Winnicott, 1958). The transactional exchanges between the baby’s maturation and the mother’s ministrations gradually create a transitional interpersonal space where the child’s needs can be met without unduly impinging on the mother’s personal agenda, giving her the flexibility to care well for the child while also pursuing the duties and satisfactions attendant to her other roles.

This interpersonal space is where subjective perceptions and objective realities connect. It is the meeting place between the sense of self as a protected private space that cannot be known by outsiders and the part of the self that is engaged in a deep relationship with an indispensable partner. The inherent tension between privacy and emotional engagement means that “good enough” is a relative and abstract concept, a summary statement about a complex relationship. In moments of strife, we have a visceral negative experience because the relationship is not meeting our innermost needs. It is not only toddlers who can yell “I hate you!” because they lose track of their love in the midst of their disappointment and rage. Most adults also experience hatred at some point in the course of a long intimate relationship, although they may manage not to say it (a veritable feat of socialization). Only when the conflict can be placed within a broader emotional context is one able to reconnect with the more satisfying aspects of the relationship and conclude that the partner and the relationship itself are “good enough.”

John Bowlby attempted to describe the main features of the interpersonal space between the private self and the self-in-an-intimate-relationship, suggesting that the initial stage of secure early attachment involves the baby's experience of being recognized and met by the mother's sensitive responsiveness to his signals of need. As the growing baby acquires greater self-regulation skills, a secure attachment is increasingly characterized by a mutuality of adjustments until it becomes a goal-corrected partnership, where mother and child can resolve conflicting individual agendas through give-and-take based on each partner's empathic awareness of the other's plans and needs (Bowlby, 1969/1982). A mature secure attachment is characterized by reciprocity, defined as the capacity to recognize and adjust to the other's experience, to repair lapses in empathy, and to restore mutual attunement following conflict. These are the key ingredients of satisfying intimate relationships across a person's lifetime.

A good-enough mother is able to love a good-enough child. She is capable of accepting the mismatches between her fantasies and the reality of the child's individual characteristics, and she stretches herself without crippling resentment to provide the kind of care needed by her particular child. Good-enough parents recognize that imperfection is the coin of the realm and are not crippled by guilt in response to lapses in attunement. Reciprocally, a good-enough child accepts (with more or less grace, depending on the moment) that the mother will fail to be attuned to all his wishes and maintains developmental progress with the understanding that frustration and disappointment are expectable and can be managed without lasting hatred or despair. The achievement of a secure enough attachment is a work in progress that accommodates the child's individual traits, temperamental style, and changing developmental capacities as well as the parent's capacity to be sufficiently available and loving depending on internal and external stresses. Such accommodation invariably involves periods of heightened tension and lack of synchrony between parent and child.

Striving to Restore Goodness

The concept of "good enough" applies to therapists as well. There will be inevitable omissions, misunderstandings, and distortions in the clinician's work. At times strong emotion will cloud good judgment and the clinician will say or do things that slow down or damage therapeutic progress. The key to a good-enough therapeutic intervention is to cultivate an attitude of self-scrutiny so that the clinician remains reasonably aware of rigidly positive or negative feelings toward different family members, is receptive to feedback about perceived failures,

cultivates a commitment to repair therapeutic lapses, and is capable of self-forgiveness for clinical mistakes. The parallel process between the vicissitudes of treatment and the ebb and flow of intimate relationships is a useful guideline for the work.

Perturbations as Transactional Processes

As defined by Anders (1989) and described in Chapter 2, a perturbation consists of a circumscribed stress in attaining a developmental milestone. Unlike more serious disturbances, perturbations tend to be short-lived and limited to one or a few domains of functioning. Sometimes perturbations are not clearly linked to environmental or maturational stresses. Other times the perturbation is a by-product of the difficulties the child is experiencing in attaining a new skill. When this is the case, the negative affect often dissipates once the milestone is achieved because the child reaches a new balance and the child–parent relationship is reorganized in response to the child’s developmental spurt and the resulting changes in parental expectations.

Periods of emotional balance, however, tend to be short-lived. Young children work toward several different milestones at the same time but at different paces, with the result that development does not involve the orderly linear attainment of developmental milestones. A new perturbation is likely to set in soon after another one is resolved because the child is striving to acquire new skills simultaneously in several domains of functioning. The parents’ and the child’s developmental fluctuations and the recurrent mismatches in their respective developmental goals also make for inevitable perturbations. A perturbation may originate in the child, in each of the parents, or in the particular poor fit between the parents’ and the child’s wishes, anxieties, and strivings at a particular juncture in their lives.

Regardless of its source, the perturbation may affect the child–parent relationship by introducing conflict and decreasing trust in oneself and in the other. In spite of these stresses, a relationship can remain “good enough” even while undergoing perturbations when the parents retain some equanimity and humor about their own stress and fatigue, support the child’s developmental strivings, and continue to create areas of pleasure in family life and in their relationship with the child. The clinician can play a pivotal role in upholding hope for the family by placing the stresses and struggles of the moment within a supportive developmental perspective.

The resolution of a perturbation can come about in a variety of ways, including attainment of a developmental milestone, mutual adap-

tation to the state of affairs, or a better parental understanding of the problem leading to beneficial changes for the child. Resolving a perturbation is not just a matter of passively “outgrowing it” because it always involves developmental change. The very use of the term “outgrowing” is a pseudo-scientific way of saying that we do not understand why or how a problem was solved. However, the term can be useful when it gives the message that many stressful periods neither last forever nor get worse over time but are temporary difficulties that precede more mature forms of functioning.

Parents often misinterpret a perturbation as “the child’s problem” and do not recognize the contributions of the context in which it occurs. For this reason, perhaps the most frequently asked question for early childhood clinicians takes the following form: “Is this behavior normal?” Examples abound. Is it normal for an 8-month-old baby to bang her head against the floor? Does a 15-month-old suffer from unusually strong separation anxiety if he cries inconsolably when his mother leaves him at day care? Should we worry when a 22-month-old hides while having a bowel movement? Is a 2-year-old who routinely bites in response to frustration showing excessive aggression? Is a 4-year-old who touches her genitals telling us that she has been exposed to sexual abuse?

Parents, child care providers, teachers, child welfare workers, judges, and others who make decisions involving children often want to know whether specific child behaviors are temporary annoyances that will disappear over time or whether these behaviors indicate that the child is not developing well or has been maltreated. Clinicians encountering these questions typically find themselves thinking: “I wish I knew.” Predicting the course of development and pinning down the precise etiology of specific behaviors are risky undertakings, and taking an unequivocal stance about the answers is more often an indication of personal hubris than professional wisdom. Behaviors occur in biological, developmental, and environmental contexts. Learning about these contexts is the first step in deciding whether the child’s functioning is unfolding in expectable or worrisome ways.

The most judicious initial response to the question “Is this behavior normal?” is usually “It depends.” Knowing about the context for the behavior is essential. Rushing to assuage uncertainty by answering “yes” or “no” to specific questions without additional information risks two kinds of errors: mistaken reassurance (“the child will outgrow it”) or mistaken pathologizing (“the child is showing a disorder”). Failure to answer clearly, on the other hand, can make the clinician appear equivocal or inept. The same behaviors can have different meanings and lead to different outcomes depending on their context. Diagnosing and pre-

dicting the future course of a child's functioning is usually probabilistic at best. As the previous chapter makes clear, an understanding of the child's functioning in different domains is essential in order to provide a reasonably accurate answer.

The question "Is this behavior normal?" is best reframed as "Is this behavior harmful to the child or others? Does it cause distress? Does it interfere with important aspects of child development or family functioning?" From these points of view, it is less crucial to predict what will happen in the future than to act in the moment to alleviate present pain and dysfunction. Even when a pernicious behavior is likely to represent a temporary upheaval rather than a long-term problem, it is necessary to provide relief to the child and the family and enable all the players to remain positively engaged with each other.

The pediatrician T. Berry Brazelton (1992) coined the term "touchpoints" to highlight the well-known principle that regressions in behavior tend to occur before a spurt of developmental achievement. Touchpoints require a heightened deployment of energy that strains the child's resources. Learning to walk, for example, demands extraordinary effort and is often accompanied by frequent night wakings, increased crying, separation anxiety, and tantrums in response to even minor frustrations. Once the child learns to walk, the emotional landscape changes both for the child and for the family. The child is absorbed in the exuberant joy of practicing the new skill and the parents are thrilled with their baby's accomplishment. The juxtaposition of frustration with dramatic developmental progress often represents an optimal opportunity for dialogue between parents and professionals about the promise hidden in these potentially vulnerable transitional periods because the child's competence is enhanced or constricted by the parents' response (Brazelton, 1992; Brazelton & Sparrow, 2001). The concept of touchpoints helps parents to appreciate that healthy development is not always conflict free.

Like touchpoints, perturbations range along the continuum from manageable stress to constriction and distortion in development. However, touchpoints are linked to specific developmental transitions, while perturbations can occur as the result of a range of circumstances and may become the kernels of ongoing difficulties that reemerge in new guises at each new developmental stage. These recurrent core conflicts are likely to reflect not only the child's challenges but also mismatches between the child's needs and the capacities of the parents and the environment to meet those needs. The discipline of developmental psychopathology has been instrumental in refining clinical practice by increasing understanding of the dynamic and transactional nature of development (Cicchetti & Sroufe, 2000). A person may move from normal function-

ing to pathological behavior and vice versa, and he may have many areas of competence even while struggling with psychopathology. The following clinical example illustrates this coexistence of different modes of adaptation.

*Example: A Competent Mother
Who Feels No Pleasure in Her Baby*

The mildly depressed mother of a 4-month-old baby expressed anguish about feeling no pleasure in her baby, but she quickly mobilized herself to pick up the child and feed him when he began to cry. This mother's depression interfered with her ability to be joyfully attuned to her baby, and she worried incessantly that she was hurting her child by not being a good mother. However, her capacity to recognize her baby's signals of distress and to respond to his basic need for food remained intact.

The baby, in turn, had a predominantly serious facial expression and often averted his gaze when the mother or the clinician tried to engage him. He seldom smiled spontaneously and had not yet acquired the delightful belly laughter so characteristic of this age. On the other hand, he responded promptly to his mother's and father's soothing when he cried. He also ate well and slept through the night, indicating good regulation of biological rhythms. His weight, height, and head circumference were appropriate for his age.

The first step in the intervention consisted of using emotional support and developmental guidance to help the mother become more conscious of her appropriate responses to her crying baby and of his ability to be soothed by her care. This approach proved clinically helpful in strengthening the mother's self-esteem and gave her hope that she could gradually expand her responsiveness to him. As treatment progressed, the therapist guided the mother's attention to her inner experience in response to the baby's different expressions of emotion. The mother reported that whenever the baby became happily excited, she cringed with fear that he would quickly revert to being serious and withdrawn if she could not sustain his enthusiasm due to her depression. The therapist guided her in experimenting with smiling and laughing in response to the baby's enthusiasm. As she did so, the mother found that, contrary to her fears, the baby did not escalate his excitement beyond her capacity to tolerate it. This realization allowed her to respond to an increasingly broad range of her baby's signals. The baby became more expressive, vocalizing loudly and using movement and facial expressions to signal his moods and wishes. The mother's mood brightened in response and she was no longer depressed by the time treatment ended when the baby

was 8 months old. In this example, the mother's motivation to get better, the baby's responsiveness, and the availability of effective intervention acted synergistically to bring about a successful outcome in the course of a few months of treatment.

Parents and mental health professionals often recognize a perturbation primarily in retrospect, once it has been resolved. Prediction is imprecise at best, and the parents may be so absorbed in the strong emotions of the moment that they find it difficult to maintain a long-term perspective while the perturbation is going on. Knowing about the emotional strains inherent in normative child development allows parents some objectivity as they struggle with the intense affect and self-questioning that can accompany developmental perturbations. Developmental guidance enables the parents to differentiate between normative stresses and the areas of conflict that brought them into treatment. The capacity to distinguish between expectable developmental perturbations and areas of persistent conflict improves the parents' ability to successfully address the perturbation.

It is always difficult to determine whether unsettling states of mind and troubling behaviors are temporary aberrations or persistent problems. In a groundbreaking longitudinal study demonstrating the importance of contextual factors in guiding the course of development, Sameroff and his colleagues found that infants' individual functioning in the first year of life was not predictive of their cognitive or mental health functioning at age 4. When these investigators assessed the relationship between individual infant functioning and the quality of the environment, they found that highly competent infants living in high-risk environments had worse scores at age 4 than did low-competent infants living in low-risk environments. The findings are noteworthy because the measures of individual functioning included 13 robust indicators of early competence between birth and 14 months, including the infant's perinatal physical condition, mental and psychomotor development indices on the Bayley Scales of Infant Development at 4 and 12 months, and observations of infant temperament and response to stress. The findings led the authors to conclude that focusing on environmental risk is more useful than focusing on the child's individual characteristics in predicting the course of an infant's cognitive and emotional development (Sameroff, Bartko, Baldwin, Baldwin, & Seifer, 1998). At the same time, individual characteristics help determine how children respond to the environment and how the environment responds to them. Developmental outcome is best understood as the product of the continuous dynamic and interdependent transactions between the child and the environment (Sameroff, 1983; Sameroff & Fiese, 2000).

This point of view has important implications for intervention because it shifts the therapeutic focus of attention from attempts to change the individual child to identifying and addressing the environmental factors that impinge negatively on the child and enhancing the conditions that have a beneficial influence on development.

How is this done? Enlisting the parents' collaboration is key. Relationship-based treatment is particularly adept at adopting the vocabulary most likely to engage the parents on behalf of the child. Talented clinicians often display marvelous versatility in describing the child's or family's predicament by using the particular terms that best suit the parent's sensibility, even when this vocabulary does not reflect the clinician's own preferred theoretical framework. For example, clinicians working within a psychodynamic paradigm may find themselves using concepts derived from temperament research to describe the mismatch between an infant and a parent's emotional styles when this terminology is the most compatible with the parent's perspective. Clinicians with a cognitive-behavioral or social learning theoretical orientation may couch their interventions in psychodynamic language when this is more congruent with a parent's style. Perhaps the current prevalence of theory-neutral terms such as "affect regulation" and "sensory processing" is rooted in a cultural *zeitgeist* that favors psychological explanations based on brain architecture and function rather than internal experience. In response, CPP is organized around the meanings that parents and children give to their experiences and incorporates intervention strategies rooted in a variety of theoretical approaches.

Developmental Transitions and the Child–Parent Relationship

Perturbations are often ushered in by the child's maturational timetable because the effort to master a developmental milestone is typically accompanied by increased irritability and unpredictable fluctuations between the child's demands for autonomy and need for parental assistance. In the first months of life, frequent crying, night wakings, feeding difficulties, and other manifestations of neurological immaturity may be mistaken as evidence of the child's difficult temperament. During the toddler and preschool years, issues of socialization and discipline become preeminent as parents and child confront the questions of "who, when, and how" in relation to mobility, toilet training, sexual curiosity, sharing, and the myriad day-to-day negotiations regarding what is allowed and what is forbidden. These constant struggles trigger bouts of negativism and temper tantrums in the child and, not infrequently, in the parents as well. If the parents blame the child in any way, they may respond with anger, withdrawal, and punitive attempts at discipline

that backfire because they are not geared to the child's developmental needs. Unwanted child behaviors can become entrenched when the parent unilaterally tries to banish them. For example, thumb sucking, using transitional objects such as pacifiers or a security blanket, and touching the genitals in social situations offer comfort and are generally temporary unless they reflect more entrenched difficulties or set the stage for a power struggle between parent and child.

Perturbations of Psychobiological Rhythms

In the first months of life, the child is acquiring regular cycles of sleeping, eating, and elimination. The physiological arousal associated with these processes may result in unexplained early crying (also known as colic), described as the heightened crying demonstrated by many healthy babies in the window of time between 4 weeks and about 4 months of life. The scientific debate about the causes of early crying and effective ways of alleviating it remains unresolved, but there is consensus that it can lead to heightened parental distress, lasting parental perceptions of the infant as vulnerable, and, in extreme cases, harmful parental responses and child abuse (St. James-Roberts, 2001).

Heightened early crying is a good example of a developmental "touchpoint" because it can either be a source of temporary stress that is resolved without lasting sequelae or it can lead to a persistent perturbation in the child-parent relationship. Cross-cultural evidence shows that many healthy and well-developing babies engage in persistent and inconsolable crying in the first 3 months of life and that this behavior tends to peak toward the later afternoon. Efforts to understand the causes for this universal early peak in crying, while still inconclusive, have yielded a variety of explanations that include evolutionary and neurophysiological hypotheses regarding its survival function. There are also strong cultural influences on how intense early crying is interpreted by parents. For example, middle-class parents in industrialized Western countries tend to find it aversive, whereas impoverished mothers in Northern Brazil interpret it as a manifestation of the baby's robustness and self-assertion (Scheper-Hughes, 1993). The early peak in crying is associated with "the crying paradox," meaning that depending on the parental and social context, the baby's crying can elicit solicitous care or may bring about repeated visits to health providers and even become the immediate trigger for shaken baby syndrome and other forms of child abuse (Barr, 2001). The same individual child behavior acquires different meaning depending on its context.

Maternal perceptions are an important ingredient in activating one or another outcome in the range of possibilities. Longitudinal studies with community samples indicate that mothers of "early high criers" do

not differ from other mothers in caregiving sensitivity and their babies do not differ in quality of attachment and other measures in the second year of life (Stifter, 2001). On the other hand, studies with clinical samples indicate that inconsolable crying may trigger in the parents acute stress, feelings of helplessness, aggressive fantasies, and guilt. Compared to community controls, infants referred to a fussy baby clinic were more likely to show behavior problems as toddlers in spite of early treatment that was deemed successful at the time (Papousek & Papousek, 1990). It is possible that these highly reactive infants had constitutional vulnerabilities that emerged in other areas as they became toddlers and their parents felt unequipped for the new caregiving challenges facing them. These findings highlight the importance of not focusing interventions narrowly on a discrete behavior.

Maternal self-efficacy is an important predictor of outcome. Mothers can acquire learned helplessness in relation to their difficult-to-soothe babies. When a mother feels that she has failed to respond adequately to her baby's crying, her later responses will be negatively affected by this perception. This sequence was demonstrated in a study where maternal expectations of success or failure were manipulated in a laboratory task in order to study the impact of these expectations on subsequent behavior. Mothers were asked to press a series of buttons to stop a tape-recorded baby's cry. Conditions were set to make it either very easy, difficult, or nearly impossible to succeed. Mothers who were first exposed to the "nearly impossible" condition were less successful when they were later exposed to the easy condition. The perceptions based on their initial performance affected their later capacity to respond. On the other hand, this expectation of failure disappeared when the mothers were told that success in the first condition was unrelated to success in the next condition. When the mothers were encouraged to expect success in the second session, they were considerably more effective in spite of their failure in the first session (Donovan & Leavitt, 1985). Maternal effectiveness in alleviating the baby's crying easily becomes a litmus test for self-perception and social judgments regarding the mother's skills. These findings highlight the centrality of attending to parental motivation as an intrinsic component of efforts to change behavior.

Dymphna van den Boom designed an intervention offering low-socioeconomic status (SES) mothers individualized help with their irritable babies. The intervention focused on mother-child interaction and consisted of one 2-hour home visit every 3 weeks during a 3 month period. The intervention began when the babies were 6 months old, past the age when excessive crying is likely to abate spontaneously or when self-sufficient mothers have found their own distinctive ways of handling it. Babies and mothers in the intervention group showed posi-

tive outcomes in individual behavior and in child–mother interaction at the end of the intervention when the babies were 9 months old and on follow-up when the babies were in their second and third year (van den Boom, 1994, 1995).

This study shows that individually tailored developmental guidance can improve child and parent functioning even when the difficulties are not within the clinical range. Mothers in van den Boom’s study did not ask for help with their babies but accepted it when it was offered and used it effectively. Long-lasting beneficial results were obtained by intervening during a window of time when the type of intervention and the child behaviors targeted for change were well matched with the mothers’ motivation to make use of treatment. This process has important policy implications. A society that cares for its own long-term well-being should attend to its future citizens by providing parents with support in raising their children before there is a critical need for clinical intervention.

Pediatric care providers play a key role in early identification and referral because they monitor the baby’s health and adequate development in the first years of life. They can be effective early interveners in alleviating perturbations and guiding parents toward effective childrearing practices. They can also use their professional credibility to make early mental health referrals when the difficulties do not remit with the interventions offered in the pediatric setting. The following case example illustrates the key role that primary health providers play in early identification and referral when the convergence of risk factors sets the stage for a negative outcome for the baby.

Example: Helping a Fussy Baby

Mrs. Adams and her baby, 2-month-old Alexis, were referred for treatment by their pediatrician after a routine baby visit in which the mother broke into tears in response to the question: “And how are things going for you?” In the ensuing conversation, the pediatrician discovered that the mother was suffering from stress and dysphoria as a result of conflicts with her husband. She also blamed herself for her baby’s frequent and intense bouts of crying. Mrs. Adams had read that maternal emotions are transmitted to the baby through the mother’s milk, and she told the pediatrician that she worried that her “sour milk” and “tense muscles” were “messing up” her child because she could not set aside her sadness and anger while caring for him. The pediatrician made a referral for infant–parent intervention when the pediatrician’s own efforts at developmental guidance regarding early colic did not relieve

the mother's concerns and when the mother declined to see a psychiatrist for a consultation about her depression.

Mrs. Adams and her husband were in their mid-20s, European American college graduates from a middle-class background who had carefully planned the pregnancy so that the baby's birth would coincide with the last payment of their student loans and the beginning of some financial freedom. They had both been sorely disappointed when, instead of the idyllic pregnancy they had anticipated, Mrs. Adams suffered from constant back pain and the delivery was long and painful although otherwise uneventful. These experiences contrasted sharply with the perceptions that Mr. and Mrs. Adams had of themselves as young, athletic, competent, and pretty much in charge of their lives.

The initial two intervention sessions showed that Alexis was feeding well, growing well, sleeping 3 hours at a time, and waking up twice for nursing during the night. He was a very visual baby who followed his parents with his eyes as they moved around the room and was quick to turn toward new sights. His facial expression tended to be sober and it took some coaxing to get him to smile, but when he did he showed delightful dimples that gave his parents clear pleasure. He was very sensitive to sound, slept lightly, and startled easily. He had sustained periods of fussiness during the day, and he was difficult to console when he cried. His mother estimated that he cried for approximately 15 minutes at a time several times a day, and once a day he cried "for 2 hours solid, without a break," to use the mother's description. He was particularly difficult to soothe in the early evenings. When Mr. Adams returned from work, Alexis's mother often greeted him with an exasperated "You take him!" and went to the bedroom to rest. This greeting clashed with Mr. Adams's fantasy of coming home to relax and talk to his wife about the events of his day. The following exchange during the first session gave a clear indication of their very different frames of mind. Mrs. Adams said tearfully: "He can be good at times, but when he cries nothing that I do pleases him." Mr. Adams replied sternly: "Babies cry. What happens is that you fall apart too easily."

These divergent perceptions were fueled by the parents' different experiences during the day. Mr. Adams was immersed in pursuing a career in the computer industry and worked long hours, while Mrs. Adams had taken a 6-month leave of absence from her administrative position at a university and missed the social and intellectual stimulation of her work life. After 2 years of being happily married they now found themselves at odds with each other, torn between their motivation to be perfect parents and their desire to continue the carefree lifestyle they had enjoyed before the baby was born. They were the first couple in their social circle to become parents, and after celebrating the baby's birth their friends

resumed the pattern of partying and going to concerts that constituted their social life. As a result, Mr. and Mrs. Adams found themselves somewhat isolated from their friends because they did not feel comfortable leaving their young baby with a babysitter in order to go out at night, and they had no family in the area for substitute care.

No evidence of psychiatric problems or other risk factors emerged from the first two sessions, which were largely devoted to an assessment of the parents and the child and to trial interventions to determine the parents' motivation and openness to treatment. During the initial session it was clear that Mr. Adams believed that his wife was overreacting to Alexis's crying and Mrs. Adams felt on the defensive about the quality of her mothering. Although Mrs. Adams wanted her husband to participate in the treatment, he declined on the grounds that the sessions would interfere with his work schedule. The clinician suppressed her strong urge to admonish Mr. Adams that his immersion in his work was endangering his marriage and that his primary commitment should be to his family. She realized that her own values were coloring her perception and that it was premature to recommend a course of action that would be perceived by the father as authoritarian and burdensome. The parents and the clinician agreed that Mr. Adams would attend the sessions whenever he was able to.

Choosing an Initial Intervention Strategy

The clinician took all these circumstances into consideration in proposing infant massage as an initial intervention modality. She hypothesized that learning to use specialized soothing techniques would set up a feedback loop between mother and baby that might enable Mrs. Adams to feel more effective and circumvent her defensiveness about her husband's perception that she was overreacting to the baby's crying. Mrs. Adams was receptive to this suggestion, which was in line with her explicitly stated wish during the assessment to learn cutting-edge approaches to infant care.

Massaging the baby offered mother and clinician opportunities to observe Alexis together and to give developmentally appropriate meaning to his responses. For example, on one occasion the clinician responded to the baby's fussing when she touched his stomach by saying: "You are telling me that your tummy is very sensitive. Let's massage your arms first." When the baby stopped fussing in response to this change, the mother commented: "I see what you are doing. You are letting him show you the way. This is good. This is good." She seemed more self-confident in touching Alexis and trying out different ways of holding him after this exchange.

The clinician also used the sessions to encourage Mrs. Adams to describe her own feelings and states of mind as she interacted with Alexis, and asked about the similarities and differences in the ways she and her husband interacted with the baby. This line of questioning led Mrs. Adams to reveal her conflicting feelings toward her husband, which included feeling critical because he was not responsive to the baby's distress, anger for his emotional distance from her, missing the happy times they had as a couple before the baby was born, and fear of being alone if he left her. The clinician listened supportively, sympathizing with the mother's experience and offering developmental guidance about mothers' and fathers' different ways of adjusting to the changes brought about by parenthood.

Adding Intervention Modalities

One month into the treatment, the clinician found out that Mrs. Adams often spent 2 or 3 days without going out of the house because she felt unattractive due to her weight gain and had little motivation to dress up just to stay at home with the baby. When she went grocery shopping, she came back to the house as quickly as she could. Commenting that what the mother interpreted as "baby blues" might have a strong component of "cabin fever," the clinician suggested activities that would get Mrs. Adams and the baby out of the house. Mrs. Adams was reluctant to follow these recommendations because she was afraid that the baby would start crying inconsolably in a public place and she would not know what to do. The clinician proposed going out together as part of the session after practicing baby massage for 20 minutes when she first arrived for the home visit. When Mrs. Adams was evasive about this offer, the clinician responded that this was a standing invitation and that she would repeat it in case the mother changed her mind. Two weeks later, Mrs. Adams reluctantly agreed to "try it next week" when the clinician brought it up again, and her appearance improved considerably when this schedule was adopted. Instead of wearing a bathrobe when the clinician arrived in the early afternoon, she was showered and casually but neatly dressed, and the baby was bathed and ready to go. These neighborhood outings—to the library, grocery store, park, or simply window shopping—gave the clinician an opportunity to point out to the mother Alexis's visual interest in the world and the positive response of passersby, who often greeted him and engaged in brief but friendly exchanges with Mrs. Adams about him. Alexis sometimes cried during these outings, but the periods of active engagement interspersed with sleep outweighed the moments of distress.

The outings with the clinician dispelled Mrs. Adams's fears of what would happen if she took the baby out for long periods, and she started

going out with Alexis outside the sessions as well. During one of these forays she discovered a gym that had babysitting services in a room adjacent to the exercise area so that the parents were easily accessible if needed, and she started going as part of resuming her daily workouts.

As Mrs. Adams focused less on her fear of the baby's response, the clinician started asking more explicitly about the marital relationship. Mrs. Adams eventually revealed that their sexual relationship had become a salient issue in their mutual dissatisfaction. Both of them were too tired and conflicted with each other to resume having sex, and both of them worried about what this meant about their relationship. Mrs. Adams reported that her husband berated her for being interested only in the baby, but he stayed up working, watching TV, or listening to music long after she went to bed even on weekends. The clinician normalized this situation as a frequent response of couples to the birth of a baby and spoke about fathers' fears of being superseded by the baby in their wives' affections. She suggested that Mr. and Mrs. Adams begin hiking together with Alexis during the weekend instead of exercising separately while the other took care of the baby. She also encouraged the mother to use a babysitter so that the couple could go out occasionally either alone or with friends and offered advice on how to interview applicants and gauge their trustworthiness. These suggestions proved welcome and beneficial. Mrs. Adams's harsh criticism of her husband and fear of abandonment softened. Soon after their first date after the baby's birth, the father actually participated in a session and asked about how to decide whether to ignore or respond to the baby's crying. This question led to a productive discussion about different personal styles and babies' capacity to adjust to their mothers' and fathers' distinct ways of relating to them.

These interventions illustrate the usefulness of integrating modalities that encourage behavioral change with clinical attention to defense mechanisms and other components of inner experience. When Mrs. Adams initially declined the clinician's suggestions for doing activities outside the home, the clinician explored the reasons for her refusal and tailored her interventions to circumvent the internal obstacles that Mrs. Adams described. During their outings together, the clinician provided emotional support and reality testing by showing the mother that the overwhelming stresses she anticipated when going out did not occur. As Mrs. Adams's trust in the clinician increased due to improvement in the most immediately salient areas of concern, therapeutic attention turned to the more emotionally charged topic of the marital relationship. Here again, empathic listening, normalizing of negative attributions by developmental guidance and reframing, and suggestions for active behavioral change led to rapid improvement.

The Outcome

After 3 months of weekly treatment, there were major transformations both in Alexis and in his mother's internal experience and parenting behavior. Mrs. Adams was more active, more enterprising, and in a better mood, and she commented that she had discovered parts of the city that she had never known while she was working. Her negative attributions to Alexis diminished substantially when she began to perceive his crying as a sign of distress rather than as an indication that he had an angry and rejecting nature. In response to her greater sensitivity and self-assurance in handling him and aided also by maturation, Alexis became cuddlier and cried less, reinforcing the mother's increasing self-confidence in ministering to him. Mrs. Adams's heightened need for her husband's complete acceptance and anger when he was not emotionally supportive diminished when she became better able to understand that his emotional upheavals were often an indication of his self-doubts in facing his new responsibilities as a father. Last but not least, the couple resumed their sexual relationship. The session in which Mrs. Adams reported this event timidly but with clear relief marked the beginning of the end of treatment, with the last session occurring 2 weeks later.

In this example, baby massage was an initial intervention that brought quick improvement to the interaction between mother and baby and enabled Mrs. Adams to adopt a more reflective stance both toward her baby and toward her conflicted marital relationship. She realized that the baby's crying was not an enduring personality trait but rather a response to a stressful internal state, and she became less self-blaming when her ministrations did not immediately help Alexis to stop crying. This understanding was linked with a new appreciation of her power to assuage or exacerbate conflict with her husband through her responses to his behavior. In working toward these changes, the clinician framed this young couple's marital and parenting challenges in the context of the normative stresses of being new parents. This developmental frame defused the mother's defensiveness, instilled hope, and fostered her readiness to experiment with new ways of responding. The very concrete contributions to the mother's mood of physical exercise and activities out of the house should not be underestimated. In addition, the beneficial effect of the improved mother-infant relationship on the marital relationship exemplifies Robert Emde's important observation regarding the effects of relationships on relationships (Emde, 1991).

It bears noting that the mother's childhood experiences were not a focus of this intervention. She talked during some sessions about childhood encounters with her mother, father, and siblings that made her feel

lonely, angry, and inadequate, but the clinician thought that there was no need to pursue the chains of associations related to these experiences because the mother and the baby were making satisfactory progress with a focus on the present. If the chosen modalities of intervention had not yielded the desired results, a probing of the “ghosts” from the past and their influence on present circumstances would have been considered a possible additional treatment modality (Fraiberg et al., 1975).

Conflicts over Self-Regulation

Parents and their children start to communicate with each other from the moment they first meet, and many of these communications involve queries about who is expected to do what in their relationship. The answers are provided in the moment-to-moment transactions during daily routines such feeding, sleeping, soothing, and toileting as well as in the realms of protection from danger, intimacy, and expression of affection, socialization, discipline, exploration, and play. Perhaps the most pointed disagreements among people who care about raising children well—including parents, teachers, clinicians, and child development experts—involve the optimal balance between protecting the child from distress and allowing the child to endure frustration in order to promote coping capacities. There is a broad range of opinion regarding such questions as the following: Should a small child ever be allowed to cry herself to sleep, and if so, at what age? How should one respond when a child is showing distress, anger, or frustration at not being able to master a skill? At what age can a child be spoiled by too much attention or indulgence? What is the appropriate way of managing a tantrum, and how does this response change with the child’s age? What are appropriate distractions and redirections when the parents need a respite?

The underlying theme in all these questions is the issue of how best to promote self-regulation within a culturally and developmentally appropriate context. High levels of unregulated arousal interfere with adequate functioning in key domains, including self-care, the ability to form and maintain satisfying relationships, and readiness to learn. Although newborns are almost completely dependent on the mother for the regulation of their biopsychological processes, they are active partners from the very beginning through gazing, closing the eyes, head turning, thumb sucking, arching, snuggling, and many other behaviors that elicit or shut off stimulation. As babies mature, they are increasingly self-assertive in synchronizing biological rhythms and guiding the maternal behaviors that minimize negative affect and maximize positive affect (Schore, 2003). This mutual attunement of mother and baby is

the essential substrate in the development of attachment. The mother's contingent responsiveness predicts the child's secure attachment and competence in age-appropriate developmental tasks, suggesting that attachment can be understood as the dyadic regulation of emotion (Sroufe, 1996).

Struggles over autonomy often reflect a mismatch between the child's and the parent's agendas about self-regulation. Parents might believe that they need to direct the child's development by deciding what and how much the child should eat, when and how long the child should sleep, the timing of toilet training, and what responses to expect from the child in a variety of situations. The child, on the other hand, may have a different subjective appraisal of what feels safe and comfortable and may respond to unilateral parental directives with refusal, noncompliance, or emotional withdrawal.

Mismatches and misattunements are normative in parent-child interactions (as in all other intimate relationships), and the repair of miscommunications is an integral component of growth-promoting relationships. The absence of miscommunication may actually suggest that something is going awry in the developmental process. Very high mutual coordination between mother and baby as they vocalize with each other is an early indicator of risk for disorganized attachment, perhaps because it signals vigilance, overmonitoring, wariness, and an excessive effort to please as a way of counteracting these concerns. Very low coordination is also a predictor of anxious attachment, suggesting that a rigid adherence to one extreme of mutual coordination or the other bodes ill for the kind of reciprocity that underscores safe intimacy between child and mother. In contrast, midrange coordination predicts secure attachment, most likely because it indicates flexibility and ease in tuning in and out of the interaction in response to a variety of factors. The value of midrange levels of maternal responsiveness in predicting better child outcomes suggests that perturbations in the parent-child relationship may occur when parents are either disengaged or overinvolved with the child (Jaffe, Beebe, Feldstein, Crown, & Jasnow, 2001).

There is a very broad range from disengagement to overinvolvement and from permissiveness to authoritarianism, and specific answers to the question of what constitutes the "golden mean" can vary greatly depending on the person's cultural background, personal values, and individual style, although there is general agreement that either extreme can hurt the child's competence. Parents are often told that they are the "experts on their child" and should follow their intuition, but this statement is of little value when the parent does not know the principles, norms, and timetable of child development and when the child's behavior feels like an enigma that is impossible to decode. Telling a befuddled

parent that he is an “expert” can feel to the parent like an additional stress when it represents one more indication of his inability to live up to the expectations of others. It is more useful to recommend a plan of action where the parent and the clinician can observe the child’s behavior together, reflect on it, and try out possible solutions. This approach conveys to the parent the clinician’s respect for the rich complexity of development and a sense of partnership in problem solving.

The example that follows illustrates intervention with a perturbation involving an autonomy struggle around feeding, one of the most common difficulties in infancy. It is estimated that approximately 25% of normally developing babies and 80% of infants with developmental handicaps have feeding problems, a phenomenon that is associated with later eating disorders, behavioral problems, and cognitive deficits (see Chatoor & Ganiban, 2004, and Maldonado-Duran & Barriguette, 2002, for reviews and two alternative theoretical formulations of this issue). Self-regulation in feeding is achieved in a developmentally predictable fashion as babies develop communication systems with their caregivers that enable them to experience, communicate, and respond to signals of hunger and satiation. This process moves from the dyadic coordination of signals between infant and caregiver to the child’s readiness to eat independently. Problems may occur at any stage of the process, either because the child’s signals are weak or ambiguous, because the parents superimpose their own interpretations on the baby’s signals as a result of their own preconceptions or conflicts over food, or because feeding becomes the domain in which broader conflicts are played out.

Example: Difficulties Feeding Amelia

The following example illustrates the treatment of a feeding perturbation between 10-month-old Amelia and her mother. The pediatric nurse practitioner referred them because the mother was force-feeding Amelia due to her fear that the child’s food refusal would result in anemia. By the mother’s report, the feeding struggles began 2 months earlier, when Amelia was weaned from the breast at 8 months of age. Since then, Amelia had lost interest in food, turning her face and pushing the spoon away when her mother tried to feed her. Although Amelia continued to gain weight and grow adequately, the conflict over food had become so intense that the child was now crying as soon as her mother started carrying her toward her high chair for a feeding.

Amelia was her parents’ third child. The parents were a couple from a remote rural village in El Salvador who had immigrated to the United States 3 years earlier. Mr. and Mrs. Sanchez were in their early

30s and had two older children, a 12-year-old boy and a 10-year-old girl. Although the pregnancy with Amelia was unplanned, both parents considered it a gift from God and a sign of His approval of their migration to this country. Everybody called Amelia *la Yanquicita* (the little Yankee), particularly when she protested or was otherwise upset. Her strong signals of pleasure and displeasure were considered an American characteristic that contrasted with their cultural expectations that girls should be stoic and compliant. Although they felt sometimes challenged by Amelia's strong temperament, the parents were also amused by how different she was from their older children. The moniker *la Yanquicita* reflected their sense that Amelia belonged in the country of her birth in a way that neither the parents nor the older children could hope to. This seemed to give them both pride and some emotional distance from her, as if she were a bit of a foreigner in their eyes but also a bridge to their new country.

Pregnancy and childbirth had been normal and uneventful. The delivery had taken place at a local hospital with a high percentage of Central American patients. Mrs. Sanchez reported that she had received excellent medical care, although she missed the midwife who had delivered her older children in her Salvadoran village. Amelia had been a healthy baby who ate well, slept well, and fit in smoothly with the family routines. Her crying was described by her parents as "energetic" but easy to understand. When Amelia continued crying in spite of her mother's ministrations, Mrs. Sanchez offered the breast, which became the primary way of soothing.

Mr. Sanchez had a steady job in construction, and Mrs. Sanchez had returned to her part-time job as a waitress when Amelia was 4 months old. While the mother worked, Amelia was left in the care of the next-door neighbor, an older woman who also cared for her own 3-year-old grandson. The parents were pleased with this child care arrangement because they trusted their neighbor and had a social relationship with her. Amelia had known this woman from family visits before she started staying with her for a few hours at a time, and the parents did not notice any pronounced changes during transitions. In their view, things were going well with their family although the possibility of deportation due to their undocumented status was a constant source of anxiety.

The First Home Visit

During the first home visit, the parents greeted the clinician politely, but after some awkward exchanges they professed surprise at the pediatric nurse practitioner's referral because they did not see anything wrong with the way they fed their daughter. Mrs. Sanchez reported that when

asked about Amelia's feeding routine during a well-baby visit, she explained that Amelia did not eat well and for this reason the mother held her face with one hand while pushing food in her mouth with the other. Amelia's efforts to fight back were not particularly distressing to Mrs. Sanchez because she believed that it was much more important to keep Amelia well nourished than to give in to the child's lack of interest in food. Both parents spoke with much feeling about the high infant mortality rate in their village. They were clearly determined to make sure that their children would be healthy and strong.

At this point, the clinician was faced with a dilemma because of the contrast between the concerns expressed by the pediatric nurse practitioner and the parents' conviction that the feeding struggles were a minor nuisance relative to the danger of malnourishment and anemia if Amelia refused to eat. The parents' point of view was understandable given the pervasiveness of malnutrition in their home country and their firsthand knowledge of children who died in infancy. Mr. and Mrs. Sanchez were experienced parents who had already raised two children successfully. If the clinician tried to persuade them that Amelia was growing well and in no immediate danger of developing anemia, she risked losing her credibility by being perceived as someone who failed to grasp the importance of appropriate early nutrition. Compounding the divergence of perspectives was the fact that Mr. and Mrs. Sanchez strongly believed that "parents know best" and should set clear directions for their children. Their culturally appropriate emphasis on the primacy of parental authority contrasted with the prevailing professional *zeitgeist* in the United States that babies develop better when their parents are responsive to their signals and follow their lead.

The initial home visit observations made clear to the clinician that Mr. and Mrs. Sanchez were caring, competent parents with well-defined ideas about how to raise their children. The older children could not be observed because they were at school, but Amelia was a healthy baby who crawled, babbled expressively, and showed a range of appropriate emotions—from initial wariness and social referencing with the mother when the clinician first arrived to chortles of delight when her father bounced her on his knees after she became restless. At the same time, Amelia repeatedly hit her mother's face and chest without apparent reason while she sat on the mother's lap. As she spoke to the parents, the clinician found herself divided between her professional loyalty to the pediatric nurse practitioner who had made the referral, her own conviction that forcing food can have damaging repercussions for a child and might explain Amelia's out-of-context hitting of her mother, and intense sympathy for these caring and hard-working parents as well as a wish to please them by agreeing with their point of view. An immigrant herself

from a Spanish-speaking country, the clinician was nevertheless taken by surprise by her unexpectedly strong identification with the parents and her reluctance to address directly the question of Amelia's feedings.

Searching for a Port of Entry

In an effort to reconcile these conflicting internal responses, the clinician decided to buy herself some time by postponing a decision about how to focus on the feeding situation. She searched instead for ports of entry that would create areas of commonality with the parents and help to establish her legitimacy as an intervener. She engaged the parents in lighthearted conversation about the differences between the United States and Latin countries, highlighting the commonalities that immigrants share in adjusting to a new country. This conversation led to Amelia's status as the only American citizen in the family and to the changes occasioned by her birth. Remembering that Amelia's lack of interest in food had begun with weaning, the clinician asked how the mother had decided that it was time to discontinue breastfeeding. Mrs. Sanchez answered that her breast milk had been steadily diminishing since she returned to work. Amelia had become irritable, a behavior that the mother interpreted as signaling that the child was hungry and that it was time to increase the amount of solid food. Mrs. Sanchez was surprised when Amelia did not take well to this change and refused solids instead of welcoming them, but both parents thought it was just a matter of time until the child got used to the new diet. In the meantime, they saw no other alternative but to force her to eat.

The pediatric nurse practitioner had explicitly objected to this practice, so that the parents' statement to the clinician that they intended to continue forceful feeding was a covert challenge. In a politely indirect way, they were telling the clinician that they were the parents, knew what they were doing, and intended to continue with their routines. Rather than addressing their statement directly, the clinician asked if the older children had been weaned the same way. The mother responded that she had breastfed the older children until they were older because they grew up in El Salvador and she did not need to go far from them in the course of her daily work.

This reminiscence led to a wistful conversation in which the parents spoke at some length about the differences between daily life in an American city and the slower pace of a rural Salvadoran village. The clinician commented: "Some things are harder here and some things are harder there. In the United States there is more money, but in our countries there is more time for the family." Both parents nodded in agreement, and the mood became sadder but more relaxed as the con-

versation turned for a while to the daily routines left behind and the difficulties of adjusting to life in this country. After a silence, the clinician went back to the topic of weaning by asking: "How did Amelia respond when you decided to wean her?" The mother said laughingly: "She screamed! She hit my breast and she tried to lift my blouse all the time. She threw her bottle on the floor." Both the mother and the father then took turns describing specific ways in which Amanda had shown her displeasure, including sleep disturbances and increased irritability during the day. The child looked soberly at the adults as they talked, while her mother absentmindedly caressed her hair or rubbed her back. Turning to Amelia, the clinician said with a lot of feeling: "You missed your mommy's milk. There is nothing that tastes so good. No wonder you don't want to eat anything else." There was a silence, as if the parents were surprised by the possibility that Amelia had indeed felt that way. The clinician then found herself confident enough to articulate her wish to find a bridge that would enable the pediatric nurse practitioner and the parents to understand each other better. She said: "You know, I can see how well Amelia is doing and how much you know about raising children. The nurse cannot come on home visits and she does not know about ways of raising children in our countries. I would like to get to know you better so that I can explain to her how you see things and tell you how she sees things so that there isn't tension between you when you go for your appointments. Can I ask permission to come next week and watch Amelia while she eats?" The parents agreed that the clinician could return the following week in time for Amelia's lunch.

The Outcome

When the clinician arrived the next week, the struggle over food between Amelia and her mother had already started. Mrs. Sanchez was trying to feed Amelia small pieces of chicken, and the child spat them as soon as the mother put them in her mouth. After watching quietly for a while as the tension between mother and child increased, the clinician said: "I can see how strong minded she is and how worried you are that she is not going to grow well if she doesn't eat." The mother sighed in frustration. She seemed tired and humiliated. She offered Amelia a baby cup with milk, which the child held by the handle and drank from readily. The clinician said: "She is so good already at holding her cup and drinking by herself. . . ." The mother nodded, but she was clearly more interested in having Amelia eat the chicken than drink the milk. The clinician added: "You know how you call her *la Yanquicita* because she seems more American than Salvadoran? Maybe I can give you an idea. American children really like to do things on their own, even when they

are still babies. Amelia is using that cup really well to drink her milk. It is hard for parents like us that children want to be so independent, but do you think maybe Amelia will fight you less if she can feed herself?" The mother replied that Amelia would not eat solids at all if left to her own devices. The clinician said: "I was watching her last week and I saw how much she likes to use her hands and her mouth. She was picking up those plastic cubes and bringing them to her mouth, remember? Maybe if you give her some sweet but healthy food that she can pick up, like grapes and pieces of banana, she will start eating them." Mrs. Sanchez commented that Amelia ate in the evenings when her brother fed her because he teased her by pretending to eat her food himself and then put it in her hand when she reached for it. She then put it in her mouth. Mother and clinician laughed at this description, and the clinician then asked what Mrs. Sanchez thought of that. She said: "He is a child, so he can do it. I am her mother and she should respect me." The clinician answered: "I agree with you. I think she wants to respect you, but she is still having a hard time missing your breast milk. Some children take weaning hard, and I think Amelia is one of them."

In the next session, Mrs. Sanchez greeted the clinician with a shy smile, saying: "I think she heard you. She started eating." Surprised, the clinician asked, "What do you think happened?" The mother said: "I thought of what you said that she missed my milk. Maybe I weaned her too fast and she got mad at me. She eats for my son and for my neighbor, so maybe the problem is with me." The clinician said softly: "You are the one she loves the most." The mother said: "I get mad at her that she is so stubborn. But then I decided to try what you said. I let her get really hungry, and then I put some banana and grapes and some boiled chicken on her tray and I did not even look at her, I pretended to be doing something else, and she started eating all by herself."

As the mother and the clinician talked, it was impressive to witness the insight that this mother with a third-grade education had into herself and her child. The pressure of her circumstances had misled Mrs. Sanchez into implementing an abrupt weaning process that disrupted the baby's age-appropriate association of well-being with her mother's milk and made her reject the food substitutes she was offered. Mrs. Sanchez had misinterpreted Amelia's responses of distress when she returned to work as an indication that the child was hungry and needed more solid food and ignored Amelia's urgent pleas—by hitting the breast, pulling the mother's blouse up, and refusing the bottle—to restore the lost intimacy of nursing as both a form of feeding and a strategy for soothing. In effect, Amelia had experienced a double loss: first, the uninterrupted maternal care that she had before Mrs. Sanchez returned to work, and then the weaning that followed soon afterward. Mrs. Sanchez had failed to recognize the meaning of both of these emotional stresses for the

child when they were happening, but the clinician's empathic naming of Amelia's sense of loss was sufficient to change the mother's inner stance from an authoritarian expectation of compliance to an understanding of the child's plight. She now felt wanted and missed rather than defied. This internal shift allowed Mrs. Sanchez to move rather quickly from denying that she cared about the power struggle with her daughter to a thoughtful acknowledgement that Amelia was angry at her. This inner shift allowed her to give Amelia the autonomy that the child now needed to feed herself.

From a psychoanalytic perspective, we can hypothesize that the failure of Mrs. Sanchez to recognize that Amelia's distress was a response to separation and to weaning, particularly in light of her extensive experience as a mother, might have been due to her ambivalent feelings toward this unplanned baby. We can also surmise that the mother's aggression found expression both in the forced feedings and in her perception of the baby as a "Yankee"—a term with distinct derogatory overtones in Latin America. The fact that the feeding perturbation was resolved without addressing its possible psychodynamic structure suggests that Mrs. Sanchez's loving commitment to Amelia significantly outweighed whatever anger she harbored toward her.

The cultural component of this intervention was an important element of its success. The clinician defused the tension created by the parents' feeling that the referral was unnecessary by openly affirming the parents' competence and authority. She then tried to make Amelia's striving for autonomy more acceptable to the parents by linking it to their perceptions of the child as "a little Yankee" who partook of the assertiveness and valuing of independence they attributed to this country. The clinician never took issue with the mother's feeding practices but suggested instead an alternative approach that incorporated what she had learned about the parents' values and point of view. This approach proved effective. In three sessions, the child's food refusal was largely resolved, as confirmed in follow-up telephone calls 1 month and 2 months later.

Expectable Anxieties of the Early Years

Along with the epigenetic development of progressively more advanced capacities to act, think, and feel, children also experience a parallel unfolding of developmentally expectable anxieties. As described in Chapter 1, the primordial anxieties consist of fear of abandonment, fear of losing the parents' love, fear of body damage, and fear of being bad (Freud, 1926/1959c). While emerging sequentially in the first 4 years of life, these four anxieties usually overlap. Each of them takes center

stage for a while before receding to the background as the child acquires adaptive coping mechanisms to manage it. All of these anxieties are also present forever, emerging throughout the person's lifetime in response to internally triggered vulnerabilities and external stresses and traumas.

Each of the anxieties signals a new stage in the child's ability to understand danger and to appreciate the role of emotions in governing human relationships. The transition from fear of abandonment (manifested in separation anxiety) to fear of losing the parent's love (manifested in fear of disapproval) indicates that the child is moving from concrete reliance on the parent's physical presence as the agent of protection and source of safety to an increased appreciation of psychological reciprocity. The child now knows that what he does and feels has an effect on what the parent feels and does, and an enormous amount of effort is deployed in trying to understand how this connection works. Toddlers have a rudimentary grasp of causality, and they consider themselves the prime movers of their universe, in a self-oriented cognitive frame of mind that Piaget famously described as "egocentric" (Piaget, 1959). Toddlers and preschoolers routinely attribute causality to juxtapositions of events that are not logically related but have meaning for them, and this meaning is often a reflection of their fears. For example, a 3-year-old boy who was the last child left in his day care center when his mother came to pick him up said to her: "I thought you forgot me." Another 3-year-old whose father was rushing around in a frenzy trying to get to work on time asked his mother: "Is daddy angry with me?" Parental behavior has such momentous import to small children that they cannot fathom its being influenced by any other reason than themselves.

The fear of losing the parent's love may be rooted in the young child's difficulty understanding that contradictory emotions can be experienced simultaneously. Toddlers are not aware of their love for the parents when angry at them, as reflected in the famous "I hate you!" that is sooner or later uttered by most toddlers and dreaded by all parents. It is only natural that toddlers assume their parent feels the same way when angry at them. The capacity for ambivalence, in the form of sustaining love while feeling hate, is a laborious undertaking that can be achieved only with practice and steady parental assistance.

Fear of body damage is represented most starkly in psychoanalytic theory by the much-maligned although persistently useful concept of castration anxiety, but it goes much beyond this circumscribed meaning. We can say that "at the beginning, there is the body" because all the affective experiences of the preverbal infant have a somatic basis. The body conveys to the emerging mind of the infant essential messages regarding its most urgent needs as well as its states of well-being.

Joyce McDougall (1992) refers to the "intimate interpenetration of psyche and soma through the bridge of affect" (p. 432). This affective bridge provides the substrate for what will become a symbolic structure to represent the somatic self. Psychosomatic integrity is based on the mother's recognition and responsiveness to the baby's body-based affective experience, a process that becomes gradually internalized by the child and is expressed in autonomous self-regulation. Conversely, psychosomatic pathology is the result of major failures and distortions in this recognition-response affective process. McDougall points out that language vividly reveals the somatic roots of emotion, particularly through metaphors such as "feeling crushed by events," "torn with sorrow," "stifled with rage," "heartsick with disappointment," and "stabbed" or "burned" by treachery. Feelings of strong emotion are very frightening to the young child, who experiences viscerally what adults later put at some distance by transforming it into metaphors.

The normative fear of body damage is likely to gain intensity from at least four sources, each of which might become particularly salient depending on the child's individual experience but all of which contribute to the child's body experience both in its pleasures and in its fears. The first source is the overpowering nature of body sensations, graphically described by Erik Erikson (1950) as "the rages of teething, the tantrums of muscular and anal impotence, the failures of falling" (p. 79) but including also the gratification of pleasurable skin, oral, anal, and genital sensations. The second source is the small child's inability to understand the nature of such diverse and highly charged bodily phenomena as urine and feces coming out of the body and hair and nails being cut. The third source is the awareness of pain in the self and others through falls, cuts, illnesses, accidents, and the myriad assaults to body integrity in the course of everyday life, including seeing children and adults with handicaps of one kind or another. The fourth source is infantile sexuality, which includes the child's absorption in bodily sensations as well as the child's effort to make sense of such mysteries as why boys and girls have different genitalia, why the genitals of mothers and fathers are different from the child's, how babies come out of the mother's body, who puts them there in the first place, and whether children of both sexes can get pregnant and give birth.

All of these areas are colored by the child's sense of self as being good or bad, loved or unloved, accepted or rejected. How parents respond to the child's curiosity about the body and sexuality affects how children think of themselves, their freedom to explore, and their guilt and shame about what they think and feel. Attitudes toward the body are shaped in part by the overlap of the primordial anxieties about abandonment, loss of love, body damage, and being bad which

lead to the formation of conflicted and conflict-free areas of functioning (Hartmann, 1939).

The fear of being bad is also known as fear of losing self-esteem or fear of superego condemnation, and it signals the young child's progressive internalization of social standards of right and wrong in the form of an emerging moral conscience. Jerome Kagan (1981) has shown that 2-year-olds cry or become upset when they are unable to perform a difficult task if they believe that they are not meeting the expectations of an adult observer. Conversely, the same children show spontaneous joy when they meet a self-imposed standard, such as solving a difficult puzzle or building a six-block tower. Forming and maintaining a moral conscience is a protracted process, with many inconsistencies between self-image, expectations, and actual behavior. It is common to observe toddlers telling themselves "no!" or "bad!" while performing the very same action they are reproaching themselves for. Between 3 and 4 years of age, children begin to feel remorse not only for their actions but also for their feelings of aggression, which they believe make bad things happen. Children of this age blame themselves for events over which they have no control, including marital quarrels and parents' bad moods, illnesses, and even death. The magical quality of their reasoning leads them to attribute to their thoughts, feelings, and fantasies the power to become reality. This might be the origin of the fear of monsters, witches, and wild animals lurking in the dark of the child's room that is so prevalent during this developmental stage.

The anxieties of infancy and early childhood cannot be articulated in words but are enacted in behavior that may seem incomprehensible and irrational from the adults' point of view. The parents may misinterpret expressions of fear as manipulation, disobedience, or bad manners, and they may respond punitively in ways that perpetuate the unwanted behavior. The role of treatment providers is to translate the child's behavioral language into words so that the parent can understand the child's inner life and there can be better emotional communication between the child and the parents. The example that follows illustrates the treatment of a perturbation that originated in the overlap between the child's fear of body damage, fear of being bad, and maternal angry response to the child's behavior.

Example: Maysa and the Tiger

Maysha, age 3 years, 4 months, was brought to treatment by her parents at her day care teacher's suggestion because she had been waking up screaming several times during the night, insisting that there was a tiger

under her bed. Maysha had also become intensely afraid of the dark and was irritable, prone to crying, and aggressive with peers during the day. This behavior had started approximately 2 months earlier and it showed no signs of abating, although some days and nights were calmer than others. Maysha's mother and father were exhausted from lack of sleep, worried about their daughter's condition, and eager for help.

The Parents' Perception of the Problem

The initial session took place with the parents alone in order to learn about the parents' perception of the situation, Maysha's developmental history, the parents' functioning and background, and the family's circumstances. Mr. and Mrs. Lester were a middle-class, college-educated African American couple in their late 20s. Both of them worked in white-collar occupations and were reasonably satisfied with their jobs, their financial situation, and their marriage. They had been married for 5 years and had fallen in love "at first sight" when they met at a church function. Mrs. Lester reported laughingly that their grandmothers had known each other since childhood and had always wanted them to meet, but they had wanted to find their own soulmates without family interference and declined their respective grandmothers' urgings to go on a blind date together. Both parents were clearly pleased by the unexpected success of their grandmothers' plans. The pregnancy had been planned and welcomed. Maysha was the first grandchild on both sides of the family, and the Lesters reported feeling blessed by the amount of support that they had in raising their child. Maysha had been attending the same neighborhood day care center since she was 6 months old and the mother had returned to work. They reported no developmental or behavioral difficulties until the problem that had brought them in for treatment.

When asked about their perceptions of Maysha's behavior, the tone of the exchanges became noticeably awkward, and each parent urged the other to take the lead. Sensing their discomfort, the clinician sought to reassure them by explaining that preschoolers often show the kind of behavior that Maysha was displaying, and added lightly that parents seldom found this reassuring because it is so hard to live with a child who woke up at night, was afraid of wild animals that did not exist, and was aggressive at school. The parents looked relieved, and the clinician went on to ask how they had already tried to change Maysha's behavior. They reported the usual range of behaviors that well-meaning parents usually employ in similar circumstances: saying a prayer before going to bed, asking Jesus to protect her, looking under Maysha's bed and in her closet to show her that there was no tiger lurking in her room, leaving

a night light on in the hallway next to her room, and talking to her reassuringly from their bedroom when she woke up during the night. When none of this helped, one of the parents came into her room for a few minutes, spoke reassuringly while patting her, and told her to go back to sleep. They then let her cry herself to sleep.

This set of strategies seemed like a textbook description of how to intervene, and when the clinician commented on this, the mother reported that she was an avid reader of childrearing books and had “done her homework” in trying to help Maysha during this difficult period. Nothing seemed to work, however, and the parents felt they needed outside help because they were beginning to worry that there was something really wrong with their child.

When the clinician asked what “really wrong” might mean, the earlier awkwardness returned. There was a long silence. The clinician asked if they worried that someone had hurt Maysha. The mother said, reluctantly: “Well, you hear so much about children being sexually abused in day care. There is a male teacher, and although he seems really nice, you never know.” The clinician asked if they had seen anything inappropriate in the teacher’s behavior, and both parents said they had not. The children at the day care center seemed to like him and the parents could detect no difference in the ways Maysha spoke about him and about the female teacher when she came home from school.

Maysha’s Concerns

The next session involved Maysha and both parents and took place in the office playroom. Maysha was a dainty little girl, dressed in a velvety pink sweater with hearts and wearing glittery pink shoes. The clinician had provided a range of age-appropriate toys that included African American mother, father, and daughter dolls; a baby doll with a bottle; a furnished doll house; a kitchen set; and a set of farm animals and wild animals. She told Maysha that her mom and dad had brought her because the clinician was a lady who helped children when they were scared and angry, and Maysha’s parents had told her that Maysha was afraid of a tiger under her bed, could not sleep at night, and was angry with her friends at day care.

While seeming to ignore the clinician’s explanation, Maysha was busy examining each of the toys and then carefully putting them back in their place before examining the next one. She then sat on the floor, sighed, and looked at her mother as if asking: “What next?” The same question seemed to be in everyone’s mind, because the parents looked at the clinician in a silent search for guidance. The clinician sat on the floor facing Maysha and said: “You can do whatever you want here. All these things are here for you.”

Without saying a word (she had not spoken since she had first come in), Maysha looked around and then, without hesitation, went to the baby doll, looked at it, and started undressing it. When she got to the underwear, she struggled with it briefly and then gave it to her mother, saying: "Take it off." Mrs. Lester complied. Maysha looked intently at the doll's genital area, which was indistinctive, and after some hesitation fingered it gingerly. She then said to her mother, very seriously: "Put her clothes on." She had clearly thought of the doll as female, but it was unclear whether this was because she attributed her own sex to the doll or because of the absence of male genitals. Maysha watched soberly as her mother dressed the doll, went to the family of dolls, and systematically undressed each of them, looking intently in their genital area. The clinician said: "I think you are trying to see the difference between girls and boys." Maysha nodded in agreement without looking up and continued manipulating the dolls. The clinician continued: "Maybe you saw boys and girls peeing and pooping in your school." Maysha nodded again, this time looking at the clinician, who said: "They are very different, aren't they? Boys and girls don't look the same where they pee."

The parents were listening attentively and exchanging glances with each other. The clinician said: "Your mom and dad did not know that you want to find out about boys and girls." Taking this cue, the mother said a little awkwardly but with much clarity: "These dolls are just pretend. They are not made like boys and girls. Boys have penises and girls have vaginas." Perking up, Maysha asked: "Do I have a penis?" The mother answered that she did not have a penis because she was not a boy, but she had a vagina because she was a girl. Maysha hit the mother's arm and said grumpily: "But I want a penis!"

This response took everyone by surprise. Mrs. Lester later told the clinician that, on the basis of her reading, she had expected questions about sex differences to emerge at some point. She had been preparing herself to answer questions about who had a penis and who had a vagina, but she was totally taken aback by Maysha's circumventing of this plan with her plaintive disagreement with how things were. In the silence that followed, Maysha looked around the room, took the giraffe from among the wild animal set, and put it between her legs. "I have a penis!," she announced.

The parents looked pained and worried. The clinician said: "You can play that you have a penis. Penises don't come off like that giraffe. Girls never have real penises and boys never have real vaginas, but they can pretend that they do." Maysha jumped all around the room holding the giraffe in place and saying: "I have a penis, I have a penis!" She then stopped in front of her father and said: "Do you have a penis?" Mr. Lester answered "Uh-uh." Maysha said: "Can I see it?" Mrs. Lester

came to her husband's rescue, saying: "No, sweetie, that is private." Maysha put the giraffe down, sat on the floor, and started trying to dress the dolls, asking her mother for help. At the end of the session, on saying goodbye, the clinician said to Maysha: "You learned something really important today. You can ask your mom and dad for help to remember it." She then suggested that the parents call her to discuss over the phone what had transpired.

During the telephone conversation, the mother expressed amazement at Maysha's clear distress over not having a penis. She said that the parents had tried to pursue the topic of sex differences on the way home, but Maysha was not interested. The clinician suggested that Maysha might have had enough of the topic for the time being, and that she might bring it up again spontaneously when she was ready. In the meantime, the parents could observe her behavior to see what they could learn from it.

Before the following session, Mrs. Lester called to inform the clinician that in the intervening week Maysha had insisted on watching when her father went to the bathroom, something that was against the parents' values and he refused to allow. The clinician supported this stance, explaining that there were different ways of teaching children about sex differences and that it was important to do it in a way that felt right to the parents. The mother also reported that Maysha had continued to place small objects between her legs and declaring that she had a penis. At school, she had asked her friend Joshua if she could look at his penis when he peed, causing much embarrassment to Joshua and some hilarity in the children who heard her request. The teacher took this opportunity to tell the class matter-of-factly about the differences between boys and girls, an explanation that was followed by the expectable series of questions about who had a penis and who had a vagina. Maysha did not participate but listened silently to this exchange.

For the next session, the clinician provided two anatomically correct dolls, a boy and a girl. When Maysha arrived, she went immediately to them and proceeded to undress them. She put the two naked dolls side by side, and looked systematically from one to the other. She said to her mother: "Why doesn't she have a penis?," pointing to the female doll. "Because she is a girl," said the mother. "Girls have vaginas so that babies can grow inside them when they are ready to be mommies." Maysha answered decisively: "Boys can have babies too growing inside them." The mother answered: "No, they can't. If they have a penis, they can't have babies inside them because they don't have room." Maysha asked: "Will I have room?" The mother answered: "Yes, you will. You are made inside so that there will be room for a baby when you grow up." The mother then spontaneously took a pen from her purse, asked

the clinician for some paper, and drew a boy and girl with the appropriate genitals. She then sang Fred Rogers's song about "girls are fancy on the inside, boys are fancy on the outside," which she had learned while growing up.

The Outcome

After this session, Maysha's behavior took a dramatic turn for the better. Her fear of the tiger diminished to the point that a cursory look under the bed was now enough to satisfy her that it wasn't there. She continued waking up once or twice during the night but went back to sleep by herself with minimal parental intervention. Her aggression in school declined markedly. She continued showing interest in pregnancy and in sex differences, but she no longer tried to go into the bathroom with her father and did not ask Joshua to watch him when he went to the bathroom. In follow-up telephone calls the next week and in the following 2 months, the mother reported that Maysha often had her hands on her genitals and looked dreamy while riding in the car, watching TV, or being told a story, and she liked to soap herself thoroughly between her legs when taking a bath. Occasionally she put a small object next to her vulva and tried to urinate standing up, but disliked having urine running down her leg and quickly sat down again. A few times she hid a doll under her shirt and said to her mother: "I am having a baby." These behaviors were taken in stride by the parents as a manifestation of Maysha's ongoing effort to learn about the sensations and possibilities associated with being a girl.

The parents' support during this process was pivotal in the resolution of the child's perturbation. The anticipatory reading that the mother had done about children's discovery of sex differences had helped her to answer Maysha's questions appropriately during the initial session. It was particularly noteworthy that she was able to use the adult words for the male and female genitals rather than resorting to colloquialisms, something that she attributed to the books that she read. In spite of this excellent preparation, the mother needed some help in retaining her flexibility and emotional balance to cope with the child's unexpected initial rejection of her gender status. Maysha's disappointment about not having a penis could well have become more persistent with a less supportive response from her parents and her teacher. The father's firm stance in preserving his privacy according to his values conveyed to Maysha a clear message about what was appropriate and was not appropriate in her family. The mother's drawing of a boy and a girl gave the child an appropriate channel to symbolize her curiosity without overstimula-

tion, so that Maysha no longer showed interest in watching her father or other boys in her day care center. The quick resolution of what had been a protracted behavior problem indicates how important it is to identify accurately the source of a child's difficulties and to respond with a combination of developmental guidance and emotional support.

The cultural differences in background between these African American parents and the Asian-born clinician did not interfere with their smooth communication. The parents asked casually about the origin of the clinician's accent in the second session. The clinician answered factually and asked whether their different backgrounds might make it more difficult for them to talk with her about their concerns. The mother replied that their pediatrician was Asian and that they were used to people of different backgrounds. The clinician invited the parents to let her know if they found that she did not understand their point of view for whatever reason, including having a different cultural perspective, and they agreed to do so. The topic did not come up again. This exchange illustrates the usefulness of addressing cultural differences as an integral component of all interventions, without waiting until the issue raises a communication problem but without making it a central topic unless this is clinically indicated.

The Role of External Events in Perturbations

Children respond to environmental events with a range of responses that are influenced by the nature and magnitude of the event, the child's individual characteristics and developmental stage, and the supports available from the parents and other significant people. Responses to environmental changes run the gamut of children's behavioral, social, and emotional problems. Temporary regressions in developmental milestones are frequent responses to environmental changes, and they include reverting to baby talk in children who were speaking at age-appropriate levels, wanting to nurse in children who had been successfully weaned, and regressions in toilet training. Mood changes and changes in biological rhythms are also a common response, with the child becoming subdued and withdrawn, losing appetite, or developing sleep problems. Other manifestations are temper tantrums, increased aggression, and oppositional behavior.

DC:0-3R includes a diagnostic category labeled adjustment disorder for mild, transient situational disturbances that last no longer than 4 months and are clearly tied to environmental changes or events, such as a family move, a change of caregiver, the mother's return to work, an illness in the family, or the birth of a sibling (Zero to Three: National

Center for Infants, Toddlers, and Families, 2005). Events that from the adult's point of view seem quite ordinary may represent a major source of worry or distress for a child. For this reason, it is imperative to ask very specific questions about any changes in the child's or the family's life when a child is referred. Seemingly minor changes might affect the meaning that the child attributes to people and routines and lead to major disruptions in the child's sense of safety and predictability.

The intensity and duration of the perturbation usually increase when the environmental change coincides with a developmental touch-point that makes the child particularly vulnerable to additional stress. When the child is undergoing such a transition, it is preferable if at all possible to postpone changes that will disrupt the child's daily routine. For example, if the child is at the height of separation anxiety it is better to wait until it subsides to institute a change in caregiving routines. Toilet training is best postponed if the child is in the midst of an intensely negativistic period. The time spent waiting for a more propitious timing will be recouped by a faster and smoother child adjustment to the new situation.

Interventions that target perturbations caused by environmental changes need to be tailored to the specific characteristics of the event, but their intent is similar to interventions for perturbations resulting from maturational changes. Both situations involve efforts to improve the child's self-regulation and developmental progress. Children can be helped to negotiate transitions by (1) familiarizing them gradually with the new environment and new caregivers before a major change takes place, (2) giving them transitional objects that will create a bridge between the familiar setting and the new situation, and (3) incorporating familiar routines into the new situation. For children who are beginning to use language and symbolic play, speaking to them about the changes, giving them a chance to express their reactions through play, and helping them to put their feelings into words are time-tested methods of helping children navigate challenging transitions.

CHAPTER 6



Ghosts and Angels in the Nursery Treating Disturbances and Disorders

Disturbances and disorders occur when environmental stresses and individual vulnerabilities overwhelm the self-righting tendencies of the child's development. Compared to perturbations, disturbances and disorders are more pervasive and more entrenched. They put the child's development and the parent-child relationship at risk in multiple domains. It is often difficult to ascertain when a disturbance becomes a disorder. We use the presence or absence of a diagnosis as a pragmatic dividing line between these two conditions. Whereas disorders meet full symptom criteria for a mental health diagnosis, disturbances refer to conditions in which functioning is substantially affected but symptoms fall short of diagnostic criteria. This differentiation is often clinically arbitrary because children's symptoms can interfere significantly with their developmental progress and daily life even when their symptoms are not numerous or severe enough to meet criteria for a formal psychiatric diagnosis (Carrión, 2006). In this chapter we discuss intervention with children who show mental health disturbances and disorders following exposure to stressful and traumatic events.

Where to Begin: Addressing Stress and Trauma

Psychodynamic treatment has traditionally relied on free association to identify those areas of conflict that become the targets of the intervention. Clinicians working within this framework often wait to address an adverse event in the child's life until the child brings it up spontaneously through play, language, or other means. The rationale is that children will reveal what is ailing them at their own pace when they trust the therapeutic process and their own capacity to tolerate the feelings that emerge in the telling. Waiting for the child to disclose an event decreases the risk of child avoidance and resistance to treatment. The message that the child's inner rhythm is being respected is a valuable gift that should not be jeopardized in the pressure for quick and effective cures.

This unstructured approach calls for modifications when the parent or child has experienced a highly stressful or traumatic experience. Avoidance of traumatic reminders is a primary feature of posttraumatic responses which may be exacerbated when the clinician mirrors parental and child behavior by not mentioning the trauma. When the client(s) and the clinician defer to each other to take the initiative in naming what happened, the silence may be misunderstood as saying that speaking about the traumatic event is not permissible or that the event is too terrible to name. There is clinical and research evidence that addressing the traumatic stressor directly is more effective than waiting for the parent or the child to bring it up (Cohen & Mannarino, 1996; Cohen et al., 2006; Lieberman, Van Horn, & Ghosh Ippen, 2005; Lieberman et al., 2006).

Traumatized parents often express relief when the clinician asks specific questions about the stress or trauma, and many of them say that they were afraid or ashamed to speak about what happened before they were invited to do so. Children often respond similarly. Two anecdotal examples stand out. A 10-year-old had been in treatment for several months before her clinician gathered the courage to ask about the physical abuse her stepmother had inflicted on her. The child responded: "What took you so long?" The second example involves an 8-year-old boy who had been in treatment for almost 1 year before his therapist asked him about his father's death. After engaging the therapist in a moving play sequence that reenacted how he had found his father's body, the child seemed visibly relieved and asked sweetly, at the end of the session: "Why didn't we do this a long time ago?" These older children were speaking for many others who might not be capable of articulating their longing to speak about the reasons for their suffering.

Not speaking may shut off the opportunity for healing. A 7-year-old girl gave eloquent if tardy expression to the anguish of keeping

secrets. This child was referred for individual psychotherapy because she had a phobia of people with disabilities and people in wheelchairs. The daughter of a prominent surgeon, the girl was afraid of going out and responded by hiding and trying to run away when she saw somebody with these conditions. Her father was opposed to the treatment and refused to participate in collateral sessions. During the assessment, the child's mother reported that this was the child's only symptom and that there were no environmental stressors that could account for it. After 4 months of weekly psychotherapy characterized by mechanical, unimaginative play that did not match this child's intelligence and school performance, the father terminated treatment because the child showed no symptom improvement. After saying goodbye during the last session, the child turned to the therapist while standing at the door and said softly: "My dad told me not to tell you what happens at home." Then she walked out, leaving the clinician with a chronic regret about not having addressed the symptom more directly in the context of eliciting the child's perception of her family life.

The aversion to speak about trauma is a well-known phenomenon that is routinely reinforced by the adults' failure to notice and their readiness to dismiss children's distress. Among abused and maltreated children, the taboo on speaking is compounded by the abuser's threats of terrible consequences if the child reveals what occurred. When the clinician does not discuss a traumatic occurrence, the child may conclude that the event is a forbidden topic and may hold on to the secret knowledge, wavering between fear of talking and hope that the clinician will signal permission to speak about the unspeakable.

The worry that their clients will be traumatized by speaking about the event is often mentioned by clinicians as a reason for not bringing it up. This attitude represents a misconception of the psychological processes involved in coping with trauma that is consciously remembered rather than repressed. Much of the shame, guilt, and fear associated with consciously remembered traumatic events stem from three sources: (1) being blamed directly or blaming oneself as being the cause of the trauma ("you are bad"; "it's my fault that it happened"), (2) being threatened with bad consequences if one speaks up, as is often the case in physical and sexual abuse, and (3) fear that speaking will trigger the same intolerably intense bodily and emotional responses that took place during the trauma. In this context, the therapist's silence may be perceived through the filter of a pathogenic belief system that is left intact when the therapist fails to address it. Speaking about trauma is not traumatizing if the therapist helps the person remain attuned to bodily sensations and affects that signal incipient emotional dysregulation and takes steps to promote mastery through self-regulation. The

message should be that the therapist will actively help in coping with overwhelming affect.

Talking about secrets is a component of all therapies, but it is also important not to convert pain and conflict into the sole focus of clinical attention. On the contrary, assisting the parent and child to remember moments of comforting intimacy in the past and create such moments in the present fosters their emotional health. Love and pleasure have vitalizing effects that fight off depression, anxiety, and despair. Summoning the “angels in the nursery” to counterbalance the destructive impact of the “ghosts” can invigorate the parent and the child by expanding their sense of possibility about themselves, each other, and their relationship (Lieberman, Padrón, Van Horn, & Harris, 2005).

Telling the Child about the Reason for Treatment

It is important to explain to children the reason for the treatment when their receptive language is good enough to make this communication meaningful. Clinicians build a spirit of collaboration when they discuss with the parent how to phrase this explanation because parents often feel awkward talking with their children about feelings or family problems but gain confidence in doing so with the therapist’s support. When the parent tells the child about the reason for treatment before the first session, the therapist can build on the parent’s explanation to give the child a sense that the adults are working together to make things better.

It is customary in individual child psychotherapy to frame treatment as a place to talk about feelings. When the child’s symptoms are linked to stress and trauma, connecting the child’s problems to the event gives the child and the parent the message that the difficult feelings have meaning and the trauma can be addressed. John Bowlby (1988) described the internal dilemma of children who “know what they are not supposed to know and feel what they are not supposed to feel.” These children must resort to damaging defensive maneuvers to preserve their understanding of what they witnessed while complying with adult expectations of not knowing. There is evidence that the early years may be a pivotal stage for the onset and consolidation of dissociation among maltreated preschoolers (MacFie, Cicchetti, & Toth, 2001). The therapist’s openness can serve a preventive function by conveying to children that they are allowed to know what they know and feel what they feel. It is equally important, however, to be tactful in addressing painful topics. Therapists need to pace their timing for speaking about the trauma in response to the child’s and caregiver’s capacity to listen, as illustrated below.

*Example: A Child Who Knows
What She Is Not Supposed to Know*

Gwen, 5 years old, was referred to treatment by her pediatrician after the child walked into her mother's bedroom and found her dead, hanging from the ceiling by a long scarf that Gwen and her aunt had bought together as the mother's Christmas present. Gwen's aunt, who was raising her, insisted during the assessment that Gwen was too young to understand what she saw and had thought that her mother was sleeping. The therapist tried without success to persuade the aunt that Gwen's outbursts of anger and refusal to speak about her dead mother suggested that Gwen understood that her mother had killed herself. The aunt responded that Gwen was "just like her mother" in her outbursts of anger, and she refused to discuss the mother's suicide with the child.

Faced with this impasse, the therapist suggested a compromise. She told the aunt that Gwen needed to be told right away that her mother was dead rather than sleeping but agreed to a "wait and see" attitude about addressing how the mother died. During a visit to Gwen's school to observe her behavior, the clinician heard Gwen tell another child: "I am too sad because my mommy killed herself." This stark statement enabled the aunt to bring the mother's suicide into the CPP sessions and, gradually, into her conversations with the child outside the sessions.

The pressure to soften the terrible features of a traumatic event is an ever-present internal reality even for clinicians who conscientiously attempt to address them. During a session with Gwen and her aunt, the therapist found herself saying to the child: "Your aunt is also very sad that your mommy died." Gwen threw a toy at the clinician while screaming: "My mother did not die! My mother killed herself!" The therapist instantly realized that the child was struggling with the horrifying knowledge that her mother did not love her enough to live for her. She apologized for making a mistake and confirmed that Gwen was right in knowing that her mother had killed herself and now was dead. The aunt burst into tears. Gwen leaned against her and asked: "Why did she use our scarf?" The aunt was taken aback for a moment and then answered: "I think she did not know that she would really die." The child's question opened another area of intervention: Gwen's guilt that her gift had killed her mother. She harbored the tormenting worry that the mother killed herself with the scarf to punish Gwen for being bad.

First sessions often set up the stage for the salient issues that will be addressed as treatment unfolds. Telling a child about the reasons for treatment may evoke a variety of responses that are an initial indication of the child's coping style and defense mechanisms and of the parent's

capacity to collaborate in the treatment. The following two examples illustrate some of these possibilities and the therapist's response.

Example: Controllingness to Manage Chaos

Jeanine, age 3, was brought to treatment by her mother after her father left the family because of methamphetamine abuse that resulted in frequent outbursts of verbal abuse and physical violence. The mother reported during the assessment that she was using some alcohol and marijuana every day to cope with her depression but declined the clinician's recommendation of substance abuse treatment. She reported that Jeanine was bossy and aggressive toward her and insisted on always being in charge. During the first treatment session, the therapist said to Jeanine: "Your mom told me that you and she are sad that your dad left, and she wants help to make things better." Jeanine responded by hitting a doll repeatedly against the back of her chair. The therapist said: "There was a lot of fighting and it was scary." Jeanine answered: "I am the boss," and she proceeded to tell the mother and the therapist how to play with the toys. In the initial phase of treatment, the child held a rigid stance of being in charge of the sessions.

Jeanine's initial response of hitting a doll against the chair gave the therapist an inkling of Jeanine's fear of chaos and body damage unless she directed what was happening, including her mother's and the therapist's behavior. This understanding guided the course of treatment. The therapist focused sequentially on helping Jeanine and her mother pay attention to what they were feeling, give names to their feelings, and understand that their distancing, avoidance, and controlling behaviors were efforts to avoid emotional disorganization, sadness, and destructive anger. At the end of a 6-month treatment, Jeanine announced: "I am not the boss anymore. We don't need bosses." The mother reported that she and Jeanine often spoke at home about their different feelings about the father, including missing him but also being afraid of him when he got angry. Jeanine became capable of richer symbolic play. Although she still tended to take the role of the protector in her play, she became much less controlling and less punitive toward her mother, showed physical affection, and allowed the mother to take care of her.

Example: Relief That the Truth Can Be Told

Aldo, age 2 years, 6 months, came to treatment with his mother following a court order because he had witnessed severe fighting between his

parents before his father was deported for being in the country illegally. Aldo started biting himself and his mother following the father's departure. The therapist told him: "You want your daddy back." Aldo came closer to the clinician and said: "I cry." The therapist responded: "You miss your daddy and you are sad. Your mom wants to help you." The mother said: "I didn't know he knows so much." The initial course of treatment involved repeated enactment by Aldo of fighting between the toy animals. This play was followed invariably by one of the animals being thrown out. The mother witnessed the play with a mixture of consternation, shame, and amazement that her child had been so aware of the parents' violence.

How Treatment Unfolds: A Case Illustration

Most life trajectories, whether involving clinical problems or not, have a treatment "terminable and interminable" quality (Freud, 1937/1959a). Polarities of satisfaction or frustration, pain or joy, or resignation or recovery may prevail at any time during the individual's lifespan and appear to color the whole of it. A snapshot of individual functioning at the end of treatment or at follow-up some time later can be deceptive because of the nonlinear nature of development and because temporary external circumstances may have a transitory impact on the person's functioning and self-report. In the rest of this chapter, we use a case example to elucidate some of the clinical mechanisms involved in creating positive change and to illustrate the fluctuations of functioning even after clinical improvement.

Ethan, age 3 years, 4 months, was referred for treatment by his child care provider because his aggression in the classroom had reached such high levels that he was suspended from his day care center and was on the verge of expulsion. He routinely hit and bit his teacher and other children and often refused to comply with the teacher's requests or with the classroom routine. The expulsion threat followed an episode in which Ethan threw a chair through the closed classroom window in a fit of rage when the teacher tried to enforce a "time out," shattering the window and terrifying his teachers and his peers. Ethan had been attending the same day care center since he was 30 months old. The child care provider stated that although Ethan had always been difficult to contain and redirect, his behavior had become increasingly more unruly since his parents' separation. It was a positive indication of the parents' ability to cooperate with each other on behalf of their child that they both agreed to the referral and came together to the first assessment session.

The Assessment Process

The assessment period involved Ethan, his mother, Mrs. Allen (age 34), and his father, Mr. Khalid (age 29). Ethan's mother and father separated when Ethan was 3 years old and divorced shortly afterward. The parents shared legal and physical custody, with Ethan spending alternate weeks with his mother and with his father. This arrangement was preceded by a protracted custody dispute because Ethan's mother initially wanted the child to spend more time with her than with his father. She reported being very upset at first by the court's decision to grant equal access to both parents but acknowledged becoming more accepting over time because of Ethan's evident love for his father. However, she was very upset about Ethan's aggression toward her when he returned from a week with his father. Mrs. Allen reported that for a day or two following his return Ethan called her a "pig," hit and kicked her, and screamed "I hate you!" for minor frustrations.

The Mother's Point of View

Mrs. Allen attributed her son's behavior to his imitation of Mr. Khalid, whom she described as becoming aggressive during their marriage when he drank during the weekends to relieve the stress of long work hours as a computer programmer. Mrs. Allen reported that after drinking, Mr. Khalid often threw things in fits of rage and repeatedly pushed her against the wall and slapped her in front of Ethan. Once, when he was very drunk, he banged her head against the wall. She called the police, and Mr. Khalid was handcuffed and spent the night in jail. Mrs. Allen had not been aware of Ethan's presence during this incident, but she found him afterward cowering under the dining room table. Ethan was 33 months old at the time. This violent episode was followed by a tearful reconciliation, in which Mrs. Allen apologized for ridiculing Mr. Khalid's traditional view of gender relationships and Mr. Khalid swore that he remembered nothing of what he had done and promised to stop drinking. He had followed his promise, but Mrs. Allen found that she could not feel close to Mr. Khalid again and filed for divorce a year later. Mrs. Allen reported that Mr. Khalid bitterly opposed the divorce, a response that surprised her because he was humiliated by his jail experience and blamed her for it. She interpreted Ethan's repeated accusations to her that "you made daddy go!" as an indication that Mr. Khalid told Ethan that the divorce was her fault.

In her self-descriptions, Mrs. Allen presented an idealized view of herself and her childhood. She described her childhood as uneventful, with loving parents and harmonious family relationships among the

parents and their three children, of whom she was the youngest. She was unaware of psychological complexity and seemed puzzled by questions about feelings or internal experiences. Good behavior and good manners were important to her, and she expressed being ashamed of having married Mr. Khalid, whom she described as a “brute.”

The life stressors listed by Mrs. Allen were domestic violence and not having full-time custody of her child. She did not identify any childhood stressors. When asked whether she remembered episodes in her childhood when she felt completely loved and accepted, she described how her mother said a prayer with her every night as she put her to bed, making her feel that the mother knew how to speak to God on her behalf so that she would be happy and safe.

The Father's Point of View

Mr. Khalid denied any aggression during the marriage, in marked contrast to Mrs. Allen's description. He explained that, “like any couple,” he and Mrs. Allen had arguments where they raised their voices but never engaged in physical aggression. He tearfully confessed that he considered the divorce the worst failure of his life. He felt used by Mrs. Allen to get pregnant before her “biological clock ran out” and to be supported during the first years of Ethan's life, and thought that Mrs. Allen “discarded” him after she felt ready to go back to work as a financial analyst when Ethan turned 3. Born in France from Algerian Moslem parents, Mr. Khalid felt a keen sense of cultural estrangement both at work and in his relationship with Mrs. Allen, saying that people in the United States place no value in family ties, use each other for short-term gains, and are incapable of lasting commitments. He denied that Ethan had any problems when staying with him and said that he had “no idea” why Ethan would be so aggressive at day care and with the mother. Mr. Khalid also denied having a drinking problem, stating forcefully that his religion forbade the use of alcohol and that although he was not observant and was influenced by the mores of his native France in this regard, he usually drank no more than a few glasses of wine or a couple of beers to relax over the weekend. He admitted that he had drunk more than usual before the episode that landed him in jail, but any regret over his behavior was overshadowed by his indignation that his own wife had called the police and that he had been jailed, in his words, “like a good-for-nothing hoodlum.”

The stressors described by Mr. Khalid consisted of immigrating to the United States, spending the night in jail, his divorce, and not having full-time access to his child. When asked about childhood experiences of feeling loved, Mr. Khalid described smelling his mother's long hair as

she held him on his lap and read him books when he was a small child. He commented: "I could have stayed on her lap forever." He went on to say: "But my father always came and asked for something to eat or scolded her for spoiling me. I always got so frightened when I heard him at the door." When asked about his fear, however, he denied there was any reason for it other than his resentment at the father's intrusion into the close times with his mother.

Child Functioning

Ethan was a child with many facets. His language skills were well developed, often making him appear older than his age when he spoke. This impression was reinforced by his poised and polite demeanor. The therapist found herself wondering whether the descriptions of Ethan's aggression by his mother and child care provider had been overdrawn. The assessment included separate play sessions of Ethan with his mother and father. These sessions took place on different days and were videotaped, reviewed, and scored as part of the process of arriving at a treatment plan. The play situations seemed models of appropriate child-parent interaction, with each of the parents engaging Ethan in warm and responsive ways. During the separation episode with each parent, Ethan entertained himself calmly, although he went to the door for a few seconds and seemed to listen for the parent to return. When the father reentered the room, Ethan looked at him and asked: "Where you go?" The father responded that he was talking to the assessor, and then father and child resumed their play.

The reunion with Mrs. Allen showed more physical contact. Ethan greeted his mother happily and then came close, leaning casually on her while showing her a toy and asking how it worked. These behaviors suggested that Ethan trusted that his parents would be consistently available to him at least during brief separations, a basic dimension of early secure attachment. This was an impressive strength of the child's relationship with both parents in the face of the weeklong separations from each of them that he had to endure on an ongoing basis.

The costly nature of Ethan's positive adaptations emerged more clearly during the toy clean-up portion of the assessment. In the session with his father, Ethan complied at first with the father's request to put the toys away, but midway through the task he became distracted, started playing with a particularly appealing dinosaur, and then resisted his father's entreaties to finish putting the toys away by saying tearfully that he did not want to leave. Mr. Khalid's solution consisted of telling Ethan that they would come back and he would play with the toys the following week, and then guided Ethan's hand in putting the toys

in the basket. Ethan grudgingly went along with his father's strategy. Mr. Khalid's gentle authoritativeness and his resourcefulness in solving the potential conflict with his son were welcome indications that he was capable of appropriate parenting behavior.

The clean-up episode between Ethan and his mother went less smoothly. Ethan refused to put the toys away, the mother pleaded with him to do so, and Ethan ignored her and continued playing. This sequence of maternal request–child refusal–maternal entreaty–child ignoring went on for about 6 minutes and ended abruptly when Mrs. Allen screamed in a frightening voice: “Do it!” Her outburst shook Ethan, who visibly flinched and wordlessly put the toys away while Mrs. Allen glared at him. Mrs. Allen's quick alternation between helplessness and rage was in sharp contrast with her self-description as being only the recipient of anger and her denial of experiencing anger herself. Mrs. Allen seemed unable to find a satisfactory balance between helplessness and rage, and this failure led to repeated impasses where mother and child were unable to find a way of bridging their competing wishes. However, we considered it a good indicator of Ethan's emerging social skills that he did not become aggressive with her in the still unfamiliar setting of the clinic's playroom. The variety of behaviors and affects during the assessment illustrate the importance of observing the child over time and in a variety of contexts in order to gather accurate information about the range of strengths and vulnerabilities in the child's functioning.

Ethan's cognitive performance in the Wechsler Preschool and Primary Scale of Intelligence (WPPSI) showed a marked discrepancy between his verbal score, which was almost 1 standard deviation above the mean, and his performance score, which was 5 points below the mean. A review of the videotaped administration of the test revealed that Ethan was frequently distracted by environmental noises and gave up easily on performance items that he did not know immediately. The presence of intrusive thoughts was apparent when he was asked about the function of the knife during one of the subtests. Instead of answering, he looked worried and said: “My mom and dad fight.” He then looked away and it took some coaxing to help him refocus on the test.

Case Formulation

The assessment raised the hypothesis that Ethan's aggression toward his mother and at child care was a manifestation of his identification with his father's reported aggression and with his mother's outbursts of unmodulated anger, which had emerged unexpectedly during the toy cleanup. Ethan's aggression could best be understood as an effort to fend

off danger to himself by adopting the feared characteristics of his parents. Ethan's readiness to follow Mr. Khalid's directives during the toy cleanup raised the possibility that he was afraid of his father's violence, while his anger at the father was diverted toward the safer targets represented by his mother, his teachers, and his peers. We also hypothesized that Ethan might be learning from his father's example that his mother and other women should be treated with violence and contempt.

Both parents reported that Ethan insisted on staying up late, had difficulty going to sleep, and woke up crying two or three times during the night screaming "no." This sleeping problem was an indication of the anxiety that coexisted with Ethan's aggression. The anxiety had also emerged during the cognitive testing in Ethan's association of the picture of the knife with his mother's and father's fighting. It was clear from the discrepancy between the high verbal score and the much lower performance score that Ethan's readiness to learn was being affected by his worries about his parents' fighting and about his safety.

The sleeping difficulties were the only area of Ethan's behavior where both parents had similar views. According to Mr. Khalid, Ethan did not have other behavior problems. Mrs. Allen, on the other hand, reported that Ethan became very distressed when it was time to leave her house to spend the week with his father and that he was angry and rebellious on his return, crying inconsolably, throwing himself on the floor, attacking and insulting her, calling her a "pig," and fighting off efforts to pick him up to put him in the car. She also reported that he had become less exuberant and less interested in exploring and learning since the parents' separation.

The discrepancy of the parents' reports raised the question of whether Ethan met criteria for a psychiatric diagnosis. Taken at face value, the father's report suggested that he did not. On the other hand, the mother's reports and our own observations indicated that Ethan qualified for the diagnosis of PTSD on DC:0-3R (Zero to Three: National Center for Infants, Toddlers, and Families, 2005). The criteria for making this diagnosis included *exposure to traumatic events* in the form of his repeated witnessing of domestic violence, culminating in the particularly frightening event of witnessing his father hitting his mother's head against the wall and then being handcuffed and led away by the police; *symptoms of reexperiencing the trauma*, in the forms of nightmares and extreme distress on separation as a reminder of the father being taken away by the police and the parents' divorce; *diminished interest in play and exploration*; and *increased arousal* in the form of outbursts of anger, temper tantrums, and sleeping problems. Ethan's aggression toward peers and adults could also be interpreted as an associated feature of the DC:0-3R diagnosis.

The parents' individual assessment indicated that both of them had character problems and difficulties with emotional regulation that would be challenging in effecting positive change. However, both parents' showed deep emotional investment in Ethan's well-being, were capable of loving interactions with him, and had ready access to memories of being loved and protected as children. The clinician expected that these strengths would serve as organizing influences to create similar experiences for their child.

Giving Feedback and Suggesting a Treatment Plan

Meeting jointly with the mother and the father to discuss the assessment findings, the clinician started by describing the positive aspects of Ethan's functioning and then placed these strengths in the context of his worrisome behaviors. She acknowledged the parents' different perceptions of their child and normalized their divergent reports by commenting that this was a common occurrence because children behave differently in different situations and with different people. She also emphasized that the different reports were useful as a reflection of the diverse feelings that Ethan had about himself and the world. The clinician did not mention the preliminary PTSD diagnosis because she did not believe that the diagnosis would expand the parents' understanding of their child or enhance their motivation for treatment. She highlighted instead the seriousness of Ethan's aggression, uncontrolled behavior, sleeping difficulties, and fear of the parents' fighting as indications of Ethan's need for help in feeling more secure and learning social skills that matched his cognitive potential.

The parents were receptive to this summary, although Mr. Khalid repeatedly minimized the descriptions of Ethan's anxiety and behavioral problems. The therapist recommended one weekly session involving Ethan and his mother and another weekly session involving Ethan and his father, for a total of two sessions each week. This plan was based on the premise that Ethan's fear, anger, and mistrust in his relationships with both his mother and his father were factors in his behavior problems. The recommendation meant that Ethan would see each parent in treatment during the week he spent with the other parent. The clinician thought that this would be beneficial in decreasing the compartmentalization between the two households, but both Mrs. Allen and Mr. Khalid argued that this arrangement was not workable for their schedules. The clinician agreed instead to their request for a weekly session with either the mother or the father to match Ethan's schedule with each parent. This arrangement illustrates the inevitable compromises that need to be made when there are constraints in the availability of resources, whether these involve motivation, time, or money.

Treatment Goals

The parents and clinician agreed that the primary treatment goals consisted of a reduction in Ethan's aggression toward the mother and in day care and improvement of Ethan's sleeping problems. The clinician believed that in order to achieve these goals, Mrs. Allen would need to acquire greater self-confidence in enforcing her expectations of Ethan's behavior and greater self-awareness about her oscillations between helplessness and rage, and Mr. Khalid would need to decrease his denial of his aggression during the marriage and his tendency to minimize Ethan's behavior problems. However, the parents were so defensive in response to any appearance of being criticized that she decided not to articulate these thoughts until the parents demonstrated greater comfort with the therapeutic situation and showed increased trust in the therapist's point of view.

Father's Unexpected Request: An Opportunity to Prevent Resistance to Treatment

The day after the joint feedback session, Mr. Khalid phoned to request an individual session prior to his first joint child-parent meeting. Although this was not part of the agreed-on format, the therapist sensed the importance of being receptive to Mr. Khalid's request in order to strengthen the therapeutic relationship. When he arrived, Mr. Khalid seemed nervous and spoke very quickly, mentioning that before the start of treatment he wanted to make sure that there would be no "stereotypes" or "labels." When the clinician asked him to explain, Mr. Khalid replied that he was concerned that he and his son would be "poked and prodded" during treatment. The clinician responded: "Thank you for telling me about your concern. Let me ask you, did you feel that I was kind of poking and prodding you and Ethan during the assessment?" Mr. Khalid stammered a little and said that he had not felt that way during the assessment, but he did not know what to expect during treatment. The clinician repeated that she welcomed his bringing up his concerns and said that she saw treatment as a collaborative process where the father would be actively involved in whatever happened. Mr. Khalid answered that he wanted to know to whom his son had been compared during the assessment, explaining that he worried that Ethan would be held up to white European standards, which in his view demanded more constricted behavior than he had grown up with. The clinician responded that cultural standards were very important, and that perhaps she, as a white woman, had not appreciated sufficiently Mr. Khalid's different cultural perspective during the assessment process. Mr. Khalid denied that this had been the case but said that Mrs. Allen had

often made fun of him because of his traditional values about gender relationships. He added that, if it were up to him, his son would be “completely free” to express his feelings, but he knew that everybody needed to conform to societal rules. He said that he liked Ethan’s energy and high activity level and he did not need to use punishment to keep the child in check but threatened instead to “kiss him” when he wanted Ethan to stop doing something.

The clinician responded that Mr. Khalid had a smile and a twinkle in his eye when he spoke about his son, and he answered that he saw “too much” of himself in his son. This led him to reminisce about his family of origin, and he disclosed for the first time that there had been much violence by his father against his mother. He explained that he had been born prematurely when his father threw his mother down the stairs while she was pregnant with him. Mr. Khalid added: “You would think there is a genetic trait of violence in my family, but there is not. I am not an aggressive person. When I was 16 years old, I stopped my father from hitting my mother by standing between them, and when my father pushed me, I fell down the stairs instead of pushing him back because I had to respect him. My mother told me that she thought many times of running away with me and my brothers when I was little, but she did not want to bring disgrace on us by being a divorced woman.”

This session revealed a great deal about Mr. Khalid’s inner conflicts. He had great empathy for his mother, whose confidences about her unhappiness with his father burdened him with the knowledge of her suffering and with the helplessness of feeling torn between his wish to protect her and his respect for his father’s authority. Mr. Khalid had allowed himself to fall down the stairs rather than push his father back in self-defense as he tried to protect his mother. At the same time, Mrs. Allen’s reports of his aggression toward her during their marriage suggested that Mr. Khalid had internalized his father’s violent example. The seeming facility with which Mr. Khalid’s wife had left him represented for him an insult to his cultural and family traditions, which were embodied in his mother’s self-sacrifice when she stayed with her abusive husband for the sake of her children.

In listening to Mr. Khalid, the clinician entertained the possibility that he derived a vicarious gratification from his son’s aggression toward Mrs. Allen and toward his teachers and peers, but he rationalized this pleasure with the wish that his son could be “completely free” in his expression of feelings. This psychodynamic formulation did not contradict the cultural understanding of Mr. Khalid’s experience. The overlapping themes reflect the complex juxtaposition of cultural and psychodynamic processes, including a person’s differential selection and valuing of those specific cultural attributes that serve unconscious

psychological needs. Mr. Khalid's worry that Ethan would be judged by white standards, while an expression of his understandable worry about ethnic stereotyping, could also be understood as a fear of losing the opportunity to express safely through his son his anger at Mrs. Allen and at his adopted country if Ethan's aggression were to decline as the result of treatment. The clinician's acceptance and interest in his experience deflected this worry, allowing Mr. Khalid to describe his own suffering as the result of his father's violence. This unscheduled session turned out to be pivotal in facilitating Ethan's treatment by diminishing the father's resistance.

Initial Session with Ethan and His Father

The first treatment session took place with Ethan and his father because of the custody schedule. The clinician told Ethan that his mother and father knew that it was hard for him to live in two different homes, and that sometimes he got so angry and upset that he hit and bit, threw things, and had trouble sleeping. She added: "Your mom and dad want to help you when you get so angry and worried." Mr. Khalid seemed comfortable with this explanation, which the clinician had encouraged the parents to use at home in explaining to Ethan the reason for treatment.

Ethan responded to this introduction with a stunning revelation: "I threw up, and daddy hit mommy." After a deep silence, the father said in an agitated voice: "I did not!" Without replying, Ethan went to the toy animals and asked the father to help him pair up the baby and parent animals so that the baby rhino was with the rhino parents, the baby giraffe with the giraffe parents, and so on. Instead of doing what his son requested, Mr. Khalid put the lions together with the tigers. Ethan became upset and told his father that those animals were not the same. Without responding, Mr. Khalid put the snake next to the baby lions. Ethan asked worriedly: "What will happen to them?" Mr. Khalid did not seem to register Ethan's level of concern. He answered: "It's OK if they are different. They like to spend time together, you see?" He then literally entangled the snakes with the lion cubs, saying: "The snakes are not going to do anything to them. They are friends with lion cubs." Ethan looked scared. The clinician commented: "Ethan, you are scared that the snakes will hurt the baby lions because snakes can bite and the babies are too little to stop them." The father listened quietly and said: "If you are worried about the snakes hurting the baby lions, I can put them in a safe place." Ethan seemed relieved as Mr. Khalid placed the snakes at a safe distance from the baby lions. The clinician commented: "Ethan, your dad listened to you. He didn't realize that the snakes could

hurt the lions, but you told him and he put the snakes away.” Father and son then spent some time putting together the baby animals with their parents. After all the animals were with whom they belonged, the clinician said: “Babies like to be with their mom and dad. That is how it was when your mom and dad lived in the same house. I think you miss being with your mom and dad together.” The father replied: “I miss it too. I wish we were all living together again.”

Ethan then opened the door of the toy cabinet and lined the animals carefully on the top of the door, where they held a precarious balance. He then moved the door back and forth, as if checking whether they would fall. He moved the animals so carefully that none of them fell. Ethan proceeded to push the baby lion with his finger so that it fell, picked it up and put it in its place. He repeated the same sequence four times. The clinician asked: “That baby lion keeps falling! What can we do to keep him safe?” Ethan then pushed all the animals off the top of the door. The clinician exclaimed: “Now everybody fell! What will happen next?” Ethan put the animals back on top of the door. The clinician commented: “Ethan is trying to stop everybody from falling down.” Turning to his father, Ethan said: “You do it too, Daddy,” and he opened the adjacent toy cabinet door to put more animals on the top of that door. The process of putting the animals up and making them fall down continued.

While Mr. Khalid joined his son in the play, he said that he was glad that the custody dispute was over and criticized Mrs. Allen for trying to minimize his access to his son. As he spoke, Ethan unexpectedly punched him forcefully in the stomach and then continued balancing the animals as if nothing had happened. The father completely ignored the child’s behavior. The clinician intervened by saying: “Ethan, that is the kind of hitting that worries your mom and dad. Everybody needs to learn not to hit. That is why you are coming here.” Turning to Mr. Khalid, she said: “What do you think happened there?” Mr. Khalid shrugged his shoulders and said: “It was nothing. It didn’t hurt.” The clinician answered: “Well, I am glad it didn’t hurt, but I don’t think it was nothing. It’s not good for Ethan and it’s not good for you when he hits like that.” The father replied: “He’s just a little boy. He’ll outgrow it.” The clinician answered gently: “He needs our help to outgrow it. I know how much you want him to grow up well, but he can’t do it alone.” Turning to Ethan, she said: “Your dad and I are talking about what happens when you hit. Maybe you saw too much hitting and now it’s hard to stop.” Ethan gave no sign of hearing her, and the therapist did not pursue the topic. Father and son continued balancing the animals on top of the cabinet door until the end of the hour. The therapist’s interventions during this interval were limited to commenting on how successful Ethan and his father were in keeping the animals from falling.

Clinical Themes and Intervention Strategies

This first session presented, as in a topographical map, the major clinical themes that Ethan and his father were struggling with in their relationship. Ethan showed an uncanny ability to articulate the crux of his internal predicament when he started the session by announcing that his father hit his mother after he threw up. This condensed statement showed that, like many children, he blamed himself for his father's violence against his mother. Other important themes followed: the question of whether animals of different kinds belong together (a symbolic expression of the tension imbuing the parents' different ethnic identities); the father's initial refusal to do what his son requested and mixing together different animals instead, including his (almost gleefully sadistic) intertwining of the snakes with the baby lions; the father's subsequent ability to understand that his behavior frightened Ethan and his willingness to reassure him by putting the snakes away; the sadness at the divorce and wish that the parents and the child were living together instead of apart; the resulting threats to the child's emotional balance, graphically represented in Ethan's game of balancing the animals on the ledge of the toy cabinet door only to make them fall; Ethan's need for his father's help in achieving internal balance; the father's failure to provide it by criticizing Ethan's mother in front of the child; Ethan's subsequent anger, manifested in his sudden punching of Mr. Khalid; and the restoration of an effort by father and child to relate to each other and achieve emotional regulation by the symbolic process of carefully balancing the toy animals on a precarious base.

The clinician resorted to a variety of intervention modalities to underscore the most emotionally salient themes and to convey her goals for the treatment. What she *did not do* is as important as what she did. For example, she did not address Ethan's initial statement about his father hitting his mother—not because she made a deliberate decision based on clinical reasoning but because, as often happens, this revelation took her by surprise and she could not think of anything useful to say. Sally Provence, the renowned child pediatrician and psychoanalyst, advised therapists to “not just do something; stand there.” This wise admonition reminds clinicians that watching and waiting may be more therapeutic than impulsive intervention when they are uncertain of what will help.

Later in the session, the therapist interpreted Ethan's wish to put together the animals that belonged with each other as an expression of the child's wish to live together with his mother and father. This interpretation was warranted by the clarity of the theme in the child's experience. When Ethan showed fear that the snakes would hurt the

baby lions, the clinician put this fear into words, simultaneously offering emotional support for Ethan and extending to Mr. Khalid the developmental guidance he needed to show a protective stance toward his son by putting the snakes away from the baby lions.

A pivotal clinical moment occurred when Ethan lost control of his anger and punched his father. The clinician chose not to interpret the aggression as a response to Mr. Khalid's criticism of Mrs. Allen, but again provided developmental guidance both for Ethan and for his father, telling each of them that hitting was not permissible. This intervention allowed her to address not only Ethan's behavior of the moment but also Ethan's earlier revelation that his father hit his mother after he threw up. When Ethan had said: "I threw up and my daddy hit my mommy," the clinician's internal response had been something along these lines: *"Ahhhaaa! Now everything is out in the open. Ethan, it is not your fault that your dad hit your mom. Mr. Khalid, you see? Your child saw you hitting his mother and blames himself. You need to apologize to him and promise to never hit anybody again."* This inner dialogue illustrates the power of countertransference reactions when the clinician feels that the parents are failing the child. To her credit, the therapist did not give free vent to her feelings but waited for Mr. Khalid's response. When he vehemently denied the violence, she did not confront him but again waited to see how the session would unfold. Much later in the session, when Ethan hit his father, the clinician took a calculated risk in saying that "everybody needs to learn not to hit." By making a general statement, she hoped to speak overtly to Ethan's experience and covertly to Mr. Khalid's unacknowledged aggression without setting up a confrontation with the father for blaming him for actions that he had denied engaging in.

The fluidity of the session, which moved on to illustrate the major issues in Ethan's relationships with his parents and ended in harmonious collaborative playing between father and child, supported the clinician's good judgment in adopting an unambiguous stance against hitting that did not blame the aggressor but targeted instead the importance of changing the hitting behavior.

Initial Session with Ethan and His Mother

Ethan's concern with safety and protection was enacted again in the first session with his mother, but this time he chose very different ways of expressing this theme. Ignoring the animals that were displayed on the floor, Ethan asked for airplanes instead. The clinician provided a small bucket with several toy airplanes and helicopters. Ethan gave Mrs. Allen a small red helicopter and instructed her to be the pilot, saying: "We

are going to fly in the sky.” He then took a green airplane and made it go up and down in the air while making airplane noises. Mrs. Allen followed Ethan’s lead and began doing the same thing, but stayed at quite a distance from Ethan’s plane. After a minute or so, Ethan told his mother to place a male doll inside the helicopter to be the pilot, and then they both resumed flying in the air. Ethan then said: “Now we are going to crash.” Mrs. Allen pulled back with a gesture of fear and began flying in the opposite direction from Ethan’s plane. Ethan scooted closer to his mother and got on his knees, hitting her helicopter with his plane and saying: “They crashed! Your plane is falling down!” while pushing the mother’s helicopter to the floor. He then said: “It’s on fire.” Mrs. Allen exclaimed: “It is!” Ethan asked her: “What should we do?” Mrs. Allen replied: “Let’s bring the ambulance to help him.” She grabbed a teenage doll wearing a pink dress and braids and said: “She is a nurse” (during the assessment session, Mrs. Allen reported that she had been a volunteer for the Red Cross when she was a teenager). She made the nurse doll whisper to the fallen pilot: “I will give you a kiss and make you feel better. Be careful when you fly. We don’t want you to get hurt.”

This scene of flying, crashing, and rescuing was repeated eight times, with no changes, until the end of the hour. At one point, when the mother did not want her helicopter to continue crashing and evaded Ethan’s plane, the child said: “My plane has guns. Look, it’s shooting at your plane.” Mrs. Allen replied: “Nothing happens to my helicopter. The bullets cannot get to him, nothing happens to him.” Ethan then got closer and pretended to shoot at the helicopter from the side, saying: “Look, now it’s on fire.” The mother, with a resigned look, crashed her helicopter and said: “Again, hurry, hurry, bring the ambulance with the nurse; this guy’s not feeling well.”

Throughout the session, the clinician made occasional comments to highlight the themes of being in danger, being scared, crashing, and the ultimately successful efforts that mother and child were making to rescue the wounded pilot. Ethan’s play was so coherent, the themes were so clearly conveyed, and the child was so emotionally absorbed in engaging his mother in the play that the therapist felt she needed to respect the child’s momentum and not intervene prematurely but to focus instead on putting the play themes into words and on trying to understand what the child was conveying through his play. Mrs. Allen’s ability to engage in her son’s play was also a very welcome revelation during this first child–mother treatment session.

Ethan had difficulty leaving at the end of the session, but he did not become aggressive when Mrs. Allen insisted that it was time to leave. He cooperated in cleaning up the toys when the therapist told him that

the next week he could come back again, first with his father and then with his mother. As they were leaving, Mrs. Allen whispered to the clinician: "Why is he crashing the planes so much?" The clinician thought to herself that perhaps the wounded pilot represented Ethan's father, who had been handcuffed and taken away by the police in front of the child and who had later made clear to the child his sorrow about the divorce. However, instead of answering the mother's question, she replied "Let's each of us think about it and talk on the phone." This response was prompted by an intuitive sense that a concrete response to the mother's question was not advisable given that this was the end of the first session and there was no time to elicit the mother's point of view.

As the clinician pondered later why she had postponed giving an answer to the mother's question, she thought of several reasons that cut across different clinical situations and represent basic principles of therapeutic work: (1) She wanted to know the mother's response to the play in order to work with her toward an interpretation that supported a hopeful view of the child; (2) she did not want to speak about Ethan in his presence as if he were an outsider to the adults' conversation; (3) she thought it was premature to give an interpretation of the child's play before knowing him better; and (4) she did not want to appear as if she alone held the definitive answers to the meaning of the child's communications. Taken together, these explanations also modeled for the mother the attitude that Ethan's play was important and the adults needed time to think about it before settling on an answer.

In a phone conversation the following day, Mrs. Allen expressed her concern that Ethan's play was destructive. Remembering the dictum of "starting with simplicity," the clinician decided to begin with developmental guidance, explaining that Ethan's interest in crashing planes was very common among 3- and 4-year-olds. She added that Ethan's interest in what they could do to help the pilot showed that he wanted to rescue him rather than kill him. When the mother seemed receptive to this approach, the clinician ventured the possibility that Ethan was trying to fix something that broke as a way of making up for what had broken in his own family. Mrs. Allen now sounded doubtful, perhaps because of her guilt about initiating the divorce. She said: "I am so worried that he will be aggressive like his father when he grows up. Do you think he can outgrow it?" The clinician answered: "Ethan is at an age when children can unlearn behaviors that are not good for them, and you are doing what he needs you to do to help him." The phone call ended on a positive note. Mrs. Allen's readiness to consider that Ethan was not destined to become aggressive like his father was a good prognostic sign that she did not have rigid negative attributions toward her child's aggressiveness.

Three Weeks into Treatment

In a session with the mother 3 weeks after the beginning of treatment, the clinician explained to Ethan that she would visit him at his school because she wanted to help him get along with his teacher and with his friends. Ethan responded “Nobody is my friend.” The clinician asked: “How come?” and Ethan shrugged his shoulders and moved away. The clinician took two boy dolls and made one say to the other: “I want to play with you.” The other doll replied: “I don’t want to play with you.” Ethan approached her and watched silently. The clinician gave him the dolls and said: “What happens next?” Ethan threw the dolls toward the corner of the room. The clinician commented, with much feeling: “You don’t like it when the children don’t want to play with you. It makes you want to hit, and then the children get scared.” Ethan and Mrs. Allen did not respond but seemed frozen. The clinician said: “Ethan, you are a little boy and you are learning to play with the other children. Sometimes it takes a long time to learn. We will teach you not to hit.” Ethan looked away from her, fingering a toy animal in an absent-minded way.

After a while, Mrs. Allen directed Ethan’s attention to the building blocks and encouraged him to build a tower. Ethan built a tower, placed a father doll and a boy doll on top of the tower, and made a dinosaur attack them so that they fell down. He then said to the mother: “Make the good dinosaur save them,” giving her another dinosaur. Mrs. Allen put the father and boy dolls back on top of the towers using the “good” dinosaur.

This game was repeated five times. Ethan then told his mother: “Bring everything down.” Mrs. Allen used the dinosaur’s head to shake the tower and made the dolls and the blocks come tumbling down. Ethan screamed: “*No! Not like that!*” Mrs. Allen said that she did what he told her, but Ethan yelled that he wanted the people, not the tower, to fall down. Mrs. Allen looked very upset. The clinician intervened, saying: “Your mom thought you wanted the people *and* the tower to come down. Sometimes people don’t understand each other.” Ethan breathed heavily, and the mother said: “We can build it again. Here, you help me.” The clinician commented: “Things can look really bad and then we can fix them again.” Five more times mother and child played at bringing down the father doll and the boy doll while keeping the tower standing up, and then putting the father and boy dolls on top of the tower again. The clinician commented: “The father and the boy fall down and they go up and are OK again.” She did not feel it necessary to make any direct connection between the play and the reality of Ethan’s situation with his father because she believed that the play

spoke in Ethan's language better than she herself could do. The theme of falling down is a common expression for toddlers' and preschoolers' sense of danger, and it is likely to have developmental roots in their experience of the many falls that preceded their relatively recent mastery of locomotion.

On reflecting about this session, the clinician and supervisor were impressed by the richness of the play that followed the announcement that the clinician would be visiting Ethan at his school, suggesting that this news enabled Ethan to play out the worries that he experienced both at home and in child care.

Observing Ethan in the Child Care Setting

The clinician's visit to Ethan's child care setting was an important component of the intervention. The visit had three main goals: to assess the quality of the child care environment, to establish a cooperative relationship with the child care provider, and to observe Ethan's relationship with the child care provider and with his peers.

During the child care visit, Ethan seemed both embarrassed and excited by the clinician's presence. He spent a lot of time playing on his own at some distance from the other children, but he participated actively in group activities. At one point, another boy walked by close to him and Ethan automatically pushed him away, but he did so lightly enough that the boy continued walking without responding. Although this incident was minor and unnoticed by the teacher, it illustrated Ethan's readiness to feel threatened by the neutral behavior of others.

Soon afterward, Ethan called out to the teacher, who did not hear him because she was busy tending to another child. Ethan called her increasingly louder, and she answered: "Use your indoor voice, Ethan," unaware that he had been doing so all along without her noticing him. Ethan responded by forcefully throwing a toy on the floor. When the teacher approached him to tell him not to do that, Ethan tried to avoid her, saying "No!" A little girl defused a potentially escalating situation by picking up the toy from the floor and offering it to Ethan, who took it and continued playing with it.

Suggesting Interventions to Ethan's Teacher

The child care observations highlighted Ethan's hypervigilance to potential sources of danger, his readiness to feel rejected, and his self-protective tendency to respond with anger as a way of coping with helplessness by making himself feel powerful. In discussing the aforementioned episodes with the teacher, the clinician focused on two themes. The first theme

was Ethan's tendency to feel threatened by his peers' neutral behavior—in other words, his misperceiving social cues as a sign of danger. The second theme was the ease with which he felt rejected when his signals were not noticed or not responded to immediately.

These observations softened the teacher's perceptions of Ethan as an aggressive bully, and led to an agreement that the teacher would engage in three kinds of interventions. One intervention consisted of reframing Ethan's perceptions of other children's behavior by explaining their motives to him. The second intervention consisted of paying attention to the early stages of Ethan's frustration in order to prevent an escalation into aggressive behavior. The third intervention involved linking Ethan's aggressive behavior, when it occurred, with his feelings of frustration and fear, while emphasizing that the teacher would help him to not hurt himself or others.

One of the challenges of mental health consultation in child care settings is that the teacher needs to remain attentive to the needs of the entire group while trying to help individual children with special problems. During this consultation, the therapist was careful to demonstrate respect for the teacher's position while focusing her attention on Ethan's needs. The therapist made a point of saying that she understood that the teacher had many children to care for and might not be able to always keep an eye on Ethan. The teacher agreed heartily, adding that conducting a classroom is not like doing therapy. Hearing the rueful undertone in the teacher's comment, the therapist commented that it was certainly more draining to spend all day every day with a group of children than to spend 1 hour a week with one individual child. She then said: "I am hoping that, if you can keep an eye on Ethan in spite of all the demands on you, you can save yourself all the trouble of picking up the pieces after he falls apart." The therapist also made herself available as a resource to the teacher, inviting her to call when she wanted a consultation.

In a telephone conversation about 1 month later, the teacher described how she was implementing the plans to help Ethan. She said: "I told him that he got sad when Andrew did not want to play with him, but that hitting is not OK even when you are sad." This direct juxtaposition of hitting with sadness when talking to the children bypassed the conversion of sadness into anger and addressed directly Ethan's feelings of rejection when his friend did not want to play with him. The teacher was very pleased with her idea of naming sadness rather than anger as the source of children's aggressive behavior, and she reported that this strategy gave her a new sense of competence in addressing behavior problems with other children as well. She observed: "They already know they are angry. What they don't know is that they are also sad. That's

what they need to learn from me.” Although the clinician thought to herself that children do not always recognize their anger while acting on it, she did not want to set up a competitive process by acting as if she knew more than the teacher. Instead, she joined in the teacher’s pleasure and commented generally that talking about feelings of all kinds helps the children to recognize and manage them. This is a rewarding example of how clinicians and child care providers can combine their respective areas of expertise on behalf of the children in their care.

Bridging Parental and Child Themes: Translating between Parent and Child

The alternating weekly child–mother and child–father sessions proceeded smoothly for approximately 2 months. The focus of the sessions continued to be on using the themes of Ethan’s play as the vehicle for speaking about danger with its attendant feelings of fear, anger, and wishing to make things better, and about protection with its attendant feelings of trust, pleasure, well-being, and love. Often one parent complained about the other as if Ethan was not listening. On those occasions, the therapist brought Ethan into the circle of communication by pointing out to the parent how Ethan was responding to the adults’ conversation and by reframing for Ethan what the parent was saying. The following narrative gives an example of how this was done during a particularly difficult session.

Mrs. Allen came in with an angry expression on her face and greeted the therapist curtly. Ethan followed behind her, looking crestfallen. The therapist commented that they both seemed upset and asked if anything had happened. Mrs. Allen replied: “Ethan’s father called to say that he had to go out of town unexpectedly and can’t take Ethan next week. He is so inconsiderate. I had all kinds of plans and now I don’t know what to do. He only cares about himself. I don’t even believe him. He probably has some kind of girlfriend that he wants to be with, and I am stuck with figuring out what to do with Ethan because I don’t want to give up my plans.” Ethan looked sad and worried as he played desultorily with the toy animals. He then left the animals on the floor, climbed on the low table, and started climbing through the open window.

Mrs. Allen screamed: “Stop!” without moving from her chair. The therapist jumped up and retrieved Ethan, saying: “That is not safe, Ethan. We don’t want you to fall off the window.” Ethan fought back by pushing wildly against the therapist, who wrapped her arms around him while telling him that he could fall through the window and she did not want him to get hurt. As Ethan kept pushing against her to

break free, the therapist said to Mrs. Allen: "I need your help. Please tell Ethan that he can't climb out of the window." Mrs. Allen said angrily: "Ethan, stop it. You can't climb out of the window." Ethan seemed to crumble in the therapist's arms. The therapist said: "Thank you, Ethan. You really scared me. I am glad that you listened to your mommy." She held the child until he seemed calmer and then brought the toy animals close to him. Ethan sat on the floor and began playing again with the toy animals.

The therapist said to Mrs. Allen: "What do you think happened just now?" Mrs. Allen replied: "That's what he does at school. I think he is hyperactive. I am thinking of asking his pediatrician to put him on Ritalin to calm him down." The therapist was taken aback by this response and had to stop herself from rebuking Mrs. Allen. She was helped in her self-restraint by knowing that not only parents but also mental health professionals confuse traumatic stress symptoms with hyperactivity in young children. After a silence to compose herself, the therapist said calmly: "Well, I can see why you would think about it when Ethan gets out of control, but I think this time Ethan was responding to what you were saying about his father." Mrs. Allen responded crossly: "He is too little to understand what I was saying." The therapist turned to Ethan and explained: "Your mom and I are trying to understand why you tried to climb out of the window. Are you sad that your dad is going away and your mom is angry at him?" Ethan nodded imperceptibly without looking up. Mrs. Allen asked him sharply: "Why did you climb out of the window?" Without looking at her, Ethan mumbled: "You don't love me." Mrs. Allen leaned toward him and asked: "What did you say?" Ethan repeated, in an even softer tone of voice: "You don't love me." Mrs. Allen asked sharply again: "What? I can't hear you!" Ethan looked up at her and said loudly: "You don't love me!" Mrs. Allen answered matter-of-factly: "Of course I love you. You are just being silly." She then turned to the therapist and said: "He is always trying to manipulate me with this business of my not loving him."

In this exchange, the therapist was faced with the quandary of how to help an angry and self-absorbed mother to recognize and empathize with her child's justifiable fear that she did not love him. How to address this difficult topic without sounding preachy or pedantic, increasing her defensiveness, and alienating her from the treatment? As earlier in the session, the therapist first resorted to silence to gain inner balance and then said: "*You* know you love him even when you are angry at him, but *he* doesn't because that is something that children don't learn until they are much older. He thinks you want to get rid of him when he hears you say that you don't know what to do with him while his father is away." Mrs. Allen's innate empathy for her son was touched by this

comment, and she said, in a surprised tone of voice: "He does?" The therapist commented: "All parents need adult time, but their children don't know that. Separations are hard on them. I think Ethan was listening to you and he got afraid that his father doesn't want him and you don't either." While ostensibly speaking to Mrs. Allen, the therapist chose simple words so that Ethan could also understand. The mother looked sad and upset. She asked: "What should I do?" The therapist answered: "What about telling Ethan what happened?" Mrs. Allen said to the child: "Ethan, I am mad at your dad that he is going away but I am not angry with you." Ethan asked, in a worried tone: "Daddy come back?" Mrs. Allen's anger at her husband returned, and she lifted her eyes to the ceiling in exasperation. The therapist answered Ethan for her, saying: "He is going away but he will come back. You will be with your mom while your dad is away, and then you will go to your daddy's house again, like you always do." Mrs. Allen recovered and added: "Ethan, your dad and I love you even when we are angry. We will always come back even when we go away." The therapist commented: "But it is very hard to wait for daddy and to wait for mommy because you want to be with them. You don't want them to go away."

This session illustrates some of the challenges involved in addressing simultaneously the parent's emotional frame of mind and the developmental needs of the child. A theoretician could write a treatise itemizing the numerous ways in which the content of the session reveals the complex interplay of personality structure, situational reactions, defensive maneuvers, and developmentally colored wishes and fears of mother and child—including Mrs. Allen's ambivalence toward her son and her very real although largely unconscious desire to get rid of him, which coexisted with her equally genuine love and commitment toward him.

In any one therapeutic session, the clinician can address only a few of the most salient individual and relational issues. Every choice inevitably entails closing off other choices. In choosing her interventions during this session, the therapist purposely stayed away from addressing Mrs. Allen's ambivalence toward her son because this would be damaging to the child. Instead, the therapist used Ethan's fear of losing the parents' love as a port of entry to help Mrs. Allen understand the child's reckless and self-destructive behavior as he tried to climb through the open window. The therapist made this choice because Ethan's fear of losing the parents' love was developmentally appropriate but exacerbated by the parents' ambivalence toward him and their conflict with each other. The clinician's first intervention was to model protective action by retrieving Ethan from the window when his mother showed no intention to do so. The subsequent interventions involved translating the meaning of Ethan's behavior to the mother, showing her that Ethan heard what

she was saying about his father as a rejection of the child. Understanding Ethan's worry enabled his mother to reframe her behavior in a way that somewhat relieved the child's worry that she did not love him. The therapist's final comment that it was hard for Ethan to wait for his father and for his mother was meant as a reminder to Mrs. Allen that speaking about love does not magically remove the pain associated for a child with separation and divorce.

A Crisis: Risk and Opportunity

Two months later, the conflict between mother and father flared up again in a way that seriously threatened the viability of the treatment. During a joint child-mother session, the mother reported that Ethan had a big bruise on his upper arm after returning from a week with his father. When Mrs. Allen asked him what had happened, Ethan said that his father got mad at him when they were at the beach because he was kicking sand, threw him on the ground, and shook him by the arms. As she spoke, Ethan started shaking the father doll on the floor. The therapist turned to him and said: "Your mom is telling me what happened. Are you showing us what your daddy was doing?" Ethan replied: "My daddy was mad and shook me. I was scared." The therapist took the father and boy dolls and asked Ethan to show her what had happened. Ethan made the father doll hit the boy doll repeatedly, and then made the boy doll fly up in the air and crash on the floor, where the father doll pummeled the boy doll. Sensing that Ethan was becoming increasingly disorganized by the request to enact the episode, the therapist asked: "And how did it all end?" The tempo of Ethan's movements decreased in intensity and he made the father and boy dolls go home and have dinner. The therapist said: "Your father forgot to use his words! He shook you really hard instead of telling you to stop kicking sand. He made a bad mistake. It is not right to shake you and give you a bruise." She touched Ethan's bruise gently and said: "It will go away and get all better, but your dad should not do that to you."

This episode raised the issue of a report to Child Protective Services (CPS). The therapist explained to the mother that she needed to make the report as part of her legal and ethical responsibilities. Mrs. Allen said that this was the right thing to do even though Mr. Khalid would get very angry. When given the choice of making the report herself in the therapist's presence or relying on the therapist to make the report after the session, Mrs. Allen chose the latter because she was worried about the father's reaction if she made the report.

Ethan's play during the rest of the session was quite disorganized and had no coherent themes except for unpredictable bouts of aggres-

sion among the toy animals and a fleeting use of the doctor's kit. This lack of coherence reflected the lingering effects of Ethan's experience with his father and his uncertainty about what would happen next. He was also affected by the anxiety of the therapist and the mother, who were both worried about Mr. Khalid's aggression and about how he would respond to the CPS report. The therapist tried to be reassuring by saying: "Ethan, when you and your dad come to see me I will tell him that he cannot shake you and bruise you like that. Your mommy and I are thinking of how to help him use his words and not hurt you." Although this had a somewhat calming effect, it was clear that Ethan remained very worried and upset. He kept touching his arm and looking at his bruise at periodic intervals throughout the session.

After they left, the therapist called Mr. Khalid and, not finding him, left a message in his voice mail explaining that she would need to make a report to CPS because of the bruise on Ethan's arm. She added that she wanted to continue working with him and requested that he call her back within the next 24 hours so they could speak before she had to make the report. Mr. Khalid called a couple of hours later, livid with fury. He accused the therapist of siding with Mrs. Allen, who had "fed Ethan lies" and made the child believe that his father was abusing him. His voice repeatedly escalated into near screams before he managed to restrain his anger and speak more calmly again. However, he confirmed that he had pushed Ethan on the sand and shaken him after the child had kicked sand toward him when he told him it was time to go home. He said angrily that Ethan was a brat at the mother's home and needed clear limits from the father. The therapist noted to herself for later intervention that this stance contrasted with the father's statement during the assessment that he had no problems with Ethan's behavior and that he only needed to threaten Ethan with "kissing" him to make him stop misbehaving.

The therapist explained to Mr. Khalid that she realized how upset he was but that she was obliged to make a CPS report because the bruise was a legally reportable incident. She then told him that, if he wanted to, he could make the report himself in her presence as a way of conveying to CPS that he was aware of the seriousness of the situation and willing to work toward controlling his angry outbursts toward Ethan. At first Mr. Khalid angrily refused to even consider such as a self-blaming action, but as the therapist continued to speak soothingly but firmly about the problems that his temper posed for him, he agreed to consider this option and to call again in an hour.

While waiting for Mr. Khalid to call back, the therapist suddenly realized that her leaving a telephone message about the CPS report might have reminded Mr. Khalid of his frightening and humiliating experience

of being taken to jail by the police. She also realized that her action would inevitably compound Mr. Khalid's already intense sense of cultural discrimination and persecution. She hoped that her nonaccusatory tone and repeated assurances that she would continue to be available to Mr. Khalid during the CPS investigation would enable him to make the CPS report himself in her presence and thus gain a measure of control over the situation. This is indeed what happened. Mr. Khalid came to the therapist's office the following day and, after the therapist called the CPS hotline and explained what would happen to the hotline worker, he took the receiver and, stammering often, described the incident on the beach in much the same way that Ethan had done. The hotline worker took the information and said that a child protection worker would be contacting him. The conversation was over in less than 10 minutes.

Converting Threat into a Positive Experience

After Mr. Khalid hung up the phone, the therapist asked him how he felt. He said, hesitatingly: "Worried ... angry ... a little relieved." He said that he had expected to be insulted by the hotline worker, who instead had been professional and polite. He still believed that the therapist had overreacted and he was convinced that Mrs. Allen would use the incident as a reason to petition the court for sole custody of Ethan. The therapist answered that it might be difficult for him to trust her in the future for fear that she would report him again, and he acknowledged that this was true. The therapist asked him if his mistrust was so strong that he wanted to stop coming to see her. He answered heatedly: "On the contrary, now I can't afford to stop. I used to come because I wanted to, but with this thing breathing down my neck, I have to be a good boy and come dutifully every week or I risk losing my child." The therapist answered: "You are reminding me of how hard you tried to be a good son when you fell down the stairs instead of pushing back at your father when you were trying to defend your mother." Mr. Khalid answered, in a defensive tone: "How is that related to anything?" The therapist answered: "Well, now you are really angry with me, but you are going to go through the motions of respecting me and coming to see me because you care so much about your son, just like you cared so much about your mother." Mr. Khalid replied: "Yes, but you are not my father." The therapist answered: "I know I am not. But I am making you do what the law in this country says, just as your father made you feel that he was the boss even if you didn't like it."

This interpretation did not have the intended effect of helping Mr. Khalid become aware of the transference elements in his reaction to the therapist, and the therapist realized that she had come across as critical

and challenging rather than helpful. After a long and tense silence, the therapist said in a conciliatory tone of voice: "Mr. Khalid, I now realize how upset you must have been when you heard my telephone message that I was going to make a CPS report. It must have felt like I betrayed you out of the blue. I did not put it together at the time with what it is like to be an immigrant of color and what it was like for you to be taken to jail by the police. I am very sorry that I just left a message about this instead of waiting to speak with you directly." Mr. Khalid softened and responded: "Thank you for saying that." There was another long silence. Then Mr. Khalid said: "You have no idea how hard my life is. I am so tired that sometimes I feel that if I sleep all I want I will never wake up. I work like a slave, but people always look at me like a potential terrorist. If it weren't for Ethan, I would go back to France, but France is also no place for a man like me to be. In the West I am a dangerous Moslem, and in Algeria I would be an apostate."

The therapist felt a mixture of compassion and detached objectivity in response to Mr. Khalid's remark. She could appreciate the reality of his cultural alienation and his self-perception as a perennial stranger, but she was also keenly aware of the defensive function served by this sense of righteous grievance that in his eyes justified his anger and his violent outbursts. At the same time, she was jarred by his comment that he was so tired that he would never wake up if he could sleep all he wanted. This statement alerted her for the first time to the possibility that he was deeply depressed. How to address all these layers of meaning when she was not his individual therapist but was working with him on behalf of his child? The joint sessions were focused on the father-son relationship and did not allow for an in-depth exploration of Mr. Khalid's psychological problems.

The therapist chose to tell Mr. Khalid that she was understanding better his stresses as an immigrant and then moved cautiously and supportively to the potentially explosive topic of his aggression. She said: "I hear what you are telling me, and you are right—I am not an immigrant of color and there is no way that I can fully feel what you feel." She went on: "I also have the impression that you are very worried that Ethan will suffer when he grows up the way you are suffering now—that he also will not be accepted by society." Mr. Khalid agreed. He thought that Mrs. Allen was ashamed of Ethan's olive skin color and dark hair and eyes, which contrasted with her own white skin, blond hair, and blue eyes. The therapist said that she had not noticed this to be the case but that she would keep this possibility in mind. Then she said: "You may not agree with me, but I think that in addition to being an immigrant of color and from a different religion, you are also still suffering from the things that happened to you when you were growing

up. You saw your father be violent to your very loving mother while you were growing up, and those memories don't go away. I think you are still angry about how your father treated your mother." Mr. Khalid nodded in agreement, and this response allowed the therapist to continue saying: "I think you learned to be angry from him without wanting to, and the anger comes out suddenly before you know it. When you were defending your mother your anger was a good thing, but now it is bad for you. It is bad for you that you were in jail and now you have to go through a CPS investigation. You don't mean to, but you sometimes hurt the people you love. Ethan's bruise was not an accident. You didn't mean to bruise him, but it happened because you shook him so hard. You can really hurt him, and then how would you feel?"

With a choked voice, Mr. Khalid said: "I see a lot of myself in Ethan. When he gets angry, I want to shake the anger out of him." The therapist asked: "Does it work?" Mr. Khalid answered: "I think he gets scared of me. After what happened at the beach, he didn't want to play with me and he ran away from me when I tried to kiss him." The therapist asked if that reminded him of anything. Mr. Khalid responded: "I used to run away from my father because I was so scared of him." He sobbed for a few minutes, and then added: "I don't want Ethan to be scared of me." The therapist responded: "It is not too late. He may be scared of you now, but he also loves you. This is the time for both of you to learn how not to hurt and scare other people."

This depth of exchange might not have been possible without the meeting that had taken place between Mr. Khalid and the therapist after the end of the initial assessment, when he asked for an individual session to discuss his worries about her possible cultural biases and revealed much about himself, including the marital violence that he had witnessed while growing up. The comfort established between Mr. Khalid and the therapist as the result of that session facilitated the candor with which they tackled the difficult issues of trust and betrayal that had been raised by the CPS report.

Individual sessions with a parent can have great value as an adjunct to child-parent sessions when they cement the parent's trust in the therapist and give an opportunity to uncover and address parental issues that would be inappropriate to explore in the presence of the child. In the case of Mr. Khalid, making conscious the overlap of aggression and fear both in his relationship with his father and with his son enabled him to recognize aspects of his dreaded father both in himself and in his son. To reach this point, the therapist needed to make a midcourse correction in her approach to Mr. Khalid, moving from a rather confrontational effort at interpreting his negative transference to a heartfelt acknowledgement that she had not been attuned to how her behavior might affect him.

Remembering through Action and Play: A Beginning Trauma Narrative

The session had a liberating effect on how Mr. Khalid related to Ethan in the ensuing weeks. There was a noticeable decrease in his minimization of Ethan's aggression and a concomitant openness to speaking candidly about the child's behavior. In the joint child–father session that followed the CPS report, the therapist explained to Ethan that she and his father had been talking about what happened on the beach when the father got so angry with him for kicking sand in his direction. Ethan looked frightened and moved away from his father toward a corner of the room. Mr. Khalid said to him: “I am sorry I hurt you, Ethan. I am sorry I gave you a bruise. I did not mean to shake you so hard.” Ethan said softly: “You were mean.” Mr. Khalid tensed up, but he made himself say: “You are right, I was mean. I don't want to be mean. I am sorry.”

Later in the session, while Mr. Khalid was speaking to the therapist about the joint custody schedule, Ethan yelled at him: “Stop talking!” Mr. Khalid said: “Are you mad because I am talking about your mom?” Ethan walked up to his father and hit him in the eye with the palm of his hand. Mr. Khalid recoiled in pain and angrily told Ethan that he hurt him. He then repeated: “Are you mad because I am talking about your mother?” Ethan ran to the other side of the room and hid under the table. Mr. Khalid asked him to come out, but Ethan did not budge. Mr. Khalid said thoughtfully: “I see what is happening. He is still mad at me. He hit me the way he thinks I hit him—tit for tat.” The therapist nodded in silent agreement, and asked: “What do you make of that?” Mr. Khalid answered: “I need to give him a different example.” The therapist commented: “It takes a lot of courage to realize that.” Ethan came out from under the table and loudly announced that he was back. His father said: “Welcome back, but no hitting. I won't hit and you won't hit.” Ethan said solemnly: “No hitting.”

What followed was a new form of play for Ethan. He took a police car and a policeman that had always been among the toys in the playroom but had never been touched by the child. He put the father hippo on the floor and placed the rest of the animals on the fire truck. He then put the policeman inside the fire truck and made him drive it away, leaving the father hippo behind. The therapist took the father hippo and made it run after the fire truck, saying: “Bad policeman! Don't take my children away!” Ethan listened attentively, then stopped the truck and put the father hippo with the rest of the animals. He took the policeman's gun and showed it to the therapist. Without waiting for a reply, he put the hippo family and two baby elephants on the top of the toy closet's door, which was open. The therapist commented that this seemed like a very dangerous place for the family and the baby ele-

phants, and asked how they got there. Ethan responded that the policeman put them there. The therapist asked how they could be made safe. Ethan said that the good dinosaur was helping them to get down and would kill the policeman. Taking the dinosaur, Ethan carefully brought down each one of the animals and put them on the floor. He said that the good policeman came and killed the bad policeman. He then took the gun and shot the policeman. The therapist said that he was making sure the policeman could not hurt the family anymore. Ethan seemed to lose interest in the game and moved on to other play.

In this session, Mr. Khalid had apologized to Ethan for having bruised him, and called for an agreement that neither he nor the child would resort to hitting again. Instead of responding to Ethan's aggression with aggression of his own (as had occurred on the beach in the incident that triggered the report to CPS), Mr. Khalid restated the no-hitting agreement after Ethan got scared for hitting him again and hid under the table. The play that followed shows Ethan's newfound ability to enact the experience of watching his father taken away by the police and his confusion about who is good and who is bad. His ready resort to killing as a way of making things better showed his continued use of violence to cope with danger and fear. However, his progress was shown in his ability to actually play symbolically with the police toys that stood for the traumatic scene of his father's arrest, instead of avoiding these traumatic reminders and using physical violence to cope with his fear.

The next session involved Mrs. Allen and the child, playing with the same set of toys. After a while, Ethan approached the doll policeman and held it in his hand. The therapist said: "Your mom told me that a policeman came to your house and took your daddy away." Ethan nodded in silence. He then threw the father hippo across the room. The therapist said: "The policeman took your daddy away to help him stop hitting. Now your dad is back and he is learning not to hit." As in the previous session, Ethan took the policeman's gun. Now he said: "I'm scared." The therapist asked: "Did you see a gun that scared you?" Ethan was quiet, but Mrs. Allen commented that the police had guns when they came to the house, although they did not take them out of their holster and she did not think Ethan had seen them. The therapist said to Ethan: "The police carry guns but they only use them with really, really bad people. They did not use a gun with your daddy."

Ethan made a row with all the baby animals, arranging the adult animals in another row in front of them. He then took two dinosaurs and gave one to the therapist, saying: "Let's fight." The two dinosaurs hit each other with their long tails in a spirited manner. Ethan took his dinosaur and whacked the therapist's dinosaur with its tail while growling loudly. The two dinosaurs continued to fight for a few minutes, with

the therapist periodically asking in a stage whisper: "Like this?" to keep the play in line with the child's needs. Ethan moved the row of baby animals closer to their adult counterparts, and said that the big animals would protect the babies. The two dinosaurs continued their fight. The therapist enacted her assigned role without comment, thinking that this play was a well-contained display of the child's internal struggle to differentiate between good and evil following his play with the good and the bad policemen and the subsequent clarification of what the police had done with his father.

Mrs. Allen attempted to interrupt the play, which perhaps unsettled her, by telling the therapist that Ethan had been having bad dreams again. Ethan responded: "No talking." The therapist smiled at the mother and said: "I think he is giving us our instructions. What about speaking on the phone about this?" The mother nodded in agreement. The topic of nightmares was discussed on the phone a few days later, but by then Mrs. Allen seemed significantly less worried about the problem and said that she knew how to comfort Ethan and reassure him that he was safe.

Treatment Outcome

Ethan continued to be an active participant in his own treatment. Through play and words, he showed the impact of the domestic violence, the parents' divorce, and each of the parent's difficulties with anger management and empathic responsiveness. On several occasions, the graphic depiction of aggression in Ethan's play was difficult for the parents, who tried to deflect or negate what the child was expressing. The therapist's interventions at these times aimed at supporting the parents and containing their feelings while providing continued permission for the child to continue his play.

In individual collateral sessions, which were often on the phone, the therapist upheld the reality of the violence that Ethan had witnessed. She described his play as his age-appropriate, growth-promoting efforts to cope with the fear and anger he experienced as a result. As Ethan's aggression toward his mother, father, teacher, and peers decreased, the parents became more trusting of the therapist's approach and increasingly better able to collaborate with each other in their child's treatment.

The treatment of Ethan and his parents lasted 1 year and ended when Ethan was 4 years, 5 months old. At termination, Mrs. Allen felt that Ethan continued to be more easily aroused to anger and to have more separation anxiety than she would prefer, but she felt better able to control her angry outbursts toward the child and was better able to help

Ethan deescalate when he became dysregulated. Mr. Khalid continued to be less concerned than Mrs. Allen about Ethan's behavior, but he had become more aware of Ethan's problems with anger and aggression. He and Ethan acquired a joint understanding that they both needed to learn to be less quick to anger. Both parents reported that they had learned to stop themselves when they started to criticize the other in front of Ethan because they did not want the child to feel a conflict of loyalty between them. Ethan's behavior at school improved remarkably. His teacher was satisfied with the decline in his aggression, and his peers had stopped avoiding him and treated him like any other child in the class. The WPPSI administered toward the end of treatment showed that his performance score was now equivalent to his verbal score, 1 standard deviation above the mean. He was no longer distractible and was able to persist at tasks that required effort to complete.

The treatment was conducted by a postdoctoral fellow who was leaving at the end of the year. Mrs. Allen expressed concern as termination approached that Ethan's aggression would escalate again after treatment ended. The possibility of a transfer to a new therapist was discussed with each parent about 4 months before the therapist's departure, and both of them agreed to wait until about 2 months before the therapist left to make a decision based on Ethan's behavior at the time. When the time came, both parents agreed that treatment was no longer necessary and that they would contact the clinic if the situation changed.

During the last session, which took place with the father, Ethan chose to have the therapist read *The Invisible String*, a book about the invisible connections that bind people who love one another, even when they are separated. Ethan had read it repeatedly in sessions with both parents as a statement of how love continues even in the absence of the person one loves. He said to the therapist: "Will you love me forever?" The therapist replied: "I will. I will always think of you and send you my love." Ethan answered: "I want to draw a picture of you and me together." They did so, and Ethan gave the picture to the therapist, saying: "This is for you. I will love you forever too."

CHAPTER 7



Variations in Child–Parent Psychotherapy

The customary CPP focus on the child–parent relationship calls for modifications when the parents cannot collaborate in the treatment in spite of persistent attempts to engage them in becoming more attuned to their child. In such situations, clinicians must find a way of helping the child while working within the paradox that the parents are paramount influences on their child’s mental health but consistently unavailable as agents of the child’s improvement. Variations in the joint child–parent format of CPP sessions are necessary in three specific circumstances: parental psychological functioning is so impaired that the parent’s problems overtake the therapeutic focus on the child; the child’s play and behavior during the sessions trigger unmanageably damaging responses from the parent; and intractable conflicts between an estranged mother and father are persistent pathogenic influences for the child. This chapter describes CPP variations that were developed to address these special circumstances. The case examples that follow illustrate how CPP modalities are applied in a modified clinical format. Treatment for these families is not described in full. As in previous chapters we highlight the themes leading the CPP therapist to step outside the classical model of joint sessions.

Individual Work with the Parent: Keeping the “Third Ear” on the Child

The initial assessment sometimes reveals that the parent is persistently unable to focus on the child’s experience. Other times treatment begins

with the traditional child–parent format, but it quickly becomes apparent that extensive collateral sessions or extended periods of treatment with the parent alone are needed to change the pathogenic conditions associated with the child’s emotional problems. Both of these conditions are substantially different from cases that call for occasional or short-term individual meetings with the parent to clarify specific issues or work out discrete perturbations in the child–parent treatment. Parents in these cases are often so bound up in coping with ever-present and overwhelming trauma reminders or defending against pervasive assaults on their sense of self that they are unable to regulate their own feelings, much less reflect on their child’s experience. These parents need the therapist to take on the task of holding the child in mind when they cannot look past their own needs.

CPP offers to these parents a therapeutic approach that focuses on their individual predicament but has one essential difference from individual psychotherapy. The therapist offering individual treatment has only the patient as the focus of attention, attending to the patient’s feelings, thoughts, and behaviors and helping the patient expand on his or her own capacity for affect regulation, mentalizing, and reflective functioning (Fonagy et al., 2002). In contrast, the CPP therapist who offers individual sessions to the parent maintains a steadfast focus on how the parent’s internal processes are enacted in the parent–child relationship and affect the child’s emotional experience. Although parents may come to sessions alone for weeks or months, the therapist never loses sight of the child’s experience and consistently introduces the child into the parent’s subjective frame of mind by exploring how the child figures into the experiences the parent is describing. The therapist holds both the parent and child in mind and works deliberately to expand the parent’s capacity to reflect not only on her or his own feelings but also on the parent’s influence on the child.

Example: The Mother Who Forgot Her Child Was Watching

The case of Ms. Harris and her daughter, Shawna, illustrates the clinical issues encountered when a parent is too affectively overwhelmed to notice the impact that her decisions and behavior have on her child.

Assessment Phase

Ms. Harris, a 22-year-old African American woman, and her 19-month-old daughter Shawna were referred for treatment by a domestic violence shelter. Reasons for the referral were that Shawna ate little, was losing

weight, and woke up crying several times during the night and Ms. Harris seemed so depressed that she could not care for Shawna and often left her unattended.

Shawna and her mother came to the shelter after Shawna's father stabbed and attempted to strangle her mother. Shawna looked on in terror and screamed during the attack. Shawna's father yelled, "Shut up, you little bitch" and hit the child so hard that she fell backward into a cabinet, knocking it over on top of her head. Reports to the police and to Child Protective Services (CPS) resulted in Shawna's father being arrested for both assaults. He was deported to his country of origin when his status as an undocumented immigrant was discovered.

The shelter staff remained concerned about the mother's and child's safety even with Shawna's father out of the picture. The mother confirmed during the assessment that she was depressed and had difficulty sleeping, lacked energy, and had frequent nightmares. She denied suicidal ideation or intent. She had intrusive thoughts about the attack and reported that sometimes her thoughts "seemed so real that I'm not sure where I am." She expressed no particular concern about Shawna, however, and dismissed the shelter staff concerns about the child's lack of appetite and nightly crying, saying that Shawna seemed fine to her and that any distress the child was experiencing was probably because of the move to the shelter.

Ms. Harris was socially isolated, with no family or long-term friendships. She reported that she had one friend: a young man who had been a friend of Shawna's father. She said that this man loved her, helped her with Shawna, and often bought things that Shawna needed. By her account, they were engaged and planned to be married now that Shawna's father was gone.

Several days after the second assessment session, an advocate from the shelter called the therapist to report that Ms. Harris had been tearful for 2 days because her friend told her that he did not love her "like a wife" and wanted to be only a friend. Ms. Harris became panicked, crying that she was all alone in the world and that no one would ever love her. The evening of the advocate's call, Ms. Harris cut her wrists deeply enough that she required stitches. Shawna witnessed the entire episode: her mother crying, the ensuing wrist cutting and bleeding, the commotion that followed, and the ambulance that came and took her mother away. A shelter advocate took Shawna to the emergency room and waited with her while the doctor saw her mother, treated her injuries, and assessed her present level of suicidality. Ms. Harris persuaded the doctor that she would make no further attempt on her life. She was released with a prescription for a short course of antidepressants and an appointment with an outpatient psychiatrist.

Shawna and Ms. Harris returned to the shelter and continued to meet with the CPP therapist. Ms. Harris kept her psychiatric appointment and began taking the antidepressants that the psychiatrist prescribed. The therapist told Ms. Harris that she was very concerned about her safety, particularly because she had cut her wrists only a few days after assuring the therapist that she was not having suicidal thoughts. The therapist added that although she wanted to help make things better for Shawna and Ms. Harris, she feared that she could not be helpful if Ms. Harris did not trust her enough to reveal such an important part of her feelings. In response, Ms. Harris began weeping and disclosed that this was not the first time she had tried to kill herself: There had been two earlier attempts when she was a teenager, before she met Shawna's father. She spoke in detail of her harrowing youth. She was the youngest child of older parents who did not want her and who beat and degraded her throughout her childhood, calling her "fat" and "stupid." During her teenage years, her mother beat her whenever Ms. Harris expressed interest in a boy, calling her a slut and telling her that she would never be anything but a "whore who gave in to any man who looked her way." Ms. Harris ran away from home when she learned she was pregnant. She moved in with Shawna's father, who was 32 years old at the time. They married almost immediately and he became violent soon after the wedding. His violence continued unabated until his arrest and deportation. Ms. Harris said that she had often thought about leaving but hoped that "having a baby would settle him down, and besides, I didn't have anywhere else to go."

Ms. Harris experimented with marijuana and cocaine as a teenager, although she denied becoming addicted and said that she had not used drugs at all after she found out that she was pregnant with Shawna. She also had a pattern of bingeing on sweets whenever she became depressed. She forced herself to vomit after a binge so that she would not "get any fatter than I already was." At the time of the assessment Ms. Harris engaged in this pattern of bingeing and purging at least three times a week.

Shawna's distress accelerated after her mother's suicide attempt to the point that Ms. Harris could no longer ignore it. The child had night terrors, clung to her mother, and cried piteously whenever Ms. Harris left the room. She touched her mother's bandaged wrists and said, "Mommy owie. Mommy cry," and then she collapsed in tears. Ms. Harris said that she was afraid for Shawna. She did not know how to prevent her bouts of crying, and she did not know how to calm her down. She reported being afraid that Shawna would grow up to be "sad and alone like me."

Assessment Feedback and Treatment Plan

The therapist consulted with her supervisor and both of them agreed that CPP might be helpful but would not be sufficient to help Shawna. Ms. Harris's problems were so extensive that she needed continuing medication and individual and group therapy in addition to a treatment focus on her relationship with her child. Therapist and supervisor doubted their ability to contain Ms. Harris's suicidality without additional treatment providers and believed that group therapy might help Ms. Harris see that she was not completely alone in her experience and might give her a chance to form some relationships that would keep her from feeling so isolated.

At the conclusion of the assessment, the therapist told Ms. Harris that she thought that CPP would be helpful but not sufficient for her and Shawna. She said that she was very worried about the mother's suicidality and her eating disorder and strongly recommended that Ms. Harris find a therapist who could work with her on those issues. She said, "The child-parent psychotherapy will help you understand Shawna better and will help with your relationship with her. But I think that you need someone for yourself. And you need to keep seeing your psychiatrist and taking your medication." She gave Ms. Harris a referral to an individual therapist and a referral to a group for women who had experienced domestic violence. She asked Ms. Harris to make a commitment to following through with these referrals, and Ms. Harris agreed that she would. Ms. Harris and the therapist agreed on two initial CPP goals: giving Shawna time and space to play about her worry about her mother and helping Ms. Harris find ways to help Shawna learn to soothe herself and to regulate her sleeping and eating. The therapist told Ms. Harris that this emphasis on affect modulation and the regulation of patterns of eating and sleeping would be helpful for the mother as well. Ms. Harris chose to have office-based treatment because of the lack of privacy both in the shelter and in the transitional housing program where she and Shawna would soon move. Ms. Harris and the therapist also agreed on what they would say to Shawna about why she was coming to the clinic to play.

First Treatment Phase: Mother and Daughter Together

For the first 8 weeks, Ms. Harris came faithfully to her appointments, always bringing Shawna with her. The therapist chose a wide range of toys to use in the sessions. Some toys elicited themes of caregiving and nurturing that might be helpful in regulating Shawna's eating and sleeping, such as dishes, pretend food, and baby dolls. Other toys encouraged

play about the scenes of traumatic violence that Shawna witnessed. These included an ambulance, male and female doll figures, a child doll figure, a knife, and a doctor's kit. At the first session, using the explanation that she and Ms. Harris had agreed to, the therapist told Shawna that she and her mother were coming to play because of the scary things that had happened to them. She said, "Your daddy hurt your mommy, and he hurt you, too. He hurt your head. And your mommy cut her arms. Those are such scary things for a little girl and for a mommy. You are coming here so that I can help both of you feel better."

During the first session, the therapist noticed something that she had not had a chance to observe in the shelter: Shawna ran to and hugged complete strangers and people she barely knew. In quick succession, she hugged the person who opened the clinic door for her and her mom, she ran to and hugged another therapist in the hallway, and she hugged the therapist. The therapist asked Ms. Harris if she was worried about this behavior. She said, "Yes. I'm afraid that when she grows up, she will go with just anyone. She'll act slutty and boys will take advantage of her." The therapist asked Ms. Harris if she was aware of what she was saying and if she had heard words like that before. She blushed and said, "It's what my mother said about me. She made me feel so dirty. I don't want Shawna to feel like that, but I don't want her to get hurt, either." Mother and therapist agreed that an additional goal of treatment would be finding ways to help Shawna be less indiscriminate with her physical displays of affection.

Shawna clearly carried all of the violence that she had witnessed and experienced in her mind. After the therapist explained the reasons for treatment in the first session, she touched her mother's neck and arms and said, "Mommy owie." She touched her own head and said, "Owie." She put the female adult doll and the girl doll in the ambulance. She threw the male doll figure across the room and said, "Go!" The therapist responded that her daddy had gone away and that she would not see him again. She also said that Shawna and her mother had both been hurt. She said, "You had to go to the doctor. He made your head better and he made your mommy's cuts better. But you still think about it, and you're still scared." But Shawna certainly did not want to spend the whole session playing about violent memories. She found toy dishes and became very engaged in "cooking" for her mother and the therapist. She rocked the baby doll. At the end of the hour, she hugged the therapist. The therapist didn't rebuff Shawna. She returned the hug quickly and said, "I'm so glad to see you, but you don't know me too well. Your hugs are for special people like your mommy who you love best of all." Shawna ran to her mother and hugged her. They walked out together holding hands.

The following sessions were similar in tone. When Shawna played with the baby doll, the therapist said that Shawna's mommy must have taken such good care of her when she was little and now Shawna knew just how to take care of the baby. Ms. Harris and the therapist talked about the time when Shawna was a baby. Ms. Harris said that she remembered some lullabies that she used to sing to Shawna. The therapist wondered if she could sing them again now as part of Shawna's bedtime routine. The idea of a bedtime routine took Ms. Harris by surprise. She said that they did not really have a routine. They went to bed and watched television until they fell asleep. The therapist explained that sometimes television can be a lot to take in right before falling asleep, especially for a young child, and wondered if that might be contributing to the troubles that they both had sleeping. She asked about things that mother and child might do to help them both feel calm at bedtime. Ms. Harris proposed that they could take a warm bath together and then read a story and sing the special lullaby. The therapist praised Ms. Harris for understanding exactly what Shawna needed to calm her down.

During the second session, the therapist asked Ms. Harris if she had made contact with the individual therapist and the group to whom the therapist had referred her. She said that she had not had time, "and besides, I'm feeling better." The therapist asked how her eating was. Ms. Harris replied that she had only purged twice in the last week, and added that she was getting along much better now because her fiancé was back in her life. She said, "I know he loves me, and with him back, things will be better." This news alarmed the therapist, who persisted in saying that she was still very worried about Ms. Harris's depression and her eating patterns. She expressed pleasure in Ms. Harris's joy that her relationship with her fiancé seemed to be back on track but added that some extra support would still be important. Again Ms. Harris promised to contact the therapist and the leader of the group. The therapist asked how Shawna was feeling about the return of her mother's fiancé. Ms. Harris said that Shawna was thrilled. "He's so good to her. They play together and he helps me buy the things that she needs." The therapist said that sometimes children were jealous of their parents' relationships because spending time with a partner could mean that the child had less of the parent's time and attention. Ms. Harris said that she thought there would be no problem. "He doesn't live with us. Shawna and I have plenty of time together."

The therapist ended the session by again helping Shawna to reserve her special hugs for her mom, and Ms. Harris smiled as she accepted Shawna's hug. She said, "I guess I am special to her." As Shawna and Ms. Harris left the room, however, the therapist felt a sense of dread. The relationship with the fiancé seemed too close, too quickly. She wor-

ried that Ms. Harris would again become deeply depressed and suicidal if there were rough spots in her relationship with her fiancé. She was concerned about containing so much negative affect in the child–parent work without frightening Shawna and resolved again to work with Ms. Harris to broaden her support system to include an individual therapist and a women’s group.

During the six sessions that followed, Ms. Harris’s relationship with Shawna seemed to bloom. They played together, tending the baby doll, coloring with markers, and pretending to cook elaborate meals for one another and for the therapist. Ms. Harris reported that both of them enjoyed the bedtime routine and that Shawna’s sleep was much better. She reflected on Shawna’s play and said, “Maybe she’s just forgotten all of the bad things that happened to us.” The therapist said that she thought that those things were still in Shawna’s mind but that she was learning to use her relationship with her mother to help her feel less frightened. She said, “Shawna is little and she is growing fast. I think we are seeing play that shows us that she is really focused on being like you in ways that make her feel good. She takes care of the baby just like you took care of her. And she cooks just like you.” Ms. Harris laughed and said that Shawna was even trying to help her clean up at home. The therapist offered some reflective developmental guidance, saying that little children love their parents and want to be just like them. She said that she thought that finding ways to be like her mom made Shawna feel calmer and stronger.

The shadow over these weeks of calm clinical work was Ms. Harris’s continued reluctance to seek support outside the CPP. She said to the therapist, “I don’t want to start all over again with a new person. I called the group, but I didn’t like the leader.” She also reported that she stopped taking her medication because she didn’t like the way it made her feel. She said that it made her feel numb and that she did not really need it because she was feeling so much better. The therapist continued to assess level of depression, suicidality, and patterns of eating. Ms. Harris denied any suicidal feelings but admitted that she continued to binge and purge once or twice every week. She argued that even that was much better because she was purging less frequently than she had in the past. She said that she was trying to help Shawna eat better, and that helped her, too. Indeed, Shawna seemed to have gained some weight. During this treatment phase, Shawna had a physical checkup and her doctor was very pleased with her condition. Ms. Harris used the doctor’s approval as evidence that things were going well and that she did not need to see any other therapist.

The therapist saw a parallel between Ms. Harris’s intensely dependent involvement with her fiancé and her wish to be exclusively involved

with a single therapist. She continued to worry about the impact that any disruption in these relationships would have for Ms. Harris. This concern was justified. Three days after the eighth treatment session, Ms. Harris called in tears, saying that her fiancé had left her again. He told her that he could be her friend but had another woman with whom he was in love and who he planned to marry. The therapist, aware that this was the precise situation that had precipitated Ms. Harris's last suicide attempt, asked if she was having thoughts about hurting or killing herself. Ms. Harris said, "I did. I was standing in the window of my bedroom on the fourth floor. I was thinking so hard about jumping, and thinking that it would be the best thing to do. I'm alone again. No one loves me. I'm afraid it will always be this way." The therapist asked Ms. Harris what had stopped her from jumping and Ms. Harris said that two things had stopped her. The first was Shawna. "I would never leave my daughter alone. I know now how important I am to her. I could never do that to her." The other was her religion. She now had a clear sense that killing herself would be a sin. The therapist asked Ms. Harris if she had anyone to take care of Shawna so that she could come in by herself to talk. Ms. Harris agreed to arrange to come in on her own the next day. She made a verbal contract to call the therapist if she began to feel suicidal again, and she agreed that she would not do anything to hurt herself until she saw the therapist the next day. She said, "Don't worry. I'm over those feelings. I'll be okay."

Confronted with this crisis, the therapist knew that Ms. Harris needed individual therapy and possibly medication to help her cope with her depression, feelings of isolation and hopelessness, and suicidal ideation. She also knew that even if Ms. Harris sought individual help immediately, it would take time to arrange appointments and to form a substantive individual therapeutic relationship. In the meantime, it would be harmful to Shawna to be exposed to discussions of her mother's suicidal feelings. The therapist consulted with her supervisor about her concerns and together they decided that the best course of action would be to offer Ms. Harris a limited number of individual sessions as well as telephone support to help her become more stable, while at the same time assist her with finding an individual therapist. They believed that the fact that Ms. Harris relied on thoughts of her daughter to protect her from suicidal behavior was a two-edged sword. It was positive that Ms. Harris had a growing understanding of her importance to Shawna and the depth of Shawna's need for her. On the other hand, Ms. Harris used her relationships with others, her fiancé and the therapist, to regulate her feelings. Threatened abandonment felt murderous to her. She was not able to imagine herself going on living without these supportive relationships. The therapist was concerned that Ms. Harris,

with her desperate need for connection, would unconsciously pressure Shawna to take on responsibility for her emotional well-being. Shawna would be forced to stay near her mother, to be vigilant about her emotional state, and to find ways to restore her mother's positive affect when she was feeling down. This role reversal would interfere with the security of Shawna's attachment to her mother and would curtail her freedom to explore the world on her own.

Second Treatment Phase: Mother Alone

As promised, Ms. Harris came alone to see the therapist the next day. Her appearance shocked the therapist. Ms. Harris usually came to her appointments well groomed and stylishly dressed and made up. Now, however, she wore no makeup and looked unkempt and exhausted. The session itself was an intense one. Ms. Harris wept throughout it. She was willing to enter into a written contract that she would not harm herself and that she would contact the therapist immediately if she felt suicidal urges. The therapist gave Ms. Harris her pager number so that she could call any time and reach the therapist immediately. She also asked permission to call Ms. Harris once during the weekend to see how she was doing, and Ms. Harris agreed. The therapist raised the question of whether Ms. Harris would be safe outside the hospital or whether she should be admitted until her suicidal ideation passed. Ms. Harris firmly asserted that she would not kill herself. She said that her situation was very bad and that she felt alone and hopeless but that she would not sin against her church and she would not leave her daughter alone. The therapist reminded her that less than 3 months earlier she had made a serious suicide attempt and asked her what was different now. Ms. Harris said that whenever she felt the urge to hurt herself, she thought about Shawna and pictured Shawna's face in her mind. The image of her daughter banished her self-destructive thoughts. The therapist urged Ms. Harris to follow through with the referrals she had been given and especially urged her to return to her psychiatrist to talk to him about whether a different medicine might be helpful to her. The therapist also offered to meet with Ms. Harris alone for the next 4 weeks so that they could work through the difficult feelings she was having. She said that these four sessions would not make it unnecessary for Ms. Harris to find her own therapist. Ms. Harris gladly agreed to the four individual sessions, and said that she would think about contacting a therapist and reestablishing contact with her psychiatrist.

Before the end of the session, the therapist told Ms. Harris that there was something different this time that they had not talked about yet. She said, "The last time your fiancé left you, you did not talk to

anyone and did not look for help before you hurt yourself. This time you were able to stop yourself, and you reached out for help. I'm so glad that you called me so that I could give you the support you needed." Ms. Harris said that she knew that was different. She said to the therapist, "You're the only one who really helps me. It feels good to talk to you." The therapist was strongly aware of the underlying danger in this statement of exclusivity but was also cautiously optimistic that Ms. Harris was using her as a resource to not hurt herself.

For the next several days, Ms. Harris and the therapist talked daily by phone, and the therapist consulted frequently with her supervisor. Ms. Harris denied any further suicidal thoughts. She came for her first individual appointment still feeling sad and hopeless but said that she no longer thought about killing herself. The therapist focused on assessing Ms. Harris's level of depression and offering her some ideas for ways that she could cope with her feelings. She gave Ms. Harris some psychoeducation on the benefit of exercise for depression. Ms. Harris agreed that until her next appointment she would get up every day and, after breakfast, take Shawna to the park for at least 30 minutes. Ms. Harris again rejected the therapist's urging that she should follow up on getting individual treatment. She said, "I don't want to start with anyone new. I feel better. I would rather just talk to you." The therapist said that Ms. Harris might feel better more quickly if she had additional support and if she followed up with her medication, but Ms. Harris was adamant. She did agree, however, that she would continue to discuss these recommendations with the CPP therapist.

As the weeks passed, Ms. Harris's mood lifted. She was taking Shawna to the park every day and sometimes stayed there longer than an hour. She was dressing more neatly and began to wear makeup again. She was, however, bingeing and purging more often again, sometimes three or four times a week. The therapist tracked Ms. Harris's depression and suicidal ideation, which Ms. Harris consistently denied. Concerned that Ms. Harris was overeating to control her sad and hopeless feelings and then purging to avoid gaining weight, the therapist worked with her on breathing and relaxation techniques. Ms. Harris continued to refuse individual treatment.

Third Treatment Phase: Searching for Shawna

The four individual sessions that Ms. Harris and the therapist had agreed to became five, then six. Ms. Harris's mood was sufficiently brighter that the therapist and her supervisor agreed that it was time to bring Shawna back into the sessions. They believed that it was likely that Ms. Harris's depression had been frightening for Shawna, and wondered if Ms.

Harris had been able to notice Shawna's fears and concerns. Although Ms. Harris was doing better, her state was still sufficiently fragile that she might have turned a deaf ear to Shawna's distress so that she could avoid the guilt and shame that she would feel if she allowed herself to know the impact that her moods had on Shawna. Therapist and supervisor were concerned that Shawna might be put in the position of taking care of her mother's emotional state by forcing herself to show a cheerfulness that she did not feel. They hoped that having Shawna back in the sessions would enable Ms. Harris to use the clinician's support to be receptive to whatever feelings Shawna would express.

During the seventh individual session, the therapist reminded Ms. Harris that they had agreed to only four individual sessions. She said, "You needed more time than that for yourself, but now I wonder what it would be like for you to bring Shawna back?" Without much discussion or reflection, Ms. Harris agreed that this would be a good idea and said that she would bring Shawna to the next meeting. She then turned immediately to a discussion of the ups and downs of her relationship with her "fiancé." She talked about how much she loved and needed him and how much she still felt committed to him even though he told her that he was going to marry another woman. She said that she did not believe him. "He still comes to see us, and he still helps me with Shawna. I know he loves me. I just have to wait." The therapist explored whether Ms. Harris was feeling better because she believed that this man would eventually come back and marry her. Ms. Harris acknowledged that she had started to feel better when he began coming to see her again. She said, "I just can't believe that he will turn his back on us when we need him so much."

The therapist was alarmed by the fragility of Ms. Harris's emotional state and her dependence on a man who seemed, at least to the therapist, almost completely undependable. In supervision, she reflected on how little faith Ms. Harris had in herself and how empty and inadequate she felt when she was on her own. She recalled how Ms. Harris's own parents had denigrated her and hurt her when she was a child. She said, "I'm glad that she trusts me enough to talk about all of these things." Her supervisor responded that the therapist had become a real lifeline for Ms. Harris, and that it seemed that Ms. Harris was using the therapeutic relationship to explore feelings that she had, until now, sought to suppress using drugs, bingeing and purging, and suicidal gestures. The supervisor said, "She's using her relationship with you to modulate the intensity of her feelings so that she can explore them. You are giving her what we hope she will some day be able to give Shawna."

The next week, Ms. Harris came to the session alone again. The therapist asked her about Shawna, and Ms. Harris said that she had

left Shawna playing with a friend whose mother had been willing to watch both children for a couple of hours. The therapist replied that it was good that Ms. Harris could get the help she needed and good that Shawna had another child to play with. Ms. Harris spent much of the session talking about some of the relationships that she had formed with the women in her transitional housing program. She seemed surprised by those relationships and said that until recently she did not have women friends. She also talked about a new man whom she had met, describing him as “nice, but kind of dull.”

Although the therapist explored these relationships with Ms. Harris, she also asked Ms. Harris to reflect on their impact on Shawna. More important, she broached the topic of how Ms. Harris’s period of depression had affected Shawna. Ms. Harris thought for several minutes and then said, “She seemed worried about me. She always tried to comfort me. It felt good to know that she was there for me.” The therapist responded that it felt good to be so loved, but wondered if Ms. Harris had felt up to comforting Shawna when Shawna expressed worry. Ms. Harris said, “Sometimes I just held her and rocked her. It felt so good to have her close. Maybe it comforted us both.”

Over the next several weeks, Ms. Harris brought Shawna to only two sessions. Shawna was glad to see the therapist and clearly glad to be back in the playroom. She was very solicitous of her mother, patting her on the cheek, cooking elaborate meals for her, and looking very worried if her mother became tearful. The therapist said, “Shawna, you are worried about your mommy. You are trying to take care of her but you are just a little girl. Your mommy is sad now, but she will feel better. I’m here to help her, and she’s taking good care of herself.” These statements were addressed to both Shawna and to Ms. Harris.

Ms. Harris continued to be preoccupied with her own problems even when Shawna was present in the sessions. She responded to Shawna’s overtures and was available to play with Shawna from time to time, but clearly her focus was on herself. The therapist said to Shawna, “Your mommy has some big, grown-up problems, and she and I are working together to figure them out. We will take care of them. It’s not your job.” Over time, this message seemed to sink in for Ms. Harris as well as for Shawna. In one session, Shawna approached her weeping mother, stroked her cheek, and said, “It’s okay, mommy. It’s okay.” Ms. Harris picked Shawna up and held her close. She said, “I’m sad now, but don’t worry. I’ll feel better again soon. You can play. In a minute I’ll feel better and I’ll play with you.” The therapist said to Shawna, “Your mommy knows that it’s not your job to take care of her. She’s the mommy and you’re the little girl. But even mommies get sad sometimes. They cry, but then they feel better.”

From the outside, it may have looked as if the individual sessions of the therapist with Ms. Harris had left behind CPP. But this was not the case. The individual sessions served as a necessary port of entry for further work on the child–parent relationship. The therapist always held Shawna in her mind during these individual sessions. As Ms. Harris could tolerate it, the therapist was asking her to hold Shawna in mind, too. Ms. Harris seemed increasingly better able to do this. Often she volunteered information about how Shawna was doing and how she was responding. She talked about the things that they did together for fun. When Shawna did come to sessions, it was clear that she was thriving. Her eating and sleeping were no longer problems and she was increasingly engaging in symbolic play. She was better able to tolerate Ms. Harris’s sadness and was not so vigilant about her mother’s moods.

Over the remainder of the treatment, the therapist became reconciled to Shawna’s off-again, on-again attendance at sessions. Ms. Harris used the sessions well when she came alone. She reflected on her intense dependence on a single person (her fiancé, her therapist) and began to see it as an effort to create in the present the feeling of being unconditionally treasured that she longed for while growing up. She explored what it meant to be drawn to men who hurt and disappointed her and bored by men who were dependably kind and reliable, and she linked it to her ambivalent love for her alternatively brutal and withdrawn father and brothers. She reflected on Shawna’s different responses to men and seemed cheered that her daughter preferred the men whom her mother found dull. Ms. Harris said, “She has better judgment than I do! She likes to be treated well.” The therapist replied, “Being treated badly is more familiar to you. But you haven’t beaten Shawna. You haven’t called her names. She expects the world to treat her well.”

Reflections on Treatment Outcome

Ms. Harris blossomed in the treatment. After several weeks in which she had not discussed her own eating patterns, she proudly announced that it had been over a month since she had done any binge eating. Although she still struggled with depression, she had not had suicidal thoughts. She returned to her psychiatrist and started a different antidepressant medication. She began to see herself as worthy of good treatment and finally turned away from the “fiancé” who had let her down so often. She said that she was not ready to commit herself to the “boring” man yet and reflected on the fact that she had done pretty well just being on her own and taking care of Shawna. Finally, she began attending a women’s group. At first she hardly spoke during the groups; gradually she participated more fully.

In treatment, Ms. Harris developed sufficiently for her to offer her daughter a relationship on which Shawna could rely. CPP was an essential element in Ms. Harris's growth, but it could be successful only in a modified format that allowed her to develop a deep working alliance with the therapist. As she experienced the therapist's holding care, Ms. Harris began to experience herself as worthy of love and kindness from herself and from others. While this work proceeded, the therapist held Shawna firmly in mind. Although there were many weeks of sessions in which Shawna was not physically present, she was never excluded from the therapeutic relationship between her mother and the therapist. The therapist consistently made bridges in her mind between what Ms. Harris reported and what Shawna might be experiencing as the result of her mother's moods and behavior. Developmental guidance was a regular component of the mother's individual sessions to reinforce and expand the work of the first treatment phase around Shawna's affect modulation, regulation of eating and sleeping patterns, and the importance of spending relaxed and pleasurable time together. When Ms. Harris was feeling strong enough to look outside herself, the therapist asked her to join her in reflecting on Shawna's inner experience. During the initial joint phase of treatment, Ms. Harris acquired the conviction that her daughter loved her and needed her. During the individual sessions, she used the therapist's steadfast and caring stance to develop into a person who could care for herself, and in doing so she became a mother who could meet her child's needs.

Individual Work with the Child: Strengthening the Sense of Self

There are situations in which the child is in urgent need of conveying her own experience, but the parent cannot tolerate witnessing what the child needs to express. The CPP variation to address this situation involves individual sessions with the child that co-occur with individual sessions with the parent. In both settings, the therapist maintains attention simultaneously on the child's individual experience and on increasing attunement to the experience of the other. The example that follows illustrates key aspects of this approach.

Example: When the Child Overwhelms the Parent

Marlee, 3 years, 6 months, and her mother, Ms. Anderson, were referred for CPP by Marlee's pediatrician after Ms. Anderson complained that Marlee was hitting her and rubbing her breasts. Ms. Anderson told

the pediatrician, “I just can’t stand her sometimes!” The pediatrician was also concerned about Marlee’s wan facial expression and lethargic demeanor. Although he did not suspect child abuse, he was concerned about the possibility of neglect and made the referral for treatment as a preventive measure rather than making a referral to CPS.

Initial Assessment

Ms. Anderson was a middle-class European American woman in her late 20s who had been married to Marlee’s father for 5 years and was currently separated from him. During the first assessment session, Ms. Anderson was as candid with the CPP therapist as she had been with the pediatrician. She said that Marlee’s “hitting and groping drive me crazy. I don’t even want to be in the room with her.” The therapist asked when this behavior had started, and Ms. Anderson replied that Marlee had been aggressive “her whole life” but “didn’t start to grab at my body until after she saw her dad rape me.” Ms. Anderson reported that Marlee’s father had raped her several times before she finally called the police and had him arrested. Because Marlee had shared a bedroom with her parents, she had likely witnessed the attacks. Ms. Anderson also disclosed, with some shame and anger, that she was not the only person Marlee was “groping.” Marlee had been found peeking at other children in her preschool when they were in the bathroom, and once she tried to forcibly remove a little boy’s jeans and underwear.

By the time the assessment period was completed, Ms. Anderson and the therapist had agreed on two treatment goals. The first was to give Marlee a contained space in which she could express her fears and concerns about what she had seen. The second was to help her find other ways besides aggression and invasion of other people’s personal boundaries to communicate her concerns. Ms. Anderson helped the therapist formulate the language that they both would use to explain the treatment to Marlee and said that she felt comfortable telling her about the treatment before the first session. The therapist began the treatment phase confident that Ms. Anderson would be a willing collaborator in helping Marlee.

Initial Treatment Phase: Mother and Child Together

In preparation for the initial session, the therapist chose a variety of toys that would help Marlee tell the story of what she had seen. The toys included a dollhouse and male, female, and child dolls ethnically matched to Marlee’s family. Two animal families, each with male and female adults and two young members of the species, were also provided

because Marlee might be more comfortable playing about her concerns with animals rather than people. Puppets that could represent a teacher and several children were also chosen because school behavior had been identified as a problem. Finally, to encourage play about themes of help and repair, the therapist made a medical kit, a police car, and an ambulance available in the playroom. There were other toys and art supplies as well, so that Marlee would have the freedom to depict in her play daily activities and developmental concerns not related to the trauma.

Marlee gravitated to the dollhouse and the dolls as soon as she and her mother entered the playroom for the first session. Even as the therapist was describing the reason for treatment, Marlee was taking the clothing off the two adult dolls. She put them in the dollhouse bed, placed them one on top of the other, and forcefully rocked them back and forth. Ms. Anderson turned pale as she watched Marlee's play. She hugged herself, turned away from the therapist, looked at the floor, and rocked back and forth. The therapist noticed Ms. Anderson's distress and said that it seemed hard for her to watch what Marlee was doing. Ms. Anderson exploded, saying that Marlee's play was "nasty" and demanding that Marlee stop.

The therapist felt torn between the very different needs of mother and daughter. She was convinced that Marlee urgently needed to depict in her play the assaults on her mother that she had witnessed; at the same time, Ms. Anderson could not bear to watch. The play served as a trauma reminder for her and she reacted with shame and rage. The therapist chose to highlight their different needs and said simply, "Marlee went to the dolls so quickly. She really needs to tell us something but it is too painful and difficult for you to hear." She hoped that this expression of empathy would be enough to help Ms. Anderson focus on Marlee, but it was not. Ms. Anderson continued to describe Marlee's play as nasty and sick. Marlee dissolved in tears. The therapist tried again, this time explaining her mother's experience directly to Marlee. She said, "When you play with the dolls, it makes your mommy remember scary things that happened to her and she feels bad." This interpretation was no more useful than the first one in softening Ms. Anderson's response, but it did make Marlee turn away from the doll house. She went to her mother, stroked her face, and said, "Sorry, Momma. Sorry. Sorry."

The therapist was keenly aware of how quickly Marlee took on responsibility for her mother's emotional state and how willing she was to give up her own needs in the service of her mother's comfort. For the remainder of the session, Marlee and her mother sat quietly together. They drew a picture of a little girl standing in a field of flowers under a sunny sky. The therapist noted that they had both had some very big feelings during the session, and that they were making a happy picture

to help them both feel better. At the end of the hour Marlee did not want to clean up the toys. When she protested, her mother said sharply that they would come back again next week but that now it was time to go. She said, "You need to listen to me. Clean up." Marlee looked startled at the anger in her mother's voice, but she complied.

The next two sessions were similar in tone and content. The therapist found that she could make no inroads on Ms. Anderson's angry rejection of Marlee's play. During the fourth session, Marlee was crying when she arrived and she actively resisted going into the playroom. The clinician asked both Marlee and her mom what was wrong. Ms. Anderson replied that she had told Marlee that she would have to "play nice today" or she would not be allowed to watch television for the rest of the week. She said that she told Marlee that she needed to "keep her hands off those dolls."

The therapist commented that it seemed that the treatment was making things harder for them instead of better, and she asked them to come into the playroom so that they could talk. When they were settled, the therapist said that she was going to propose something different from the kind of treatment that she had discussed with Ms. Anderson during the assessment. She said, "I'm going to suggest that for the next 6 weeks, I meet with each of you separately. I think that it is important for Marlee to be able to play about what she saw. It's plainly on her mind and she's worried about it. But, Ms. Anderson, it's just too hard for you to watch. I think it reminds you too much of what happened to you. That's why I'm recommending separate sessions. I'm suggesting we try it for 6 weeks, and then get together again to see if things go better." Ms. Anderson agreed and said that they could start right then. She seemed relieved to leave the room and to leave Marlee behind.

Second Treatment Phase: Individual Child and Mother Sessions

The therapist had different goals for Marlee and for her mother during the 6 weeks of separate sessions. She believed that her role with Ms. Anderson should not be to process directly the rapes that Ms. Anderson had experienced. That seemed the province of individual therapy which, to date, Ms. Anderson had rejected because she did not want to tell her story in detail. The therapist decided to devote her attention to Ms. Anderson's experience of watching Marlee play, and also to keep Ms. Anderson informed of developments in Marlee's play so that, once her own affect was sufficiently regulated, she would be able to shoulder her role as Marlee's secure base and developmental guide.

Different goals guided the treatment with Marlee. The child needed, first and foremost, to play out her concerns about her mother's rape

without being coerced away from her narrative by her mother's arousal. She also needed relief from the fear that she was at fault for the frightening things that had happened and from the conviction that it was her job to take care of her mother. She also needed to be taught kindly rather than punitively about cultural norms regarding physical boundaries, touching other people's bodies, and personal privacy.

Each week the therapist met for 45 minutes with Marlee, and then arranged for a colleague to stay with Marlee so that she could talk with Ms. Anderson. This arrangement was made because Ms. Anderson's work schedule and child care arrangements did not allow her to come to the office on two separate days.

Marlee used the individual sessions fully to play out her concerns about her mother's safety and to convey her own aroused feelings of sexuality mixed with fear. In one session, Marlee spread her legs and rubbed a doll against her genitals in a hard and driven manner. The therapist suppressed her wish to stop her and said instead, as calmly as she could: "What is happening?" Marlee instantly looked crestfallen, stopped what she was doing, and tried to hide behind the armchair. The therapist asked: "Are you worried that I am mad at you?" Marlee peeked out with a very serious expression and said nothing. The therapist said: "I am not mad at you. I know that it feels good to touch oneself, but sometimes it is also scary when it is too strong." Marlee's face softened as she stared silently at the therapist, still half-hidden behind the armchair. The therapist continued, "Marlee, you are a little girl and you are learning many things. You are learning when it feels good and when it feels scary to touch oneself." Marlee cried out, "But my mommy hits me when I do that!" This was a revelation for the therapist because Ms. Anderson had staunchly denied hitting Marlee. The therapist answered: "It is so scary when your mommy hits you." Marlee looked very sad. The therapist said: "Your mommy knows that it not right to hit you but she did not learn not to hit. I will try to help her. It's not good to hit. It's not good to scare you." Marlee came out from behind the armchair and sat very close to the therapist, playing with her hands. The therapist put her hand on Marlee's hands and said, "Hands are for playing and for feeling good, not for hitting." She then reached out to the doll that Marlee had used to poke at her genitals and said, "Hi, doll. Do you want to play with Marlee?" She then handed the doll to Marlee, who handled it briefly and then moved to play with the kitchen utensils until the end of the session.

This session illustrates the use of developmental guidance and emotional support to help the child manage anxiety about unmodulated sexual feelings associated with traumatic overstimulation. Marlee's trust in the therapist enabled her to demonstrate the behaviors that gave

her deepest shame and fear of losing the mother's love. Developmental guidance and reframing of the mother's behavior were also used to help Marlee know that the mother's hitting was not a response to the child's inherent "badness" but rather a reflection of Ms. Anderson's failure to learn. In this session, the therapist did not make an explicit link between Marlee's sexual play and the violent sexuality she had witnessed between her parents. She chose instead to give Marlee permission to feel sexual feelings without immediately associating them with "nasty" behavior, as Marlee's mother tended to do. In choosing this course of action, the therapist believed that she was providing corrective emotional experience to Marlee's feelings of shame, self-blame, and fear surrounding sexuality and aggression.

The therapist now faced the challenge of how to bring up the themes of Marlee's session with Ms. Anderson in the individual session with the mother that followed immediately after the individual session with the child. Ms. Anderson started the session in a manner that had become predictable, harshly complaining about Marlee's general "nastiness" by playing sexually at school, talking back, and refusing to comply with her commands. The therapist listened quietly for a while and then said, "I can hear how burdened you are by Marlee's behavior. You know, I think she wants to please you but she just can't stop herself." The mother answered, crossly: "What does that mean? Of course she can stop herself. She does not want to! I told her again and again to stop touching herself and to stop touching others. She could care less." The therapist, fortified in her resolve by the image of Marlee's sad face and despairing tone in the hour before, said softly, "I don't know about that. Do you know how we try and try to do good and not to do bad things, and then we lose it and we're back to square one? It happens even to us grownups. She's only 3." This statement served as a point of departure for talking about loss of control of one's strong emotions. By acknowledging that this happened to everybody, including herself, the therapist normalized behaviors that cause shame and self-blame and decreased Ms. Anderson's defensiveness. When she found herself on a surer footing, the therapist asked, casually, "For example, many parents don't want to spank their kids, but they get so mad at times that they can't stop themselves." Ms. Anderson said, "That happens to me too." The therapist answered matter-of-factly, "I am not surprised. You have so much on your shoulders. The problem is that spanking usually makes things worse, because children get so scared and angry and then they don't feel like doing what one wants them to do." Ms. Anderson replied, "Marlee gets angry but not scared. She is nasty." The therapist answered, "That is how she looks to you because you are so embarrassed by what she does. But when we are alone she lets me see

how important it is for her to please you, and how worried she is when she can't stop herself."

In this intervention, the therapist used the information Marlee had given her without attributing it directly to the child in order to protect her from possible maternal retribution. In the course of many individual sessions with Ms. Anderson, the therapist asked her about the feelings that had emerged when she watched Marlee put the dolls on top of each other and made them move forcefully. Ms. Anderson replied that the play made her feel that she was being raped all over again. The play had clearly served as a trauma reminder that Ms. Anderson could not tolerate. In addition, watching her daughter play had aroused deep feelings of guilt and shame that she had been so vulnerable in front of her daughter and that she had allowed her daughter to be exposed to something so frightening and "nasty." When asked about the word "nasty," Ms. Anderson revealed that she and her husband had sex in front of Marlee, thinking that the child was asleep, even on occasions when it was consensual. She was ashamed that her sexual desire for her husband prevailed over her wishes to protect her child from adult behavior. As she spoke, Ms. Anderson began to see that her anger at Marlee was only one component of a more pervasive anger at her husband and at herself. As she began to understand the complex interconnections between anger, helplessness, and fear, she listened with increased tolerance and interest to the themes of Marlee's play.

When the 6 weeks of separate sessions came to their close, Ms. Anderson agreed that she was ready to return to joint sessions. She could tolerate detailed descriptions of Marlee's play without becoming overly aroused and angry and she believed that she would be able to tolerate the play itself as well. She was correct in her judgment. Marlee continued to play out sexual themes but with less pressure. Ms. Anderson was able to witness the play and to empathize with Marlee's fears. She was also able to speak convincingly about how much better she felt and reassured Marlee that although she had been frightened and angry at the time, she was feeling stronger and would make sure she and the child would be safe.

The remainder of CPP treatment was conducted in the traditional joint session format. Over time, Marlee and her mother constructed a narrative of what had happened on the night that Marlee's father was taken away by the police. Ms. Anderson was able to tolerate hearing that Marlee was frightened about what was happening to both of her parents and that she missed her father. The balance in the parent-child relationship was restored, with Ms. Anderson providing comfort and reassurance. At the end of the treatment, both Ms. Anderson and the therapist believed that it was a success.

Coparenting after Violence: When Treatment with a Single Parent Is Not Enough

Children do best when their parents are strongly allied in working for their children's best interest. In a sound coparenting alliance, each parent is invested in the child, values the other parent's involvement with the child, respects the judgment of the other parent, and communicates with the other parent about the child's needs (McHale, 2007; Weissman & Cohen, 1985). Hostile, withdrawn coparenting relationships are associated with greater anxiety and depression in children (Katz & Low, 2004).

Children's need for their parents to collaborate on their behalf is particularly urgent when the parents have separated following domestic violence. Children in such situations are particularly vulnerable to mental health problems because of their exposure to frightening scenes of violence and because of their loss of consistent daily interactions with both parents. Their development is placed at great risk when their parents continue to be embroiled in conflict even after the separation.

The CPP coparenting model is a treatment variation designed to address the needs of young children whose parents separated after physical and/or emotional violence. The goal is to help the parents form and sustain sound coparenting alliances on behalf of the child. The following features are integral components of the coparenting model.

1. A single therapist meets weekly in separate sessions with the child and father and with the child and mother. This format enables the therapist to remain firmly allied with the child, who is the unifying link across the sessions. When this frequency is not feasible, joint child-mother and joint child-father sessions take place on alternate weeks.

2. The coparenting format is agreed on by both parents at the time of the intake assessment. The assessment includes identical procedures with each parent separately. The feedback is provided to each parent separately. The participation of each parent from the beginning of the process increases the likelihood that both parents will feel equally invested in the treatment process.

3. The parents agree to waive confidentiality vis-à-vis the other parent of the material that emerges during the sessions. This is an important component of the coparenting agreement because therapists need to be able to use their clinical judgment in disclosing information that will promote the child's well-being and foster better understanding and communication between the parents.

The coparenting treatment format has parallels between the child's and the therapist's experiences. Like the child, the therapist needs to form a strong working relationship with each parent. The therapist is also subject to pressures for loyalty similar to those that the parents place on the child. In meeting regularly with each parent, the therapist communicates to the child that it is possible to handle the conflicting desires and pressures that come from the parents. For these reasons, having a single clinician conduct the treatment is an essential feature of the model. We have found that when two therapists are involved, they are likely to each become allied with the parent with whom they are working and to act out the transference pressures from the parents in their own relationship with each other.

Example: A Child Caught in the Middle

Ellen Scott was 4 years, 6 months old when her parents separated. Paula and Edward Scott had been married for 8 years, and both of them described the first 4 years of their marriage as good. Mr. Scott said, "When Paula got pregnant we were thrilled. We loved each other and thought we would spend the rest of our lives together. But Ellen was born too soon and she was sick. She had trouble feeding and we were desperately worried that she wouldn't gain weight." Their worries soon outweighed the positive aspects of their relationship. According to both parents, by the time Ellen was 1 year old they were fighting daily. Mrs. Scott said, "We screamed at each other. We hit each other. Finally we couldn't stand it any longer and we agreed to part ways."

Even their separation, however, was filled with conflict and rage. Mrs. Scott said that their discussions about separation had been rational and amicable in the beginning but quickly changed in tone. During one discussion about how they should share their time with Ellen, Mr. Scott backed Mrs. Scott into a corner and screamed at her. In what she described as a desperate attempt to get away from him, she slapped him and scratched his face. This happened as Ellen looked on, crying and screaming for them to stop. Mr. Scott called the police, and because he had visible signs of injury, Mrs. Scott was arrested and charged with an act of domestic violence. Mr. Scott ultimately dropped the criminal charges but not until he had gone to family court and obtained full physical and legal custody of Ellen. Mrs. Scott ultimately succeeded in convincing the judge that she should have shared legal and physical custody of Ellen. The court recommended but did not require that the parents seek therapy to help Ellen with her feelings about the violence

she had witnessed and to help her cope with her parents' highly conflicted relationship. The Scotts agreed.

The Assessment Period

Mr. and Mrs. Scott came separately for their assessment meetings. Both of them made it clear at the outset that they were unwilling to be seen for joint sessions. Both of them had concerns about Ellen, but their concerns were markedly different. They also saw the causes for the disintegration of their relationship through markedly different lenses.

MR. SCOTT'S STORY

Mr. Scott believed that his wife was the direct cause of all that had gone wrong in their marriage and that Ellen's difficult infancy had made her neurotic and fearful. He said that Mrs. Scott had many irrational fears that something was wrong with Ellen and that her constant worries about the baby left little room for anything else in her mind. She had turned away from him, he said, and her refusal to talk and her turning inward after the baby was born had made him feel pushed away and excluded. In his view, she became angry and isolated herself further whenever he tried to get her to talk about what was going on, and ultimately she became physically violent toward him. Mr. Scott described several incidents in which she scratched his arms and threw things at him while "screaming like a shrew," often in front of Ellen. He denied having ever been physically violent, although he acknowledged that he and his wife both became involved in loud verbal arguments and this might have been frightening for Ellen.

Mr. Scott described his family of origin as one in which problems could be freely discussed and resolved by talking them out. He appeared to idealize his parents and particularly his mother, whom he described as "pure loving kindness." He believed that his wife's family was more troubled, that she had been treated abusively by her father, and that her troubled youth was the source of the "neurosis" that made her so anxious and withdrawn when Ellen was small. He spoke about Mrs. Scott's early life in a way that seemed sometimes empathic and sometimes condescending. It was clear that when he compared his wife's childhood to his own, Mr. Scott found hers wanting and believed that from that deficient childhood a deficient adult had emerged.

Mr. Scott's concerns about Ellen were directly related to what he saw as the deficiencies in Ellen's mother. He said, "Lately Ellen has been acting just like Paula. I don't know how to describe it other than that

she is imitating what she has seen her mother do. She stomps her feet. She screams at me. She's tried to hit me, as she saw her mother do." Other than this imitative behavior, Mr. Scott expressed no concerns about Ellen. He described her as a bright, imaginative, loving child who was well attached to both of her parents but capable of independence and initiative. He said that she was doing well at preschool both socially and academically. She had many friends, and "her teacher says that she wishes all of her students were like Ellen."

Mr. Scott said that he had sought sole custody of Ellen to protect her from her mother's violence and her moodiness, but he also acknowledged that Mrs. Scott was generally a good mother who was very attentive to Ellen. His stated concern was, "I don't want Paula to rub off on Ellen. I don't want her to grow up to be neurotic and violent as Paula is. I'm afraid that is what will happen if they are together too much." He was very worried that the court had been willing to give Mrs. Scott joint custody of Ellen, but he was also somewhat relieved that the time Ellen spent with her mother would be increased only gradually, beginning with 2 days and 1 night each week and increasing to a 50–50 sharing of parental responsibility over the course of 2 months.

Mr. Scott denied that he had any problems at the time of the assessment. He endorsed no symptoms of depression and no symptoms of PTSD. He did not use substances in excess, either by his own report or by his wife's report. He was employed and was successful in his work. He reported having a circle of supportive friends. His only stated concern and the reason for his seeking treatment, was to "help Ellen get over her mother's anger and get on with her life."

Mr. Scott's interactions with Ellen during the assessment period gave no cause for concern. He was responsive to her needs, reasoned with her when he needed to set limits, and was warmly affectionate. Ellen was a bright, verbal child whose father seemed genuinely delighted with her ability to tell a story and genuinely interested in her ideas. He was able to follow her lead in play and to engage in play with her, although her imaginative play was limited to enacting daily household activities such as bathing and dressing a baby doll and pretending to cook dinner for her father, the baby doll, and herself.

Within this generally favorable picture, there was some indication that Mr. Scott became uncomfortable whenever Ellen was distressed. He wanted her to quickly turn away from any negative feelings, whether sad or angry. When she expressed sadness, he distracted her by tickling her and joking with her. This was especially evident when Ellen protested at the end of the session. She began to cry and said that she did not want to clean up and leave. Mr. Scott picked her up, tickled her until she started laughing and said, "You don't have to clean up. It's okay.

We can just go.” He described himself as an optimistic person and said that he wanted his daughter to be optimistic, too.

MRS. SCOTT’S STORY

Mrs. Scott gave a somewhat different picture of the history of violence in her marriage. While she acknowledged that she had been both verbally and physically aggressive with her husband and confirmed much of what he had said, she also reported that he had been violent with her: grabbing her, pulling her hair, and, most significant from her point of view, blocking her in corners or against the wall at times that she tried to get away from him or end an argument. She said that it was at those times, feeling cornered by him, that she would hit or scratch at him. She also acknowledged tearfully that Ellen had witnessed much of this fighting.

Mrs. Scott also confirmed her husband’s statement that she had a very rocky relationship with her parents while growing up. She hesitated to characterize them as abusive but said that they were very controlling and overly harsh and critical and made her feel “small and like I didn’t matter at all.” She stated that she never wanted her daughter to have that experience.

Mrs. Scott said that she and her husband had both been terrified when Ellen was born several weeks premature. Ellen was difficult to feed as an infant and lost weight after her birth. Mrs. Scott said that as an infant, Ellen felt “incredibly fragile, like she would break.” Caring for her was anxiety provoking. Mrs. Scott felt worried during much of Ellen’s first year of life and she did not believe that her husband was supportive of her concerns, although she acknowledged that he did help her maintain the household so that she could spend time with the baby. Before Ellen’s birth, Mrs. Scott had been a successful businesswoman, and she said that it was a new experience for her to feel so isolated and incompetent as a stay-at-home mother.

It seemed that Mr. and Mrs. Scott’s relationship never recovered from the stress of Ellen’s fragile infancy. Mr. Scott found his wife to be neurotic; she found him to be harsh and unsupportive. The schism in their relationship only deepened as they argued and struggled with each other and neither seemed able to hear the other one. Both were concerned that Ellen had been badly scarred by all of their fighting, although Mr. Scott held his wife fully responsible for this damage to Ellen and saw himself as rescuing Ellen and protecting her from her mother’s lability and neurosis.

Mrs. Scott had her own worries about Ellen that were different from her former husband’s. She agreed with him that Ellen did well in

school and did well with her peers. She did not see Ellen as overly bossy and controlling or as imitating her behavior. Her concern was that Ellen was too constricted in her feelings. She believed that Ellen could not tolerate feeling sad or angry and that she put on a falsely cheerful face to please people and particularly to please her father.

Mrs. Scott acknowledged that she suffered from a moderate level of depression and moderately severe anxiety. She was fearful that Mr. Scott would take Ellen away from her. She was frightened that she would not be able to support herself in spite of her successful career as a businesswoman before Ellen's birth. She still had worries about Ellen's health. Although she believed that these worries were exaggerated, she did not seem able to get them out of her mind and reported that these worries interfered with her ability to concentrate and with her sleeping. Mrs. Scott did not abuse substances, either by her report or by her husband's. She was employed, had friends whom she found supportive, and had adequate housing. Although she was depressed and anxious, she was managing well the concrete demands of her daily life. She had begun individual psychotherapy, and neither she nor her therapist believed that her depression and anxiety were sufficiently severe to require medication.

Mrs. Scott's play with Ellen was warm and intimate, with easy and frequent physical contact between them. Ellen's play with her mother contrasted with her play with the father in one important respect: In her mother's presence, she quickly developed and sustained a narrative of the violence she had witnessed. Upon entering the playroom with her mother, Ellen went immediately to the dollhouse and took all of the furniture out of it. She carefully rearranged the furniture in the house while her mother looked on. She placed two adult doll figures in the living room and a small child doll figure in a bed nearby. She said, "The little girl is in bed and they are taking a break." She sat the adult doll figures on the sofa. Then she picked them up and shook them vigorously and said, "They're yelling now." Finally, she threw the female adult across the room. She shook the male doll and said, "I'm calling the police. You get out of here. Don't come back!" as she threw the female doll. The assessor asked Ellen what happened with the little girl. She said, "The little girl cried because she missed her mom."

Mrs. Scott watched this play silently, sitting near Ellen. When Ellen said that the little girl missed her mom, Mrs. Scott reached out and scooped her up. They sat silently for a few minutes. Ellen wept briefly in her mother's arms. Her mother rocked her and said, "That's very sad. That's very hard." After a few minutes, Ellen leapt from her mother's arms and started to dance around the room with a big smile

on her face. She was displaying the phony cheerfulness her mother had described as her mechanism to fend off sadness, just as her father wanted her to.

At the end of the play session, Ellen again protested. Mrs. Scott said that they would come back again but that Ellen really did have to help clean up and say goodbye. Ellen accepted her mother's help, and they cleaned up the toys together. Ellen left without crying.

FEEDBACK FOR THE PARENTS

Both Mr. and Mrs. Scott were aware of Ellen's distress, although they viewed it differently. Each of the parents commented, during the separate feedback session, that the assessment had helped them understand how hard their continuing conflict had been on their child. Both parents reflected on ways in which their own behavior might have been frightening and overwhelming for their daughter, and both were receptive to the suggestion that she needed to hear from them that she was not responsible for the conflict in their relationship, that they would both always love her and take care of her, and that they wanted her to love the other parent. It was encouraging to see that both Mr. Scott and Mrs. Scott seemed sincere when they said that they knew that Ellen needed them both. The therapist sensed that although their feelings for each other were still overwhelmingly negative, they would try to keep those feelings from spilling into their relationships with Ellen.

The therapist used her feedback session with each parent to plan what to say to Ellen about why she would be coming to play. Initially, Mrs. Scott wanted to focus only on the separation as a source of distress for Ellen. The therapist urged Mrs. Scott to think about whether this focus might leave Ellen with the impression that her mother was willing to talk about the separation but not about the conflicts that preceded it. Mrs. Scott said that she hoped that Ellen had put all the fighting out of her mind. This was surprising given the graphic depiction of fighting that Ellen had engaged in during the play session with the mother, and after some questioning by the therapist Mrs. Scott agreed that Ellen had seemed badly frightened during the fighting and it was unlikely that she would forget these terrifying scenes so easily. Ultimately, both parents said they thought it would be important to acknowledge that Ellen might still be having uncomfortable feelings about both the conflict and the separation that followed it. They also both agreed that they would tell Ellen why she was coming with them to see the therapist, and that the therapist should repeat these reasons during the first session with each of them.

Ellen and Mr. Scott: The First Session

Ellen seemed happy to be back in the playroom when she came with her father for the first treatment session. She looked eagerly for the toys that she had played with during the assessment. As Ellen explored the room, the therapist asked her if her dad had told her why they were coming to play. Ellen said that he had. The therapist was surprised, however, when Ellen reported what her father had told her. "He said that all the fighting scared me and I can talk about that if I want to."

The therapist looked at Mr. Scott with questioning eyes. He said, "Things are better now, aren't they? Because there isn't any more hitting at our house." Ellen nodded.

The therapist said, "It's good that there isn't any more hitting. The hitting and yelling must have been very scary."

Ellen replied, "I didn't like it. It made me cry."

The therapist answered, "It sounds like it scared you a lot. We can talk and play about that here, because your dad wants to make sure that you get help with all those sad, scary feelings. But your mom and dad aren't living together anymore, and sometimes that is hard for kids, too."

Ellen nodded, but Mr. Scott broke in, "Things are better now. It's not so bad any more. We can be happy because there isn't fighting." He scooped Ellen up and gave her a big hug.

The therapist said quietly, "It's hard for your dad to think that you might still be unhappy. He wants you to have a good life, and he wants all of your unhappy feelings to be behind you."

Ellen said, "I miss my mom." Her dad held her and stroked her hair softly.

After this moment passed, it did not take long for Ellen to show the therapist her fiercer side. She was playing with the dishes, fixing a meal for her father. She said, "I'll feed the baby, too!" She picked up the baby and said in an angry tone. "You stop that crying. You need a time out for 3 days. I need a break!" She put the baby in its chair and, turning her back on everyone, went to sit in the corner.

Mr. Scott said, "You see what I mean? That's just the kind of thing that she heard. She imitates it."

The therapist said to Ellen, "Your dad is telling me that you used to hear your mom talk like that. I think you're telling us that it's still on your mind." Again, Mr. Scott scooped Ellen up and held her, rocking her and saying, "It's all over now. There's no more fighting at our house now, right?" Ellen nodded and stroked his cheek. She said, "My daddy. It's all okay now."

Ellen and Mrs. Scott: The First Session

Ellen held her mother's hand as she came into the playroom for their first session, and she stayed near her mother as they sat down. The therapist greeted her and said, "The last time you came to play with your dad, and now you're coming with your mom. Did she tell you why she's bringing you here?" Ellen sat silently.

Mrs. Scott said, "Remember what I told you? You used to cry so much when Daddy and I fought. And now we don't live together and you have to live in two houses." Ellen nodded.

The therapist added, "Your mom and dad both want things to be better for you. They want you to be able to talk about the things that scare you and make you sad, and they want you to be able to talk to them about your feelings. So sometimes you'll come to play with your dad, and sometimes you'll come with your mom. My job is to help all of you feel better."

Mrs. Scott said, "That's right. Your dad and I both love you even if we can't live together any more. We both get too mad at each other. So, even though we still care about each other, we can't live together. We don't want any more fighting. But we both love you, and we'll always take care of you."

For the rest of the session, Ellen and her mother played with the dollhouse. Ellen told stories about parents fighting and babies being left alone to cry. The therapist said, "You're telling us what you remember. You remember your parents fighting. You were alone and sad. They couldn't help you because they were too mad."

Mrs. Scott held Ellen close and said, "I'm sorry you were so frightened. Your dad and I won't fight like that anymore."

Supervision

In supervision, the therapist reflected on the differences between Mr. and Mrs. Scott. They both loved Ellen and were warm and comforting when she needed them. Mrs. Scott, however, seemed to be able to better tolerate Ellen's negative feelings. Although he spoke of wanting to support all of Ellen's feelings, Mr. Scott showed repeatedly that he could not tolerate her distress. He quickly tried to distract her from any negative feeling, or to convince her that there was no longer a reason for her to feel bad, and Ellen responded by assuming a cheerful expression or even comforting her father. Recalling Mr. Scott's very idealized view of his mother as "pure loving kindness," therapist and supervisor wondered whether his own negative feelings had been tolerated when he was a child. They also considered how difficult it would be for anyone, including Mrs. Scott

or Ellen, to approach that ideal. They planned to continue reflecting to Mr. Scott how difficult it was for him to acknowledge negative feelings, either his own or Ellen's, and to help him see that he was encouraging his daughter to assume a false cheer in order to comfort him.

Mrs. Scott, on the other hand, had not felt the need to distract Ellen from her sadness. She had helped her daughter narrate her fear and sense of abandonment during her parents' fights. She had not, however, acknowledged that she had personally been responsible for frightening Ellen. The therapist also wondered when Mrs. Scott would demonstrate the hot temper and impulsiveness of which Mr. Scott had complained; she believed that her own fear of Mrs. Scott's temper had led her to avoid exploring this topic. She determined, after consultation with her supervisor, to be more direct about expressions of anger with Mrs. Scott to see whether the mother could acknowledge her own part in the violence Ellen had witnessed.

Ellen Finds the Help She Needs

Ellen seemed to know instinctively what she needed from each of her parents. Over the next several weeks, Ellen became fascinated with enacting fairytales with her parents. She relentlessly tried to give her father the role of villain; he either rejected the role outright or "magically" transformed the villain into a hero. Ellen protested when he did this, pleading that she needed him to be bad. He complained, "She always wants me to be the bad one. It's like this at home, too. And I just don't like it."

The therapist replied, "It's hard for you. You really struggle when Ellen feels bad, and you struggle when she wants you to be the bad one. You would like everything to be positive." When Mr. Scott reminded the therapist of his optimistic nature, she answered saying, "Of course you're optimistic, and you want Ellen to share that quality. But she has some important things to tell us about how she feels when things aren't so good, or when you do something that makes her unhappy."

Still, Mr. Scott was not willing to be the villain in Ellen's stories. After several sessions, she appeared to give up trying to place him in this role. Instead, she assigned the role of villain to the therapist and let her father play the hero. She always instructed the therapist to "try to get me" and delighted in finding ways to outsmart the villain's ploys. Ellen never seemed to fully ally herself with either the villain or the hero in these stories, although Mr. Scott and the therapist both did their best to lure her in. She delighted instead in toying with each of them: sometimes siding with one and sometimes with the other. After several weeks her play changed. Although she still cast the therapist in the role of villain

and her father in the role of hero, Ellen now wanted the villain to kill hero. She gave detailed instructions on how this should be done, which the therapist followed. Ellen then mourned the slain hero, weeping over his fallen body before she brought him back to life to be killed again.

Mr. Scott was able to follow Ellen's lead through these weeks of fantasy, although he sometimes rebelled at the idea that she could so lightly order him killed. Ellen was not interested in talk and interpretation during the sessions. She wanted to play. In collateral telephone conversations, the therapist reflected on Ellen's play with Mr. Scott. He was decidedly relieved not to have to "be the bad guy all the time" but he was uncomfortable with the aggression in Ellen's stories, and with her sometimes allying with the "evil character." He also most emphatically did not like his character being killed. The therapist told him that Ellen, like any young child, was struggling to understand and come to terms with her own aggression. She said, "All children have aggressive impulses, and they use stories to try to understand them. In Ellen's case, she's seen her parents be aggressive, and she knows how frightening aggression can be. But she knows she has those feelings, and she needs to come to terms with them. She's working very hard at it."

Mrs. Scott was much more willing to take on the role of villain in her daughter's stories. This allowed the therapist to be less active during these sessions, and to observe and reflect rather than participate as a character in the child-mother play. During one session, Ellen told her mother, "You be the monster, and you have to chase me and get me!" Mrs. Scott followed Ellen's instructions to the letter. She made a mean face and, assuming a menacing posture, she stalked Ellen, finally grabbing her wrist and pulling her close. Ellen burst into tears and sunk to the floor, sobbing. Mrs. Scott looked on in horror and then picked Ellen up and rocked her. She said that she was sorry, and that they shouldn't play that game because it was too scary. Ellen wiped her tears away. She said, "I'm okay. I want to play." She gave her mother the same instructions, and when Mrs. Scott hesitated, she said, "Do it! I'm fine!" Once again, Mrs. Scott pursued and grabbed Ellen. Once again, Ellen collapsed crying, though she quickly responded to her mother's comforting.

The therapist spoke to them as they sat quietly. She said, "Ellen is trying so hard to understand how to deal with her angry feelings. She does it when she plays with her dad, too. But this is the first time I've seen her cry like this. What do you think might be so upsetting?"

Mrs. Scott said, "I don't know. But it's very hard to see her be so upset. I don't want to play like this if it's going to scare her."

The therapist said, "I'm wondering if the fact that you really did grab her wrist is what made her cry."

Mrs. Scott said, helplessly, "But she told me to. She begged me to!"

The therapist responded, "I know she did, but I wonder if that made it more real than she expected. She's seen you do scary things. She's seen you hit and yell in real life. I wonder if just now she remembered what happened then when you grabbed her wrist and it just got too real. It stopped feeling like pretend, and felt more like something that really happened." Mrs. Scott looked thoughtful as she rocked Ellen. She said, "I'm sorry, baby. I didn't mean to scare you, then or now."

Supervision

Using play, Ellen was able to get immediately to the heart of her problem. She urgently needed to integrate the conflicting feelings that she had about her parents as well as her growing awareness of her own aggression. Confronted again and again with the overwhelming scenes of her parents fighting, Ellen was faced with a conflict she could not resolve. She loved and needed her parents, but she was simultaneously terrified of them. She could not go to them for help and comfort when they were the ones who frightened her. Ellen could enact that conflict in her play in an effort at resolution.

The therapist and her supervisor were delighted with the creative way that Ellen had enacted, in play, her central problem with each of her parents. She had found a way to sustain sad and aggressive feelings in her father's presence without having him distract her from them. She had confronted her mother with her own terrifying behavior, and Mrs. Scott had acknowledged, without becoming angry and frightening, the impact of her behavior on her daughter. The next question in the treatment was whether the foundation had been laid for Ellen to show her parents how she felt about their separation.

Finding a Family

Ellen's play with both of her parents shifted away from the tales of good and evil. She almost seemed to be taking a break from the hard work that she was doing as she turned her interest to art projects. Ellen loved to draw and color with both parents. Sometimes she drew her own pictures and sometimes she asked them to draw something for her. During one session, Ellen handed her father a piece of paper and said, "Draw a picture of mommy." Mr. Scott took the paper and drew a woman's face. He said, "We'll give her curly yellow hair because your mom has curly hair. And we'll give her blue eyes like your mom."

Ellen watched him closely, making comments and giving directions. She chose a lipstick color for the mouth on the drawing, and told him to make her mom wearing a red dress because that was her favorite color. She said, "Now draw some tears on her face. She has tears because she's sad from missing her little girl."

Mr. Scott drew the tears. "Like that?" he asked.

"More tears," Ellen replied.

He drew more tears and then put the drawing aside and took Ellen's hand. He said, "Of course she needs many tears if she misses her little girl. She's very sad, just like your mom is very sad when she's not with you. She loves you very much and it makes her sad not to be with you."

Ellen said, "Can I give this picture to my mom?" Mr. Scott agreed that she could. She folded it carefully and asked the therapist for another piece of paper and some tape. She wrapped the picture in the paper and taped it carefully, with her father's help. She handed the wrapped picture to the therapist and said, "Keep it here. When I come with my mom I'll give it to her."

Several days later, Ellen came to the clinic with her mother. She asked the therapist eagerly, "Do you have the present for my mom?" The therapist handed Ellen the picture and she gave it to her mother, who opened it with delight. Ellen said, "It's a picture of you, Mommy. I asked Daddy to draw it and he did!"

Mrs. Scott looked distressed. "Why am I crying?" she asked.

Ellen replied, "Because you miss your little girl." The therapist told Mrs. Scott what Mr. Scott had said.

"He said that?" she asked. "I can't believe it." Then she turned to Ellen. "Your dad was right. I do miss you when we're not together. But remember what I told you? I have your picture on my dresser and every night before I go to sleep I give it a kiss. And it's the first thing I see when I wake up in the morning! I miss you when you're not with me, but I'm thinking of you all the time and thinking of what we'll do when we're together again."

Ellen said, "I want to make a present for my dad."

Mrs. Scott agreed to help her. She traced the outline of Ellen's hand, and Ellen colored it in. Then she wrapped that picture and handed it to the therapist. "You keep it, and I'll give it to Daddy."

Mrs. Scott said, "Your dad misses you, too, you know. When you're not with him, he thinks of you and misses you."

The therapist said, "Ellen, your parents both miss you when you aren't with them. And I think you miss them, too. When you aren't with Dad, you miss him. When you aren't with Mom, you miss her. Making presents for them makes them feel closer to you."

This began a ritual that Ellen adhered to for many weeks. In each session she asked the parent to help her make a present for the absent parent. Both her parents and the therapist used these occasions to talk to Ellen about how much they both loved her and missed her, and how they would always be her parents and always take care of her. The therapist also used the exchange of presents as an opportunity to tell each parent how warmly the other parent was talking to Ellen about how much she needed both of them, and how much they both loved her. The therapist took every opportunity to praise Mr. and Mrs. Scott for their generosity in supporting one another's relationships with their daughter.

In time, these efforts paid off richly. Although Mr. and Mrs. Scott never came for a joint session, they began to work together collaboratively on Ellen's behalf. Although they were unwilling to speak to each other at the beginning of treatment, within 4 months they had, at Mrs. Scott's suggestion, adopted a pattern of twice-weekly telephone calls to discuss how Ellen was doing during her time with each of them. By the end of treatment, they were meeting once a week in a coffee shop near Mrs. Scott's new apartment so that Ellen could spend an hour or so with the parent she was not with during that week. Their relationship moved from the kind of hostile, withdrawn coparenting relationship that is associated with anxiety and depression in children (Katz & Low, 2004) to a warmer, more connected coparenting alliance in which each parent felt supported by the other. They did not resume their romantic relationship, but they gave their daughter the gift of two parents who believed wholeheartedly that the other was important to their child.

Variations on a Theme

The three treatments described in this chapter departed from the usual CPP frame of one caregiver and one child. Although the formats were different, the principles underlying these treatments are consistent. In each of the treatments, the parent was acknowledged as the child's essential guide in the process of recovering from experiences of stress, trauma, and loss.

In the case of Shawna and her mother, the mother needed an extra measure of support to allow her to develop inner strength and trust her own instincts. Without these capacities, she would not have been able to think about and understand her child's experience. The child's best interest demanded that the therapist devote many hours of singular attention to the mother while consistently keeping the child's needs in mind. This dual holding helped the mother to integrate her own needs

with her daughter's needs, and it enabled her to think about herself and her daughter separately but simultaneously, as the therapist had.

In the case of Marlee and her mother, treatment for the mother's experience of violence would not have been enough to help the child. Marlee was driven to play in a way that was too hard for her mother to watch, but her need was urgent and could not be ignored. Shawna could benefit from her mother's improved capacity to attend to her needs without separate therapeutic intervention, but Marlee could not. She needed to tell a supportive adult about her experiences and her fears, and she could not wait for her mother to gain the strength that she needed to become that supportive adult. Both Marlee and her mother needed individual attention before they were able to make room for the other's experience.

In the third case, Ellen's family was shattered after years of conflict and violence. She was required to make sense of the violence she had witnessed and to make relationships with each parent separately. In the beginning, neither parent could tolerate the full range of their daughter's emotional experience, nor could they take responsibility for their own part in her distress. They regarded each other with suspicion and each was content to hold the other primarily responsible for their daughter's difficulties. Only through work on the separate parent-child relationships could the parents own their own aggression and allow their daughter the full range of her feelings. Just as important, the parents learned to see one another through their daughter's eyes. The changes in them freed their child to love them both and to express herself more fully to each of them.

These case examples show that CPP is not always strictly dyadic. What it must invariably do is hold in mind the central importance of the parent to the child. The parent is the protective shield that fends off the child's overwhelming feelings, titrating these feelings in ways that enable the child to process and integrate them. When the protective shield fails and traumatic experiences shatter the child's trust in the parent's willingness and capacity to protect, CPP can restore to the parent that privileged protective role and hold the parent accountable to it. The therapist consistently holds in mind the child's experience, the parent's experience, and the ideal of the parent's role as the child's guide and protector. CPP, in whatever form it takes, leads both child and parent toward that ideal.

CHAPTER 8



Lapses in Attunement Failures in the Therapeutic Relationship

When it is working smoothly, the process of CPP is kaleidoscopic, with new patterns of meaning emerging as child, parent, and therapist become attuned to each other while maintaining their own voice and sense of themselves. Therapists cultivate a therapeutic stance where parent and child feel recognized in their own unique and separate subjectivity while enabled to recognize, meet, and at times transform the subjectivity of the other. This therapeutic attitude aims at correcting the relational imbalances inherent in traumatized and traumatizing relationships by replacing mutuality for the polarities of punishing or being punished, dominating or being dominated. This chapter addresses the obstacles to maintaining this therapeutic stance and the treatment failures that result from the inability to do so. It also addresses factors that lead to the failure of treatment in spite of the therapist's clinical skill and capacity for attunement.

The example of Mr. Khalid and his son, Ethan, described in Chapter 6, illustrates how attunement can be gradually expanded after the parent's initial inability to entertain and accept the child's point of view. Early in the treatment, Ethan reported, "I threw up and Daddy hit Mommy," but Mr. Khalid negated the child's perception by replying sharply "I did not!" Father and child held contradictory pictures of the events and of themselves. The clinician did not confront Mr. Khalid's denial directly, and both Ethan and Mr. Khalid tolerated the ambiguity of the lingering question about what actually happened without demanding that the other acquiesce to his view. By choosing to wait and reflect instead of taking immediate action, the clinician converted

this moment of potential impasse into an opportunity to formulate a point of view that included both father and child. She formed in her mind models of Ethan and Mr. Khalid that acknowledged their separate subjectivities: Ethan as a child who had witnessed, been frightened by, and assumed responsibility for his father's violence and who needed his father to know about this experience, and Mr. Khalid as a committed father who was too deeply shamed by his failures of control and his capacity to hurt to acknowledge them. To find a bridge between these conflicting subjectivities, the clinician looked for times when Mr. Khalid understood Ethan's emotional needs, reinforcing Mr. Khalid's efforts on those occasions with comments that made Ethan aware of his father's support. Over time, Mr. Khalid grew to experience the clinician as someone who understood and accepted him with both his strengths and weaknesses, and this trust enabled him to tolerate a direct discussion of his violence. This outcome was made possible by the active contributions of Mr. Khalid, Ethan, and the therapist. Mr. Khalid was able to integrate the aggression he had so fiercely and dangerously disowned. Ethan learned that fear could be tempered with trust. The therapist modeled an attitude of reflectiveness and acceptance of intolerable states of being. All of them understood, in a role-appropriate way, that it was more important to be receptive to the experience of the other than to coercively attempt to impose their point of view. By accepting the legitimacy of the other, they expanded their own selves.

Obstacles to Therapeutic Attunement

Treatment does not always unfold in this relatively seamless way. All forms of psychotherapy can flounder when there are empathic breaks, but CPP holds specific risks because the therapist must simultaneously hold in mind the experience of the parent(s) and of the child without rigid alignment with either. In the sections that follow, we describe frequent clinical quandaries that endanger the therapeutic search for balanced intersubjective attunement. These therapeutic risks reflect polarities of experience between parent and child, which are enacted in the therapist's inability to hold an even perspective on the separate subjectivities of each partner. The therapist overidentifies with the child at the cost of overlooking the parent's experience, or overidentifies with the parent and remains oblivious to the child. In both cases, the therapist loses sight of the centrality of the parent-child relationship as a vehicle to the child's mental health and allows her own emotional alliance with one or the other partner to distort the mutuality of the relationship. There are, of course, cases when therapists must recommend termination

of parental rights because of the ongoing risk of maltreatment. Even in these situations, however, attunement to the parent's experience can introduce a humanizing dimension to this always painful decision.

Overidentification with the Child at the Expense of the Parent

Unbounded compassion for a hurt, frightened child is an ever-present pitfall for the CPP therapist. Therapists often find themselves harboring wishes to rescue the child from a harsh or neglectful parent or struggling with the conviction that they are uniquely well positioned to offer the child the empathy the parent cannot provide. When immersed in these feelings, therapists risk objectifying the parent and losing track of the parent's pain as a tool for transformation. They notice only the parent's harshness and forget that the parent's own adverse experiences create the breaches of understanding for the child. Rather than simultaneously holding herself, the child, and the parent as separate but equal subjects, the therapist merges her own subjective identity with the child's and cannot regard the parent as a partner in the treatment. The examples that follow describe some manifestations of how this happens and the varying degrees of success as therapists pursue different strategies to achieve their goals.

Being a Better Parent Than the Parent

The clinician's knowledge of early development and understanding of children's emotional needs are potent ingredients in bringing about therapeutic change. The potential for misuse of these indispensable skills resides in the unexamined assumption that the clinician knows more than the parent and can tell the parents how to raise the child. This attitude collides with the parents' visceral need to be at the center of their child's emotional life. Treatments can be prematurely terminated or derailed when parent and clinician engage in a competitive struggle to prevail over the other in deciding what is best for the child.

Example

Ms. Lee sought therapy for her 5-year-old twin daughters at their teacher's suggestion because the girls were having trouble adjusting to kindergarten. Their teacher reported that they were quiet and withdrawn, looked sad, rarely left each other's side, and did not seem interested in making friends. They also seemed to find little pleasure in spontaneous play.

The initial assessment revealed that Ms. Lee grew up in an Asian country ravaged by war and was witness to many acts of brutality while growing up. She immigrated with her parents to the United States in her early teens and described a relatively easy adjustment and a peaceful life in her parents' home after their arrival. Her parents did not discuss their past but made clear their expectation that she would work hard to succeed in her new country. Ms. Lee married a man who was also an immigrant from her home country when she was 20, and 3 years later she gave birth to her twin daughters, Susan and Andrea. Her husband had not been physically abusive before Ms. Lee's pregnancy but became increasingly more controlling and ultimately violent as the pregnancy progressed. This behavior continued after the children were born. Ms. Lee left her husband when the girls were 3 years old, after they had witnessed several episodes of their father hitting their mother and pushing her against the wall. Ms. Lee obtained exclusive physical and legal custody of Susan and Andrea, and the father disappeared from their lives when the court limited their contact with him to supervised visits.

Ms. Lee had completed college before her children were born and worked at a good job, although one that paid just enough to support the comfortable lifestyle she aspired to for herself and her daughters. She worked hard and had high expectations of the girls. She came across as a duty-bound woman who was emotionally invested in her daughters but did not place value on the children's pleasure or spontaneous play. Susan and Andrea related to her with some reserve, frequently turning to her for permission or approval. They approached her with ease when they needed help but did not engage in physical contact or affection with her or with each other. The therapist, who was also an immigrant from the same Asian country as the mother, understood that the mother's and children's behavior was influenced by their cultural mores but found the mother's rules more constricting than the cultural norm. She developed a treatment plan that included the mother's wish to enhance the children's involvement with other children in classroom activities. She also set for herself the goal of helping the children and the mother broach the unspoken topic of the father's violence and eventual disappearance from their lives. She did not share this goal with the mother because she believed the mother was not ready to accept this part of the plan.

Treatment took place at the family's home in the evenings. During the initial sessions, the therapist tried to facilitate play between the girls and their mother. Ms. Lee was reluctant to take part. She appeared not to notice the girls' sadness and focused exclusively on their academic success, trying to enlist the therapist's support in promoting it as an explicit focus of treatment. Sometimes Ms. Lee forbade one or the other

of the girls to join in the sessions if they had not finished their schoolwork to her satisfaction.

The therapist started to feel more and more critical of Ms. Lee. She tried to persuade her that the children should participate in the sessions regardless of whether they had finished their schoolwork, but Ms. Lee was adamant about her belief that school achievement was the highest priority. The therapist was particularly incensed whenever she came for a home visit only to learn that neither of the girls would be allowed to join the session. On these occasions, Ms. Lee invited the therapist in and spoke with her about the events of the week and the girls' progress in school, but the therapist invariably cut these sessions short.

When Susan and Andrea were allowed to join, their play was subdued but richly symbolic. They used dolls and animal figures to act out scenes of sorrow about separation as well as scenes of aggression and fear. When Ms. Lee joined the sessions, she observed the girls' play but did not take part in it. The therapist described what she understood to be the meaning of the girls' play: expressions of both fear and longing for their father, who had been missing from their lives since their parents' separation. Although Ms. Lee indicated that she understood the therapist's interpretation, she did not elaborate on it by talking with her daughter about the reasons for their father's absence or supporting their feelings about it. She sat quietly and watched the play and the therapist's interaction with the children but did not participate. She also began to leave the sessions to attend to chores. The therapist felt increasingly relieved when this happened. She encouraged the girls to play, offered them the comfort and reassurance she thought they needed, and made few if any efforts to engage their mother.

As the treatment progressed, the therapist saw few changes in the girls. They continued to be sad, and although their academic performance was consistently excellent, their teacher remained concerned about their lack of friends. The therapist believed that Ms. Lee did not understand her children and cared more about their success than about their feelings. She repeatedly asked Ms. Lee to relax her rule of denying them participation in the therapy sessions when their schoolwork was not finished. Ms. Lee refused, saying that the girls needed to learn good habits and self-discipline if they were to succeed. The therapist and Ms. Lee were at an impasse that continued without resolution for several weeks.

The girls' birthday was approaching, and the therapist initiated a discussion of what they might do to celebrate it together. Ms. Lee responded that she was taking treats to school for the girls' birthday and that she would make a special family dinner for them. The therapist asked if she might also do something to celebrate. Ms. Lee was initially

silent, but after her daughters clamored for her agreement she answered that the therapist could do as she wished.

The therapist was an accomplished seamstress, and on the evening before the girls' birthday, she brought each child a doll dressed in an elaborate handmade costume. Ms. Lee let Susan and Andrea open their gifts and then immediately told them to put the dolls away. They had not finished their studies and would not be allowed to take part in the session. Susan and Andrea left the room crying. Ms. Lee then proceeded to tell the therapist that she and her children would not be able to meet at the scheduled time for the next 3 weeks because of other commitments. She declined the therapist's offer of alternative times to meet, saying that she was committed elsewhere. The therapist left the home convinced that the mother's rigidity was bordering on emotional abuse and concerned that Susan and Andrea would remain stunted in their emotional health. Ms. Lee declined repeated telephone offers to schedule an appointment to discuss the state of the treatment, and eventually she asked the therapist not to call again. The therapist said that she would remain available if the mother wanted to contact her in the future, but Ms. Lee never called.

The therapist felt keenly disappointed in the failure of treatment and felt deep sadness for the loss of her relationship with Susan and Andrea. She could not, however, find a way to empathize with their mother. She was so deeply attuned to the girls' sadness that she could not simultaneously make room for understanding how Ms. Lee's life experiences shaped the mother's conviction that hard work was more important to survival and well-being than exploration of feelings. Identification with the children also blinded the therapist to the possibility that Ms. Lee was engaging in a defensive maneuver to fend off the shame and grief associated with the violence she had endured and the collapse of her marriage. Avoidance is a common feature of traumatic responses, and it is possible that it was expressed in Ms. Lee's detachment from the children's play. It is also possible that the mother wanted time for herself with the therapist, and that she felt rejected when the therapist cut the sessions short if Susan and Andrea were not allowed to participate in the sessions. The additional possibility that Ms. Lee was jealous of the hold that the therapist had on her daughters and felt upstaged was also not entertained by the therapist.

Strong countertransference responses constrict the ability to formulate and test alternative hypotheses in response to clinical impasses. Over time, the emotional gulf between mother and therapist deepened and the therapist became increasingly locked into a critical perception of Ms. Lee. Rather than being motivated to understand the conscious and

unconscious underpinnings for the mother's behavior, she experienced herself instead as more attuned to the children and a better caregiver for them than the mother was. The resulting empathic failure culminated on Susan and Andrea's birthday. The therapist inserted herself in the celebration without being invited, claiming for herself a space in the family that the mother had not granted her. In bringing gifts that were more elaborate than what Ms. Lee offered, she also enacted her unacknowledged competition with the mother and her wish to replace her as the better parent. The therapist unconsciously tried to shut Ms. Lee out of her own relationship with Susan and Andrea. Ms. Lee defended herself by shutting out the therapist and effectively ending the treatment.

The therapist might have averted this failure by acknowledging with Ms. Lee the differences in their points of view and showing willingness to learn about Ms. Lee's values and goals. That exploration might have led to a conversation about Ms. Lee's belief in working hard for future success rather than focusing on the past. It might also have led to opportunities to process with Ms. Lee her own responses to the domestic violence and the divorce and her sense of how these events affected her children. The power of the therapist's negative countertransference to the mother prevented her from opening herself to these therapeutic possibilities.

Errors of Timing: Rushing to "Correct" the Parent's Point of View

CPP challenges the therapist to attend simultaneously to a parent and a child who have disparate views of key events in their lives, different ways of processing those events, and different levels of tolerance for the feelings engendered by them. A common therapeutic mistake involves moving too fast to persuade the parent to forego his subjective experience and to adopt the child's point of view. This approach risks overlooking parental motivations that need to be incorporated into a broader understanding of the clinical situation. It also risks making the parents resentful that the child's position ranks higher than their own in the clinician's mind.

Example

Mrs. Todd came to treatment with her 12-month-old niece, Juliet, after this child and her 7-year-old brother, Sam, witnessed their mother's murder. They were present when their father stabbed their mother to death after years of domestic violence that the children had also witnessed. Following the murder, both children came to live with their maternal aunt.

Mrs. Todd was concerned about both children's behavior and emotional well-being. Although she found individual therapy for Sam, she often discussed her concerns about him with the CPP therapist because Sam's individual therapist did not offer regular collateral sessions.

In one session, Mrs. Todd spoke heatedly of her anger and disappointment with Sam, who was defiant, sullen, and had started swearing at her when she asked him to do chores. As she listened, the therapist formed an understanding of the multiple meanings of Sam's behavior. In her view, Sam's anger at the aunt was an expression of anger at the loss of his parents, which was displaced onto the "nonparent" who was now taking their place; as a way of remembering his aggressive father by identifying with him through imitation; and as a dysregulated response to the frustration of being asked to interrupt more pleasurable activities in order to carry out his aunt's requests. In an effort to share her understanding with Mrs. Todd, the clinician started with the simplest explanation, saying that perhaps Sam learned to use the verbal aggression he heard his father use against his mother. As the therapist spoke, Mrs. Todd sank back in her chair and covered her face with one hand. She replied that her mother had never allowed her children to swear at her, that Mrs. Todd had not allowed her own (now grown) children to swear, and that they had all "turned out all right." She added that Sam's behavior was "disrespectful and unacceptable" and she could not tolerate it.

The therapist understood Mrs. Todd's defeated posture and sharp tone as a warning sign that she was off the mark. At this point the therapist might have followed one of several paths. She might have asserted her own point of view and continued to press her belief that Sam's behavior was dictated by grief and trauma rather than disrespect. Alternatively, she might have submitted to Mrs. Todd's bleak view of Sam, surrendering her own point of view in order to align herself with the aunt. Instead, the therapist made a beginning gesture of understanding for Mrs. Todd's position while holding to her own understanding of Sam's behavior. She said, "I imagine you've told him how you feel." Mrs. Todd moved her hand away from her face and said, "I certainly have." Mrs. Todd seemed more receptive as a result of having her position acknowledged. Next, the therapist moved to bring in yet another perspective while still not insisting on advancing her own: She indirectly invited Mrs. Todd to consider the impact on Juliet of her conflicts with Sam. Turning to Juliet, who was playing silently nearby, she said, "I think your auntie is worried that you see so much anger." Mrs. Todd responded that in fact she was concerned about Juliet, too. She said that Juliet was also aggressive and that just the day before she had ripped two pages from a magazine.

Mrs. Todd's attribution of deliberate aggression to this 12-month-old made the therapist realize that the aunt's traumatic response to the horror of her sister's murder was coloring the way she experienced both children's behavior. The aunt harbored the traumatic expectation that these small children would develop into adults who, like their violent father, would be murderously aggressive. Anticipating this outcome, she overinterpreted the children's behavior as dangerous. At the same time, Mrs. Todd's conviction that the children needed to be appropriately socialized in their expression of anger was a legitimate and important goal to uphold. The therapist realized that her initial suggestion that Sam was using swear words he learned from his father unwittingly confirmed the aunt's fear that he would grow up to be like his father. She decided to give a place to Mrs. Todd's subjective experience before moving to offer an alternative understanding of the children's behavior. Using Mrs. Todd's earlier words, the therapist said that she could see how worried and frightened Mrs. Todd must be about how Sam and Juliet would turn out, and how important it was to help them grow up to be respectful people who could contain their anger and have good relationships with others. Mrs. Todd showed visible relief at having been understood and agreed that both of those things were important to her. Reciprocally, she made a small acknowledgement of the therapist's point of view. She reached toward Juliet and said softly, "There's been way too much anger for you." The therapist asked quietly, "Tell me what you think is behind all that anger." Mrs. Todd responded, "They have been through a lot." The therapist used this opening to repeat her earlier interpretation that Sam might be modeling his father's aggressive behavior. This time she also included her acknowledgement of Mrs. Todd's position by adding that living with Mrs. Todd would give both Sam and Juliet the opportunity to learn a different way to be and to behave. Mrs. Todd nodded in agreement in response to this expanded therapeutic intervention, which integrated two points of view that had been initially a source of polarization.

How can we understand what happened? In her first interpretation, the therapist was misattuned to Mrs. Todd's values and subjective experience. She asserted her own views before fully acknowledging Mrs. Todd's. In response, Mrs. Todd asserted herself, putting the two in potential conflict. Sensing this, the therapist moved to an expression of understanding for Mrs. Todd's position. As the therapist empathized with Mrs. Todd and supported her feelings, however, she did not abandon her own subjectivity, nor did she abandon Juliet's. The therapist's gentle reference to Juliet's experience while also holding Mrs. Todd's allowed the aunt to move to an affective stance in which she could

simultaneously reflect on Juliet's feelings and her own. From there, she could open herself to accept a psychoeducational intervention that embraced both the severity of the children's experience and her wish for them to learn to be better modulated and more respectful.

Mrs. Todd was an empathic caregiver whose capacity to reflect on her niece and nephew's experience had been narrowed by the traumatic experience of the murder. Mrs. Todd's own well-developed empathy and the therapist's ability to be clear about her own position while understanding and reflecting on Mrs. Todd's allowed the two of them to work together to mend what might otherwise have become a broader rift in their relationship.

Underestimating the Parent's Emotional Constraints

CPP engages the parent as an ally in fostering the child's mental health. This approach becomes a liability when held too literally because the therapist mistakenly equates the child's individual mental health with the quality of the parent's attunement to the child. When this happens, the therapist overlooks how the parents' psychological problems interfere with their ability to understand the child's experience. When parents cannot help the child at any given point in treatment, the therapist needs to recognize this limitation and use the opportunities available to support the child's individual progress.

Example

Ms. Henry and her son Charles, 3 years, 8 months old, were referred for treatment toward reunification by their child protection worker. The episode prompting the child's foster care placement occurred when Ms. Henry collapsed on the street and Charles stood over her crying, "Mommy dead! Mommy dead!" A passerby discovered that Ms. Henry was unresponsive but still breathing and called for emergency medical assistance. The medical technicians administered CPR, witnessed by Charles, and then took Ms. Henry to the hospital. Charles was placed in foster care because there was nobody else to take care of him. He did not see his mother for 2 months and then began to have supervised visits with her.

During the CPP assessment period, Ms. Henry disclosed that she had lost consciousness after an accidental drug overdose. She admitted to her substance use but denied that she had intended to hurt herself. She was currently in residential drug treatment and had been clean and sober since the overdose episode 6 months earlier. She said that she

hoped Charles could soon be placed with her at the drug treatment program and felt optimistic that CPP treatment would help.

The early weeks of treatment went smoothly. Charles was easily dysregulated and had little tolerance for frustration. Early sessions focused on helping him develop the capacity to wait and to express strong feelings in words, and his mother was allied with the therapist in these efforts. During this period, Charles came to live with his mother in the residential treatment program. Ms. Henry was effective in using the techniques that she and the therapist had worked on together during the sessions to help Charles maintain his calm at home. She reported that she was beginning to establish predictable daily routines and that she was almost always able to help Charles calm down when he was upset.

With Charles in better control of his feelings, the treatment moved to a new level. The therapist introduced toys that were explicitly suggestive of Charles's experiences when his mother collapsed on the street, including a doctor's kit, age and ethnically matched dolls, and an ambulance. Charles's attention was immediately drawn to these figures. He insisted that his mother play with the female doll and he instructed her to make the doll die. Using a superhero doll, Charles then saved the female doll and brought her back to life. The therapist commented that Charles was remembering the day he thought his mother had died. Ms. Henry turned to the therapist and said, "He's just playing like the other kids at the house. It doesn't mean anything." Charles persisted, however. Several times during the remainder of the session Charles declared that his mother's doll had died and then brought it back to life. The therapist asked Ms. Henry what she thought Charles's play meant. Again the mother said that it meant nothing and that Charles was only copying what he'd seen other children do. She said to the therapist, "You psychologists make too much of everything. You think everything has some deep meaning. He's just playing."

The next week, Charles repeated in his play the themes of dying and resuscitation. He placed a small mask over the face of the mother doll and put her in the ambulance. The therapist asked Charles if he had seen his mother with a mask, and he nodded. Ms. Henry exploded, "You will not let up! He's just playing. Don't pretend that everything means something. He's just playing!" The therapist realized that he was moving too quickly, and watched quietly for several minutes as Charles continued to play. Charles asked his mother to help him with the mask and she did. He then asked the therapist for help fitting the doll into the ambulance. The therapist offered some help and then handed the doll to the mother, inviting her to join in the play. Ms. Henry took the doll and, turning her back to the therapist, helped Charles fit it into the

ambulance. For the rest of the hour, Charles played with the doll and the ambulance, sometimes saying that the doll had died and bringing the superhero to rescue her. Although he played with deep absorption, his affect was calm. The therapist sat silently for much of the hour searching for a way to help the mother recognize and acknowledge Charles's experience. He felt frustrated and angry that Ms. Henry did not recognize the meaning of Charles's play. Toward the end of the session, as Charles brought his superhero once again to rescue the doll, the therapist said, "You really wanted to help." He hoped that this more general comment would be acceptable to Ms. Henry but it was not. She heard the unspoken suggestion that Charles had wanted to help *her*. She was sullenly silent for the rest of the session, did not participate in the toy cleanup, and left without saying goodbye.

The therapist's error in this session consisted of his premature expectation that Ms. Henry, as the adult member of the dyad, would be able to recognize and accept the meaning of Charles's play, put aside her own discomfort, and offer him emotional support. The therapist was also influenced by the common clinical fallacy that explicit verbal linking of play themes to real-life events is the best medium to help the child process a frightening event. The verbal interpretations he made, while not disorganizing for Charles, were too stressful for his mother. Ms. Henry was not yet ready to bear the full weight of her son's distress at the events surrounding her overdose and needed to deny the emotional impact of these events. Although she could witness Charles's play and take part in it to some degree, the therapist's verbal interpretation of the play themes was overwhelming for her.

Charles's organized affect as he played offered a clue that he was able, during the therapy session, to use his mother's and the therapist's presence to support his play without the addition of words. The simple act of playing about his experiences in the presence of adults, especially his mother—who could witness his play and participate to the degree that he asked—enabled Charles to begin the process of integrating his recollection and feelings about what had happened. It is possible that quiet observation of her son's play activities, over time, would have opened for Ms. Henry a window into his experience, allowing her to use her own observations of his play to help her understand Charles's distress, his wish to help, and his confusion about the incident. Her own feelings of guilt about having done something that caused her child so much pain made it impossible for her to tolerate the therapist's interpretations. She and Charles were out of step in this regard. He needed to process what he had experienced; his mother needed support to recognize that although what happened was deeply upsetting for Charles, it

did not destroy him. When one member of the dyad is “ahead” of the other in readiness to explore an adverse or traumatic experience, the child–parent therapist must find ways to accommodate both partners or risk derailing the treatment. Playing either without interpretation or with interpretations that stay within the metaphor of the play is one possible solution to this dilemma.

Another possible solution is to offer individual collateral sessions to the mother for at least a brief period of time. These sessions might give the mother a safe space to consider her responses to Charles’s play, the feelings that his play aroused in her, and her beliefs about what Charles remembered and understood about her overdose. The individual sessions would honor her individual experience without the expectation that she sacrifice her subjectivity for Charles.

Overidentification with the Parent

Sometimes the parent–therapist relationship overtakes the therapeutic focus on the child. The therapist’s effort to understand the parent shifts unwittingly from being a vehicle for helping the child to becoming an end in itself. At these times, the clinician can become so engrossed in the parent’s emotional experience that the child is overlooked during the sessions. Therapists may offer the rationale that they are building a therapeutic alliance with the parent in order to better help the child in the long term. Although this is at times tenable, treatment that is consistently imbalanced in the direction of the parent’s needs holds the risk of reinforcing the parent’s self-absorption and confirming the unimportance or lack of legitimacy of the child’s experience. Children respond to this situation by silently complying with their own marginalization through emotional withdrawal or role reversal, becoming demanding and aggressive in an effort to be emotionally met, or an alternation of efforts to dominate with yielding to the parents’ coercive structuring of their subjective reality.

Example

Ms. Flores sought treatment for her 4-year-old daughter, Magda, because she did not know how to reply to her daughter’s urgent pleas that she wanted a father. Mr. Flores had died in ambiguous circumstances before the child’s birth after a scuffle outside a nightclub. Ms. Flores became deeply depressed after her husband’s death, lost her emotional investment in her pregnancy, and could not care for Magda for many months

after the baby's birth. She gradually became less depressed under the care of a very supportive psychiatrist and the solicitous support of her mother, sister, and other extended family members. This progress was halted when Magda started asking for a father after starting child care and seeing other children's fathers. Ms. Flores found herself angry and withdrawn in response.

Ms. Flores used the assessment period to describe in detail her own frame of mind. She was a good observer of her daughter's feelings and behaviors but reported that she could not find the words to speak with Magda about the child's father or his death. In the initial 3 months of treatment, the mother collaborated actively with the treatment goals of helping her describe to Magda who her father had been and the sadness that he died and could not come back. Magda responded well to this approach. Her expressive language improved, her symbolic play became richer, and there was a noticeable increase in the spontaneous affection that mother and daughter showed to each other.

After a few months of treatment, Ms. Flores was asked to work an extra shift in her job as a janitor. This demand confronted Ms. Flores with her fear, dating back to the time of her husband's death, of staying out of the house when it was dark. She started using the sessions to describe her fears and spoke openly about the possibility of sending Magda to her home country for a few months until she could work out a solution to her work situation. The therapist guided Ms. Flores into reflecting about what this would mean for Magda. She observed Magda's play and behavior while the mother spoke in order to gauge the child's feelings, and she included Magda in the conversation by translating for her what her mother was saying. Gradually, however, the therapist became so engrossed in the mother's vivid description of her circumstances and feelings that, while continuing to monitor Magda's play, the therapist "forgot" to bring Magda to her mother's attention or to extend the circles of communication to include the child. Magda's behavior changed markedly in response. Instead of greeting the therapist with her customary joy, she had to be dragged into the playroom by her mother and looked angrily at the therapist as the adults talked. She often put her hand over her mother's mouth and said: "Don't talk!" She refused to clean up the toys at the end of the session. The therapist responded to this behavior by commenting on the child's anger, but it did not occur to her that the child was angry specifically at being left out of conversations that she associated with her immediate well-being. This impasse continued until the therapist realized that her increasingly unilateral interest in the mother was experienced by the child as an emotional abandonment by both adults.

The foregoing examples describe treatment failures when therapists falter in their ability to be simultaneously attuned to the parent and to the child and do not build bridges of communication between them. Treatment can also fail even when therapists excel in their ability to do so. The sections that follow address some of these situations.

Parental Inability to Hold the Child's Perspective in Mind

Some parents demand complete acceptance of their subjective reality by the therapist and by the child. When a person grows into adulthood without his or her subjectivity being held by another, it may be impossible to tolerate the idea that different people understand the same events differently. Adults who have not been held in the mind of the parent may cling rigidly to their perceptions, attempting to belatedly achieve emotional recognition by insisting that others see the world through their eyes. It is as if any deviation from their reality annihilates them. In individual psychotherapy, therapists can join clients with this mind-set sufficiently to make them feel understood and then gradually introduce more flexible alternatives that accommodate their differences. In child-parent psychotherapy, however, the parent's rigid schema of self and insistence on creating a reality that accommodates it present an urgent clinical dilemma. Children feel that to preserve the parent's love they must deny their own sense of reality and surrender their subjectivity to the parent. This maneuver protects the child's relationship with the parent but sacrifices the child's relationship with the self. Children who use this course of action are at risk of growing into adults who either cling insistently to what they believe to be true or never learn to trust their own perceptions and abandon them at the slightest pressure from another. Because neither of these outcomes is conducive to mental health, the CPP therapist must find ways to support children in expressing their own reality and subjectivity. The treatment is threatened when parents cannot tolerate this therapeutic stance and instead experience both child and therapist as attacking or destroying them.

Example

Lidia, age 4, and her parents, Mr. and Mrs. Carr, came to treatment after the parents separated. Each parent told a different version of the event that led to their separation. Mr. Carr reported that his wife hit him on the head with a cast-iron pan. In Mrs. Carr's version, her husband

had hit himself with the pan and then called the police claiming that she had done it. Both parents explained that when the police arrived Mrs. Carr was arrested and charged with an act of domestic violence. The court ordered that Mr. and Mrs. Carr share custody of Lidia and recommended that each of them participate in CPP to lessen their post-separation conflict.

In separate weekly child-parent sessions with her mother and her father, Lidia was able to turn to each of the parents when she needed help, and both parents were able to comfort her and to follow her play. After 6 weeks of treatment, Mr. Carr said that he did not believe that there were any major problems in his relationship with Lidia. He explained that he was willing to continue meeting individually with the therapist if this would help iron out coparenting differences with Mrs. Carr, but he did not see any point in bringing Lidia to joint sessions because Lidia was doing well in his care. He also said that he had no objection to Lidia's continuing to come to treatment with Mrs. Carr.

When apprised of the father's decision, Mrs. Carr decided to continue the joint treatment with Lidia, saying that she was having some problems with Lidia at home and hoped that the therapy could help. For several weeks, the focus of the sessions was on establishing predictable postdivorce routines and finding words to explain to Lidia that the divorce was not her fault, that her father and mother both loved her, and that they would both continue to take care of her. The therapist noted with discomfort that Mrs. Carr seemed very intolerant of the slightly different household rules that Mr. Carr had established for Lidia when she stayed with him. To alleviate this stern maternal stance, the therapist devoted considerable energy to helping Mrs. Carr reflect on the fact that Lidia was doing well in both homes and was making the transitions between her parents' households with a minimum of difficulty in spite of the differences in rules and routines. Nevertheless, Mrs. Carr had a hard time containing her anger at the fact that Mr. Carr was doing things differently from what had been the home routine before the separation.

In spite of this tension, the treatment sessions went generally smoothly and Lidia seemed comfortable talking with her mother about most things. The therapist was taken aback one day when Lidia asked her mother, "Mom, why did you hit my daddy with that pan?" Mrs. Carr became immediately enraged. She turned to the therapist and said in a loud and pressured voice, "You see what he does? He's poisoning her mind! He's filling her head with lies." She said to Lidia, "You know I didn't do that! Don't listen to your father when he talks that way. You

know that isn't what happened!" Lidia stared at her mother silently, her eyes round with fear.

The therapist wanted to say something that would support both Lidia and her mother, and so she started tentatively as she endeavored for a balanced frame of mind. She said, "This is hard for everyone, I think. The two of you are thinking such different things." Mrs. Carr responded, "There aren't different things to think. I did not hit him. He knows it and she knows it and he's filling her head with lies. That's why she's saying these things." Lidia started to cry and said, "My daddy doesn't lie." Mrs. Carr turned to her and said, "Then you're calling me a liar." Lidia tried to hug her, but Mrs. Carr turned away from the child.

The therapist intervened again, this time more directly. She said, "I wasn't there, and so I can't say for sure what happened. But I see that you and Lidia are remembering this differently. Maybe Lidia is saying things that her father told her, I don't know. But I think it must be very hard for her to hear you saying that what she remembers didn't happen. Could we talk about what you are both feeling now?"

Mrs. Carr would not be moved. She continued to insist that there was only one way to see the event. Lidia lapsed into silence and didn't say anything more. Shortly before the session was scheduled to end, Mrs. Carr said that they had to go. She took Lidia by the hand and they left.

The next day the therapist called Mrs. Carr and asked if she would be willing to come in without Lidia to talk about what had happened. The mother agreed and came for the appointment. No amount of support from the therapist, however, seemed enough to open Mrs. Carr's mind to include Lidia's view of events. Mrs. Carr remained adamant about what had happened and about the importance of making sure that Lidia understood it. She said that she was hurt and disappointed that the therapist had suggested that there might be a different interpretation. She said, "If you can't see this my way, then you can't help me, and you can't help Lidia." The therapist tried to explore the unconscious ramifications of this conflict by asking Mrs. Carr whether she had ever experienced herself before in a situation in which she was not believed. Mrs. Carr responded defensively, stating that she did not want to talk about herself. The therapist felt that she could not capitulate to Mrs. Carr's insistence that Lidia should believe what the mother told her to believe. She said that she wanted to be helpful but that she needed to be mindful of both Lidia's and Mrs. Carr's feelings. Mrs. Carr repeated that the therapist could not help if she did not see things from the mother's point of view. She left the session saying that she would think

about whether or not she would bring Lidia back but never contacted the therapist again. When the therapist telephoned her, she did not return the calls.

In this case, the therapist was mindful of the need to hold two disparate realities and to try to help mother and child understand one another's positions. She resisted becoming embroiled in a conflict over facts but tried to focus instead on how mother and child each felt about their different understanding of what happened. Mrs. Carr was unable to tolerate even that mild departure from absolute agreement with her position. She experienced as a betrayal the therapist's suggestion that Lidia might find it difficult to have her own reality so strongly denied. CPP makes strong demands on the adult participants. They must have enough flexibility to at least acknowledge the possibility of another point of view. When parents refuse to entertain the child's point of view, this treatment approach is unlikely to succeed. In the example that follows, we see how a similar clinical problem could be resolved because the mother was able to acknowledge her young daughter's state of mind.

Example

Leah, age 5, and her mother came to treatment following the parents' separation to help Leah with her difficulties transitioning from one household to the other. Mrs. Taylor had felt deeply betrayed by her husband at the time of their separation. She had believed that they had worked out an understanding that would give her time to find work and rent an apartment before moving out of their home. She also believed that the father had agreed that Leah would live with her. Instead, when Mrs. Taylor came home from searching for work one day, she found a police officer waiting to serve her with a restraining order that Mr. Taylor had obtained based on the allegation that she had threatened to hurt him. The restraining order evicted Mrs. Taylor from the family home, which had belonged to Mr. Taylor's family for several generations, and severely limited her contact with Leah.

Although Mrs. Taylor went to court and ultimately succeeded in obtaining shared custody of Leah, her fury returned with full force as the anniversary of the separation approached. During a joint parent-child therapy session she spoke in a loud and angry tone about how badly Leah's father had hurt her by putting her on the street with nowhere to go. "He made me homeless and he tried to steal my child," she said

forcefully. Leah looked on, near tears. The therapist asked, "Did Leah ever hear you talk about these things in such a strong way?" Mrs. Taylor responded, "She was there. She knows what happened." The therapist replied, "I know that what happened hurt you very badly. I also know that in the past you spoke differently about the separation. You were very hurt last year. I understand that. But I'm wondering what it's like for Leah now to hear you telling this very extreme version of the story. It's like you're speaking about the very furthest edge of her reality, and I wonder what that's like." Mrs. Taylor said, "Well, I think it's important for her to know the truth." Then she turned to Leah and said, "How do you think I should talk about it?" Leah said quietly but firmly, "Don't talk about the edges. Talk about the middle." Mrs. Taylor laughed, hugged Leah and said, "Well, I don't know ... but I'll try."

This case had a very different outcome although the therapist was no more skilled in her handling of the present moment than Mrs. Carr's CPP therapist had been. The difference was the quality of Mrs. Taylor's capacity to put herself in her child's position. This mother was able to hold onto the reality of her own view about what happened, but she also realized that her view was too overwhelming for her daughter. She wanted Leah to know "the truth" but she could accept that, at 5, Leah might find some truths too painful to know. This is not the same as acknowledging that there is a different way to interpret the story, but it does allow different gradations of feeling and different levels of tolerance for what happened. It is impossible to know whether this session would have gone as smoothly as it did if Leah had contradicted her mother (as Lidia had) by saying, "Daddy didn't make you leave." Mrs. Taylor might or might not have been able to allow Leah that completely contradictory interpretation of events.

When the parents cannot allow the child some degree of autonomous subjectivity, the best solution may be individual treatment for the child and, if feasible, for the parent as well. In some cases, the CPP therapist can offer parallel individual sessions to the parent to focus on the different points of view. In these sessions, the therapist aligns herself with the parent's subjectivity, exploring the parent's perceptions and feelings. She works to understand the parent's world view and the relational and cultural factors that created it. At the same time, she holds the child's subjectivity in mind and maintains her own. She does not allow the parent's point of view to dominate her but accepts its psychological reality for the parent. In doing so, she enlarges the possibility that the parent will grow in her ability to see her child as someone who views the world differently and with whom she can engage in reciprocal exchanges, moving toward increased understanding.

The Cumulative Weight of Adversity

In all the cases discussed up to this point, treatments floundered on the shoals of failed intersubjective attunement: one individual's inability or unwillingness to take the perspective of another. Treatments also can fail through the cumulative weight of chronic adverse circumstances that render the parent unable to change and that exhaust the therapist's capacity to persist in attempting to promote improvement. The failure of empathy in these cases is more general: Society at large creates conditions in which some individuals and families are held at a distance as "others," their plight unwitnessed and their cries unheard by those with power to change the circumstances of their lives. These families have been mired in poverty, marginalization, racism, and violence often for generations. The parents' character structure is marred by the internalization of these societal factors. Within a mental health framework, they can be most fairly diagnosed as having a developmental trauma disorder—a personality style so profoundly shaped by the unrelieved experience of internal and external danger that it is bereft of the ability to appraise danger realistically, respond protectively, trust in a benevolent social order and the possibility of loving intimate relationships, learn without major constrictions, and operate confidently in pursuit of personal goals. While people with personality disorders are found in all social classes and at all levels of society, parents growing up in chronically adverse environmental circumstances have access to fewer protective factors and often feel that there is no one who shares their perspective or understands their point of view. Their own parents were too preoccupied with the struggles of daily living to provide "good-enough" care. As they grew up, they internalized the larger societal message that they are without intrinsic value. To defend against their grief, rage, and loss, they may adopt coping strategies such as substance abuse or the assumption of a mask of aggressive bravado that serve only to make their problems more complex and intractable because everyday coping is constantly under assault by the daily hassles of poverty and lack of resources that convert routine problems into major crises.

The young children in such families are at grave risk and their parents are difficult to engage in effective treatment because of their expectation that they will be blamed, belittled, and misunderstood. They may interpret therapeutic attempts to form a working alliance as phoniness or even trickery. When parents and children laboring under such difficult circumstances are referred for treatment through the child protection system, as is often the case, the request for treatment raises the question of whether it might be in the children's best interest to help them say goodbye to parents with such profound difficulties, grieve their

losses, and find families that are better equipped to guide and love them. There are several reasons to resist that temptation to recommend severing parent-child ties and to make determined efforts to hold families together. First, the children may be strongly even if anxiously attached to their parents, and breaking that bond will make it more difficult for children to forge healthy affective bonds with new families. Second, there is rarely any real assurance that an emotionally healthier and more stable family situation actually awaits the child. All too often, children are cared for in a succession of foster homes by adults who either share similar backgrounds or resist the temptation to love the child for fear that their own hearts will be broken when the child leaves. Nevertheless, clinicians working with families beset by these multiple hardships must be clear-eyed about the challenges that await them and must be willing to engage public and private systems of care to form the most protective possible safety net as they do their work (Lieberman & Pawl, 1984; Lieberman & Harris, 2007).

Example: Gabriel and Ms. Tanner—The End of the Story

In Chapter 4 we met Gabriel and his mother, who were referred for treatment by a child protection worker who had engaged them in voluntary services following reports that Gabriel was neglected. Following assessment, the assessor and Ms. Tanner had set three initial treatment goals: (1) helping Ms. Tanner cope with her depression and intense negative feelings; (2) helping Gabriel better modulate his affective hyperarousal; and (3) helping mother and child find mutual pleasure in developmentally appropriate activities. The course of treatment is described below.

Beginning Treatment

The therapist arrived to the first home visit with specific strategies in mind to help both Gabriel and Ms. Tanner with their affective hyperarousal. Her first task, however, was to help Gabriel understand why she was coming to his home and what he could expect from the treatment. As the therapist sat down on the floor with her bag of toys, Gabriel immediately emptied the bag and examined each toy briefly before throwing it on the floor. The therapist asked whether his mom had told him why she was coming to his house. Gabriel looked at her blankly and Ms. Tanner said, "I couldn't think of what to say. I thought you could tell him." This response showed the therapist that the mother had not been able to hold in mind the careful explanation they had

prepared together during the feedback session. The therapist now told Gabriel that she was coming to play with him and his mom because he had seen his dad do some very frightening things to his mom. He said, "My daddy hits my momma." The therapist answered with much feeling, "It's very scary for kids to see their daddies hit their mothers, and sometimes kids have big feelings after that happens. They feel sad or scared or angry. And they miss their daddies, too." Gabriel broke in and said, "My daddy's in jail." The therapist said that Gabriel had certainly been through a lot with his dad and continued, "Your mom is worried that you are having trouble in school and trouble feeling safe because of all the things that happened with your dad. So when I come we can talk about that, and play, and I will try to help you and your mom feel better."

It took Gabriel only a few minutes to go through all the toys. He didn't really play with anything. He simply looked at each toy and then tossed it aside. Then he turned to the soft ball and threw it forcefully across the room, barely missing his mother's face. Ms. Tanner did not respond. The therapist asked the mother, "If I weren't here, would you let him hit you like that?" Ms. Tanner said, "It's okay. It didn't hurt me." The therapist believed that it was important to help both Gabriel and Ms. Tanner understand that Gabriel's present aggressive behavior was tied to the violence he had witnessed. She replied, "It's not good for him to hit you. Kids know that they shouldn't hit adults, and when they can get away with it, it's too scary." She turned to Gabriel and said, "I think you're remembering when your dad hit your mom. We were talking about it just a minute ago. I think you remember it a lot, and when you remember it you want to hit, too." Gabriel replied, "He made her cry." The therapist said, "He was wrong to make her cry. I think it scared you to see her cry. Your daddy made a big mistake when he hit her. He shouldn't have done it. And you shouldn't hit her either. We know you're mad and frustrated. You can ask for help if you need it, but we can't let you hit your mom."

This intervention calmed Gabriel. As he played with the toys, the therapist tried to no avail to discuss this exchange with Ms. Tanner, who sat huddled on the couch. The therapist commented that she thought that Gabriel's aggression had been very frightening to Ms. Tanner, but Ms. Tanner shook her head and said, "I'm not scared, I just don't feel good." When the therapist brought the session to an end, Gabriel became dysregulated again, throwing the toys and screaming. Ms. Tanner made no move to comfort him. The therapist was unable to calm him, and he kept screaming as she left.

Over the next weeks, the therapist became concerned about the mother's inability to engage in the intervention. Ms. Tanner talked read-

ily with the therapist, but her conversation was focused exclusively on the minute details of her day-to-day activities. Her speech held the therapist at a distance. There was little room to address how Ms. Tanner felt about any of the details she reported, and when the therapist inquired, Ms. Tanner deflected her questions. Ms. Tanner also deflected questions about her advancing pregnancy and her plans for the baby after it was born. When the therapist commented on how difficult it seemed for Ms. Tanner to discuss her feelings, Ms. Tanner denied that it was difficult and added, "There just isn't anything to discuss." Avoidance, cognitive numbing, and isolation of affect were major defensive strategies for her. She was equally disengaged from Gabriel's play. Her talk flowed over him; she seemed unable to take part in what he was doing, and she hardly noticed him except when he did something she found annoying. The therapist commented to the mother that what she was seeing now was very different from what happened during the assessment, and she reminded Ms. Tanner of the fun that she and Gabriel had together as they played with the dishes and pretended to prepare and eat a meal. Ms. Tanner said dismissively that the assessment was different. "There wasn't anything to do there but play. There's lots of other stuff going on here."

Unlike his mother, Gabriel did not hold the therapist at a distance. He seemed comforted by the therapist's predictable weekly visits and became quickly engaged with her. He responded well to body-based interventions designed to help him slow down his responses and think before he acted. The therapist helped him learn to tense and relax his muscles and to take deep breaths when he felt frustrated. Gabriel liked the deep breathing and he adopted it in multiple settings. Over the next several weeks, both Ms. Tanner and his teacher reported that he was less readily angered when things did not go the way he wanted and he was less reactive and aggressive at preschool. The therapy gave Gabriel the opportunity to experience a relationship with someone who was dependable and attentive to his needs.

As he learned that his relationship with the therapist could be a source of comfort and structure, Gabriel turned to his mother for similar help. During one session in the second month of treatment, Gabriel was building a tower of blocks, and the tower fell when he reached to put the top block on. He restrained himself, took a deep breath, and said, "I'll build it again." The therapist congratulated him on being able to stay calm even when something disappointing happened. He smiled, then turned to his mother and asked her to help him rebuild the tower. Ms. Tanner continued talking to the therapist as if she had not heard him. Gabriel approached her, leaned against her knee and, reaching

up to hug her, again asked for help. Ms. Tanner recoiled from his hug and Gabriel turned away. The therapist was aware of feeling both sad for Gabriel and irritated with Ms. Tanner for rebuffing Gabriel's bid for affection. She chose to maintain a broad focus on exploring the moment and asked, "What just happened?" Ms. Tanner did not deflect that question. She said, "I don't like to be touched, and he knows it." The therapist commented on how hard that must be for both of them because young children express their affection so physically. Ms. Tanner shrugged and Gabriel continued playing. The therapist had the definite sense that mother and child had given up on each other, and she struggled to hold onto a sense of hope as she faced their ingrained expectations that relationships could be either overwhelming or disappointing but in both cases, emotionally unsatisfying.

In the seventh week of the treatment, the therapist arrived to a surprise: Ms. Tanner had given birth and was sitting on the living room couch bottlefeeding the baby. Gabriel was gently stroking the baby's feet. Ms. Tanner seemed detached from the baby. She didn't look at his face as she fed him. Gabriel, on the other hand, was transfixed by his baby brother. He crooned quietly to him and stroked him softly. The therapist said, "You're such a wonderful big brother. You know how important it is to be quiet and gentle with the baby." Gabriel smiled, but Ms. Tanner seemed not to hear the clinician's remark and began a complicated story about the long and difficult labor and delivery. Her urgent need for the therapist's support at a time of threat to her physical and emotional integrity foreclosed the moment of intimacy between Gabriel, the mother, and the therapist around the baby. The mother's agitation as she spoke of the delivery distressed the baby, who started to cry. Gabriel wandered away. The therapist struggled with her conflicting feelings. On the one hand, she wanted to support Gabriel's closeness to the baby and to his mother. On the other hand, she knew that intimacy was difficult for Ms. Tanner, and she did not want to support a closeness to the baby that would lead to even greater distress at separation if, as she had said before, Ms. Tanner planned to send him to be cared for by her mother.

As they talked about Ms. Tanner's plans for the baby, it became clear that the plan to send the baby away had not changed. Ms. Tanner's mother was coming in 3 weeks to take the baby back to Texas. Ms. Tanner said, "He'll stay there for a year so I can get my GED and get started in college. Then he'll come home." The clinician told Gabriel, "Your mom is telling me that she needs some help taking care of the new baby. She can't take care of him, and you, and go to school. So your grandma is going to help her with the baby."

Gabriel replied, "I want him to stay."

Ms. Tanner said, "You'll see him. She'll bring him to visit. And then after a little, he'll come home."

When the therapist arrived the next week, Gabriel was still at preschool and the baby was already gone. Ms. Tanner explained that her mother had gotten some time off work and had come to take him earlier than expected. The therapist asked, "Do you miss him?" Ms. Tanner replied, "Yeah, but it's for the best. I can't take care of him with everything else. I've got to finish school. Gabriel already knows me and he needs me. The baby will be okay with my mom, and he'll be home in a year."

The therapist said, "I have two questions and I don't know which one to ask first. But I guess I'll start with Gabriel. How did he handle it when his brother went away?"

Ms. Tanner responded, "He's okay. He cried, but he'll get over it. What's your next question?"

The therapist laughed and said, "Well, now I have another one about Gabriel. Do you think he maybe worries that if you can send his baby brother away, you could send him away, too?"

Ms. Tanner thought for a minute and said, "No. He knows I won't send him off. I need him too much. I couldn't stand it if I lost him. What's your next question?"

"It seems hard for you to talk about this. You really want me to get to the next question."

Ms. Tanner said, "There's nothing to talk about. Gabriel's okay. The baby's gone. It's just what I had to do. And like I told Gabriel, he'll be back."

The therapist relented and said, "That's my next question. What do you think it will be like for the baby to lose your mom after a year when he comes back to you?"

Ms. Tanner shook her head. She said, "He'll be okay. He'll know who his momma is. My mom is going to bring him to visit. He'll know this is home. He'll just know."

The therapist tried, in this session, to encourage Ms. Tanner's capacity to reflect on the relational needs of her children. Ms. Tanner's response was a defended refusal to reflect and to feel. The therapist decided not to breach this self-protective stance and accepted Ms. Tanner's unwillingness to discuss the hardships that the baby's departure and ultimate return would pose for the children. In simply letting the subject drop, however, the therapist surrendered her own point of view and suspended her advocacy for the children's perspective. She became, in effect, subservient to Ms. Tanner's defense.

A number of alternative therapeutic responses were possible. One response would be to interpret the defense by saying, for example, "Close relationships have caused you so much pain. I think that makes it hard to think about these things." Another response would be to follow this interpretation with a comment highlighting the motivation behind the defense, such as, "You don't want your children to feel as hurt as you did. I imagine that it's tempting to think that if they don't feel too close to each other they won't get hurt." Either of these courses of action would have upheld Ms. Tanner's subjective experience while expanding its boundaries and introducing the idea that her children might have a different internal reality.

Concerns about the Mother's State of Mind

Two weeks after Ms. Tanner's mother took the baby to Texas, Ms. Tanner greeted the therapist in tears. She said that she had left Gabriel with her aunt and had some friends over to her house to party. She passed out and when she woke up she had the feeling that someone had raped her while she was unconscious. The therapist was alarmed. Ms. Tanner's mind seemed literally divided: At one moment she asked angrily who could have raped her, and the next moment she wondered how she could ever be sure that the rape had actually happened. The therapist was also concerned about Ms. Tanner's drinking. This was the first time since the treatment began that Ms. Tanner had admitted to drinking, but she did not seem concerned about drinking so much that she passed out. She focused instead on feeling both betrayed by her friends who had let this happen but strangely unsure of whether anything had happened at all.

For the next several weeks, the therapist asked Ms. Tanner in each session whether she had been drinking, and Ms. Tanner denied that she had. The therapist once again made the mistake of surrendering to Ms. Tanner's stated view of herself as someone without a drinking problem, this time in the face of additional evidence to the contrary. The therapist did not raise the need for substance abuse treatment and did not link Ms. Tanner's drinking to her depression or to her lack of motivation to follow through with her plans to complete her GED and enroll in college classes. Most important, she did not tie the binge that had resulted in Ms. Tanner's losing consciousness to any feelings she might have had about her baby's departure. The mother's emotional distancing was reflected in the therapist's reluctance to name what was happening. There was a compelling but unexamined parallel process between Ms. Tanner's inability to feel and the therapist's compliance with the message that she did not want to feel.

Compounded Adversity

This pattern continued for several weeks until one day Ms. Tanner telephoned the therapist, sobbing uncontrollably. She said, "They took Gabriel!" It took the therapist several minutes to obtain a coherent story. The night before, Ms. Tanner and Gabriel had gone to a friend's home and she had a lot to drink. She borrowed a stroller to push Gabriel home because he had fallen asleep. While walking home she tripped over a curb and fell, pulling the stroller over. Gabriel started to cry, and a policeman who had been standing near the corner came to help. He arrested Ms. Tanner for public intoxication and child endangerment and took Gabriel into protective custody. Ms. Tanner had been released from jail the next morning, but Gabriel was now in foster care. Several days later, he was placed with the aunt who had kept him for much of his first year of life.

Things started to deteriorate quickly from there. Ms. Tanner was required to take part in substance abuse treatment as a condition for reunification with Gabriel but she resisted this requirement, insisting that she did not really have a drinking problem. The child protection worker told the therapist that he had lost faith in Ms. Tanner's ability to care for Gabriel. He noted that it was fortunate that she had sent her second son to her mother and commented that perhaps that child would have a chance at a good life. He said that Ms. Tanner had not made good use of services before and it seemed unlikely that she would make good use of them now.

The clinician advocated for and secured individual therapy for Ms. Tanner, but her attendance was spotty. With Gabriel in foster care and with no transportation worker available to bring him to sessions, the CPP ended. The therapist made a visit to Gabriel's foster home to say goodbye; he clearly missed his mother and wanted to go home. For several weeks the therapist continued to support Ms. Tanner in attending substance abuse treatment, focusing her arguments on how important Ms. Tanner was to Gabriel. Ms. Tanner, however, could not give up her view that she did not have a problem with alcohol. The child welfare worker did not extend himself to help Ms. Tanner find a program that might meet her needs, and the therapist's attempts to use Gabriel's ties to his mother as motivation were not useful.

What Went Wrong

Although there were small successes woven through the therapeutic process, the treatment failed to accomplish the ultimate goal of helping

Gabriel and his mother form a relationship that could sustain healthy development for both of them. Two major clinical errors underlie the failure. First, the therapist was wishfully unrealistic in believing Ms. Tanner's assertions that she had no problem with alcohol. The therapist could not have helped Ms. Tanner manage her alcohol problem without expert assistance, but she could have asserted Ms. Tanner's need to seek treatment. Once Child Protective Services (CPS) became involved with the family again, the therapist could have worked more collaboratively with the CPS worker to engage Ms. Tanner in a substance abuse intervention. The CPS worker appeared to give up easily on his relationship with Ms. Tanner and anticipated that she would simply be unable to raise Gabriel. The outcome might have been different had the therapist insisted that she and the CPS worker collaborate to help Ms. Tanner overcome her resistance to the substance abuse treatment that she needed. Even the stamina of devoted and skillful therapists wears thin in the face of cumulative therapeutic stresses and persistent resistance.

The second mistake was the therapist's tendency to go along with Ms. Tanner's viewpoints. The therapist did not consistently present her own point of view because, by deferring to the mother's position, she hoped to offer Ms. Tanner an experience of genuine acceptance that she had lacked in her other relationships. The resulting lack of internal focus ultimately prevented the therapist from applying all she knew to help Ms. Tanner expand her perceptions of her own behavior and of Gabriel's needs.

Would treatment have succeeded without these therapeutic errors? The answer is by no means clear. Ms. Tanner had lived her life at the margins of society. She expected to be hurt by others, and she withdrew defensively into an addiction that kept her marginalized and isolated. The systems on which Ms. Tanner needed to rely expected little of her and lacked the will to reach out to her. By submitting herself to Ms. Tanner's point of view, the therapist unwittingly joined in the systemic rejection that Ms. Tanner both expected and endured. As Benjamin (1988) points out, when an individual submits to the will of another, that individual becomes merely an object and can no longer bring a subjective self to the relationship. Ms. Tanner did not have a conscious intent to dominate her therapist; the therapist did not have a conscious intent to submit to Ms. Tanner's world view. But as she yielded, the therapist lost the ability to stand up to the systems that were failing Ms. Tanner and her efforts became one more casualty of the internal forces within the mother and the external forces in society conspiring against keeping mother and child together.

Keeping Track: The Role of Clinical Supervision

Therapists often need help in maintaining the course of therapy and sorting out the myriad obstacles that interfere with their clear clinical judgment. Clinical supervision can provide a safe psychological space to reflect about the treatment with the guidance of a more experienced clinician who has sufficient distance from the immediate process to offer nonjudgmental feedback and direction. In reflective supervision, the supervisor offers not only clinical knowledge but also an emotional holding environment for the feelings that working with troubled parents and young children arouse in the clinician, including such countertransference feelings as the wish to rescue, anger at a harsh or abusing parent or at systems of care, hopelessness, and helplessness. Supervision also provides a nonjudgmental and supportive relationship in which clinicians can track and reflect on whether the pressures of their work are leading to secondary traumatization or burnout (Figley, 2002; McCann & Perlman, 1990). In reflective supervision, clinicians can discuss whether the problems of the families they treat are invading the clinician's private lives in the form of intrusive thoughts, nightmares, or uncharacteristic hypervigilance and can monitor the effectiveness of their self-care practices (Osofsky, 2004a). This supportive emotional experience enables the therapist to provide a similar holding environment for the child–parent dyad (Fenichel, 1992; Shahmoon-Shanok, Gilkerson, Eggbeer, & Fenichel, 1995).

Work with young children makes therapists vulnerable to primitive feelings that emerge from their own early childhood. Infants, toddlers, and preschoolers have not yet mastered the capacity to regulate and modulate the expression of emotion, and their raw affect can be contagious for both the parent and the therapist, summoning the ghosts that under less challenging circumstances might not intrude in their functioning. Trauma prototypically dysregulates affect and can magnify this effect. Child–parent psychotherapists need a protected space in which they can reflect on the therapeutic process with a trusted supervisor even when treatments are going well.

Supervision becomes even more important when the therapist reaches a clinical impasse. In these cases, supervisors help therapists recognize the blind spots, misattunements, and failures of empathy that put therapeutic outcomes at risk. Supervision can also be the first clue that the treatment is in trouble. When supervisors find themselves feeling misaligned with the therapist, these feelings may indicate a parallel process in the therapy. To illustrate this point, we return to one of the examples described earlier in this chapter.

Supervision in the Case of Ms. Lee and Her Daughters

Although the treatment of this family began well, the supervisor became concerned as it unfolded because Ms. Lee was consistently absent from the therapist's narrative notes of treatment sessions. The therapist quickly became defensive when the supervisor commented on this omission. She answered that she did her best to include Ms. Lee but sometimes she had to put all of her energy into making sure that Ms. Lee would even allow the children to take part in the session. When the supervisor inquired about why the children might not be allowed to take part in the therapy, the therapist explained that they were not allowed to play or participate in the therapy if they had not finished their homework. She also expressed her anger at Ms. Lee for "not letting her children have what they needed." The supervisor felt herself growing increasingly impatient with the therapist. She asked, in the calmest voice she could muster, if the therapist had an understanding of why Ms. Lee might put so much emphasis on the children's homework. Without directly answering the question, the therapist said in a clipped and angry tone that it was almost abusive for a mother to deny treatment to children who were suffering so much. The supervisor tried as many ways as she could think of to encourage the therapist to reflect on Ms. Lee's feelings and motivations, but each effort was met with resistance. She pointed out the parallel process, saying that it seemed that both she and the therapist were frustrated by the conversation that was occurring in the supervision and noting that this often meant that there was a similar frustration occurring in the communication between the therapist and the mother. The therapist stated that she was beyond frustration with Ms. Lee and that she, in fact, felt anger and almost hatred toward her because of the way she was treating her children. Several supervision sessions passed in this fashion, with the therapist becoming more and more rigid and angry in her presentation. She did not tell her supervisor about the birthday gifts that she had taken to the girls until after it became clear that the treatment had ended badly.

This supervision might have been more helpful in averting a failed treatment if the supervisor had done what she wished the therapist would do: reflect more on the point of view of the other person in the relationship—in this case, the therapist. The supervisor had a view about how the treatment should proceed and did not empathically consider the therapist's position. Similarly, the therapist held to a particular idea about what would be most helpful to Ms. Lee's children (i.e., therapy) and was unable to make room for Ms. Lee's beliefs about what her children needed if they were to develop well and succeed (i.e., school-work).

It is not always possible for a supervisor to step back from the impasses in the supervisory relationship and examine dispassionately both her own subjectivity and the subjectivity of the therapist, but supervisors should strive for this goal. Supervisory failure to find a balance between the supervisor's and the therapist's perceptions will often find a parallel in the therapist's failure to fully embrace the subjectivity of the parent or the parent's failure to embrace the subjectivity of the child. As the person at the greatest remove from the storm of affect that so often surrounds the treatment of traumatized young children and their parents, the supervisor is the one with the primary responsibility to ensure that there is room for everyone to be held in mind.

CHAPTER 9



Integrating Child–Parent Psychotherapy with Other Service Systems

Many social institutions are charged with protecting children across the continuum of need. Pediatricians, pediatric health nurses, and child care providers are engaged with the child and the family in the normal course of development and can provide early identification and referral for problems outside their areas of expertise. Child Protective Services (CPS) and the legal system come into play when the child's safety is endangered by parental maltreatment. The involvement of CPS and the legal system affects every aspect of treatment by mandating courses of action that are largely unrelated to the developmental stage and mental health needs of the child. Coordinating mental health treatment with the often contradictory demands of different systems of care should constitute standard "best practice" for child mental health providers. This chapter describes the practice of CPP when other service systems are active in the family's life.

CPP and the CPS System

No player in the drama of CPS has an easy role. CPS workers must often make a child placement decision in the moment, with very little information about the parents' strengths and sources of support. Their primary mandate is to protect the child's physical safety. This goal may lead them to err on the side of removal because the danger of physical

or sexual abuse looms as a bigger immediate evil than the young child's emotional collapse in being separated from the parent.

Most CPS workers know the dangers of placing a child in foster care, including the risks of physical and sexual abuse and frequent changes of placement. Even in benign conditions, foster parents are not trained to address the child's mental health problems, which are exacerbated by the trauma of separation from the parent (Heineman, 1998). For the CPS worker, the stress of making a decision is compounded by the fact that ambiguity is the rule rather than the exception in many situations. Examples abound. Different CPS workers routinely respond in different ways to the same circumstances. The supervisor frequently overrules the decisions made by the worker. The judge may overrule the decisions made by the supervisor. Moreover, all of these actions usually occur in quick succession. Predictability is the first casualty of involvement in the child protective system. In addition, the decision to remove the child is followed by a cascade of legal consequences that prevent the worker from immediately returning the child if the foster care placement proved unnecessary.

The role of mental health clinicians gives them the leisure to second-guess whether circumstances warranted the CPS worker's in-the-moment decisions. By the time a case is referred to the clinician, there is much more information available about parents and child, both because there has been more time to learn the facts and because the clinician is trained to elicit psychologically relevant information that may not be within the purview of the CPS worker. Clinicians also cultivate comfort with ambiguity as an integral component of their professional identity. This is often a source of frustration for CPS workers, who turn to the clinician for clear-cut recommendations that the clinician is often unwilling to give. Lack of communication and coordination across systems can lead to serious harm, as may happen, for example, when the CPS worker moves the child from one foster home to another without notifying the child's therapist. These sudden moves represent a missed opportunity to prepare the child and the parents for the change and to help them mobilize the appropriate coping resources to adapt to it. Sometimes the unexpected changes in foster care could be avoided with thoughtful planning. Other times they are the result of sudden decisions by the foster parent which take the CPS worker by surprise.

Many solutions have been repeatedly proposed for the system deficiencies involving maltreated children, and there are numerous determined efforts to implement them. For the purposes of this chapter, the key message is to encourage clinicians working in a variety of venues, including private practice, to press for system change so that the practices of the child welfare system become developmentally informed (Harden, 2007; Silver, Amster, & Haecker, 1999). Clinicians can also

help to improve access to services by including in their practices work with children involved in the CPS system. The model of *Building a Home Within* (Heineman & Ehrensaft, 2005) consists of individual clinicians who include in their private practice at least one child who is in the child protection system. These clinicians make a commitment to provide continuity of treatment under the credo “One child. One therapist. For as long as it takes.” The clinician’s collaborative attitude toward the CPS worker, with realistic recognition of the pressures and limitations inherent in the child protective system, is a crucial element to promote cross-system communication, reduce polarization, and enhance an integrated service approach on behalf of the child.

Obstacles to a Therapeutic Relationship with Parents in the CPS System

The CPP therapist providing treatment to a child and family involved with the CPS system faces multiple and often contradictory pressures that represent obstacles to the therapeutic work. The sections that follow address the nature of obstacles to treatment and possible ways of circumventing their negative impact on parental participation.

Voluntary versus Mandated Treatment: Power Differentials

The most immediate clinical conundrum is the power differential between the clinician and the child’s parents. This power differential is starkly demonstrated in the fact that treatment is usually mandated by the legal system rather than voluntary, and it is accentuated by the parents’ frequent poverty and social disempowerment. These factors have profound repercussions for the legitimacy of treatment. In a freely chosen therapeutic contract, power tends to be relatively equally apportioned between therapist and client. The therapist has knowledge and skills that the client wants. The client, in turn, has something to offer to the clinician, ranging from financial remuneration to a feeling of being valued and even admired for what one has to offer. The resulting sense of reciprocity in voluntary treatment gives clinician and client a sense of personal efficacy vis-à-vis the other that provides a buffer from the emotional hardships of the clinical process.

Clinical reciprocity is absent when a family is referred as the result of CPS involvement. Unlike a freely chosen therapist, the clinician assigned to the family does not have anything the client consciously wants. On the contrary, treatment is often perceived by the parent as involving “trouble” and loss of control. Moreover, clinicians often feel burdened by the sheer enormity of the child’s maltreatment and the

family's presenting problems, which are compounded by the myriad collateral responsibilities of working with families referred by CPS or the legal system. The result is that the client may have little to offer (at least before a relationship is established) that the clinician wants, particularly in these times of low remuneration and increasingly large and demanding clinical case loads in the public mental health system.

In this situation, both sides may feel powerless in many respects, but there is a difference between the clinician's and the client's experience of powerlessness. Clinicians know that their overall well-being does not depend on the client, whereas parents perceive the clinician as having the power to change their life. The inherent power inequality sets the stage for the parents' resistance and hostility to the clinician. As a rule, parents in the child protective system have been threatened, rejected, or abused since childhood by the important adults in their lives. Their involvement with the legal system and with the clinician rekindles early experiences of being at the mercy of someone who is bigger and more powerful but who uses power in arbitrary and hurtful ways. One mother gave a graphic, although unintended, description of her experience during the first assessment session: "There are all these people who pretend to be nice and even slip a \$20 bill under your door, and when you open the door they clobber you." This woman had no reason to see the clinician in a different light. She had been sexually and physically abused since early childhood, both in her mother's home and in multiple subsequent foster care placements. There was nothing personal in her refusal to trust the clinician. She simply and naturally included the therapist in her internal model of what people are like. To a greater or lesser extent, these negative attributions characterize most parents referred to treatment by the legal system.

This scenario interferes with the feasibility of a genuine therapeutic alliance between the parents and the clinician, but without such a partnership the effectiveness of treatment is doomed. A "good-enough" collaboration with the parents depends in major ways on how the clinician addresses four concrete obstacles: the negative parental expectations evoked by mandatory treatment; potential lack of clarity about the clinician's role; the limits to confidentiality inherent in mandatory treatment; and differing perceptions of the child's best interests among the different service providers and between these service providers and the parent.

Negative Parental Expectations of Mandatory Treatment

Psychotherapy has been traditionally regarded as a deeply personal voluntary decision except when the person is deemed a danger to the self and others, a situation that poses thorny ethical and legal issues

in the effort to balance the public's safety with the rights of the individual. Pediatricians, pediatric nurse practitioners, child care providers, and friends or relatives are the most frequent sources of mental health referrals when a young child has emotional and behavioral problems that do not raise the possibility of abuse or neglect. The parents are free to pursue or decline the referral and, if they agree to mental health treatment, they can choose the therapist and decide when and why to terminate treatment.

Parental choice does not apply when the parent and child are referred to treatment due to domestic violence, abuse, or neglect. Mandatory treatment carries the explicit or implicit message that the alternative may be child foster care placement or termination of parental rights. This threat may generate terror, rage, or a combination of both in the parent and prompt the parents to hide information that is important for effective treatment. The very concept of mandatory treatment involves a contradiction in terms because inner change cannot usually be coerced but emerges from a person's awareness that things are not going well and one must develop new patterns of being and behaving. Parents referred for mandatory treatment seldom start out with this frame of mind. Even when they have an obscure sense that they did not do well by their child, the very fact of their involvement with the legal system brings up enough shame, guilt, anger, resentment and suspicion that it becomes easier to blame the system than themselves. Often the system offers sufficient objective reasons for the blame, and the clinician is invariably perceived by the parent (both rightly and wrongly) as an integral part of the system.

Clinicians need to anticipate and address the parent's negative attributions in ways that show the parent that nonpunitive interpersonal patterns are possible. The clinical challenge involves finding ways to empathize without colluding and to encourage change without casting blame. In the example of the woman who expected to be clobbered when she opened the door to retrieve the \$20 bill, the clinician struggled inwardly to find a way of articulating her motivation to help without making unrealistic promises about the outcome of treatment. After waiting for an opportune moment to address the mother's fear and suspicion, she said, slowly and with deep conviction: "I have been thinking while you talked about how many people betrayed you and hurt you and how much you suffered for it. It is very unfair that these bad things happened to you. I want to help things be better for you and your child, and I hope that you will tell me if I am hurting you in any way because that is not my intention." The mother said nothing but her face softened in response, and when she left she said spontaneously: "Thank you. I will see you next week." This statement had deep meaning in light of this mother's initial guardedness. It signified that she trusted the therapist

enough to return for another session. To reach this point, the therapist needed to strive for the inner balance to empathize with the mother's emotional experience without losing track of the maltreatment she had inflicted on her child. This awareness of the different facets of a clinical situation, including the suffering that is simultaneously endured and inflicted by different family members, is a cornerstone of treatment for maltreating parents and their children.

The parent's negative attitude to mandatory treatment is magnified when the child-parent treatment is one of several mandated interventions. The family must often comply also with court-ordered individual or group psychotherapy for one or both parents, couples or family therapy, substance abuse treatment, and appointments for job training, housing, and other concrete needs. Service providers often downplay the concrete hardships and emotional burdens posed by these multiple demands. The time and energy consumed by transportation (particularly when the parent does not own a car and must use unreliable public transportation) and the psychological pressure of complying with the different expectations of multiple service providers can be staggering. These factors may compound the parents' inability to participate in services. The clinician can provide emotional support by asking about the range of mandated services and their impact on the parent's everyday life. This attitude of sympathetic enquiry can become the first step in problem-solving to achieve a realistic coordination of services.

In spite of the problems it poses, mandatory treatment is sometimes the only feasible alternative to permanent removal of the child from the parent's care. When parents do not fathom the damage they have inflicted, only the possibility of losing their child may seem immediate and concrete enough to mobilize them to change. Mandatory treatment, if conducted with clinical skill and with full awareness of its complexities, can in time become a voluntary parental choice when the motivation to keep or regain custody of a child is stronger than the psychological obstacles that stand in the way of adequate parenting. This does not mean that the threat to terminate parental rights should be entertained lightly. Severing the child-parent attachment, even if its quality is far from optimal, invariably represents a major psychological trauma for the child as well as for the parent and should be employed only when it is the lesser of two evils. We have witnessed the plight of many children placed for adoption at young ages who, in spite of adequate care in their new homes, continue to pine for their lost biological mothers for many years, and as adolescents enact the biological parents' lifestyle that they witnessed as toddlers or preschoolers (Lieberman & Harris, 2007). Adoption is often successful and may in fact be the best possible outcome for the child. However, rupturing a child's attachment

to the parent is not risk free, and repairing the bonds of love that unite biological parent and child should be attempted as the first choice in most circumstances.

Lack of Clarity about the Clinician's Role

The clinician's role is often perceived by the different parties through the lens of what they want to achieve. The parent, the CPS worker, the different attorneys, and the judge may have different expectations of what the clinician should provide. The first step in providing effective treatment is understanding what each of these parties expects and clear, preferably written, communication about which of these expectations can be met and those requests that are outside the clinician's role. Clinicians need to tell the service providers and the parent what they can and cannot offer. For example, a clinician should not be simultaneously a treatment provider for the family and an expert witness at the trial.

It is important to make clear to the parent during the referral process that the clinician is not part of the legal system and cannot be mandated to provide treatment, but is willing to offer it if the parent wants it and the assessment indicates that it is warranted. Clinicians are often unable to influence legal decisions about child long-term placement even when their input is explicitly requested by CPS. This needs to be clearly stated to the parents, who often assume that the CPS worker or the court will do what the clinician recommends.

A frequent source of misunderstanding is that the CPS worker or judge may refer the parent and the child for treatment and expect that the clinician will use the clinical information to testify about the best placement for the child. Such a dual role as treatment provider and consultant to the legal system is untenable unless two preconditions have been met: (1) the clinician arrives at an explicit understanding with the parent that the assessment and treatment have the goal of providing guidelines about the child's placement; and (2) the clinician conducts an assessment of all the people considered for possible placement, including their competence as caregivers and the child's relationships with them. In these circumstances, clinicians should respect the centrality of their clinical relationship with the parent by disclosing their recommendation to the parent before informing the CPS worker or the court. This may involve showing the parent a draft of the written report before the final version is submitted to the legal system, unless doing so may pose a danger to the clinician or the child.

An initial assessment period enables parent and clinician to get to know one another and decide together, at the end of the assessment, whether to continue treatment or whether it is better to make a referral

to another agency or type of treatment. The clinician has an important educational role in explaining to the parent what the system is requesting, making sure that the parent understands the purpose of assessment and treatment, describing the scope and limits of confidentiality, and obtaining signed informed consent in the first session. The issues to be clarified are often so thorny that most often a couple of initial sessions should take place individually with the parent. Individual sessions with the parent should continue to be woven into the assessment and treatment because it is essential to keep track of the parent's experience of treatment and to inform the parent of the clinician's sense of how the treatment is progressing and of ongoing areas of concern. Such ongoing communication prevents unpleasant surprises if the clinician's recommendation to the court about child placement differs from what the parent wants and expects.

The Scope and Limits of Confidentiality

In voluntary psychotherapy, clinicians traditionally explain to their clients that what they say is confidential unless it endangers themselves or others. In contrast, confidentiality is much more ambiguous in mandated treatment because the parents and child are involved with multiple service providers who exchange information with each other, often in crisis situations that blur professional judgment about what constitutes confidential information. For example, the content of psychiatric and psychological evaluations is routinely discussed in planning meetings where a variety of service providers are present. As a result, the parents have little control over the dissemination of important information involving very private matters and may respond self-protectively by withholding aspects of their lives that are crucial for the progress of treatment.

Clinicians need to address the limitations of confidentiality with candor, explaining that only information relevant to the child's and parent's safety and to placement decisions will be disclosed to other parties. The therapeutic frame must give explicit assurance to the parents that the clinician will not share intimate details of their lives with the legal system or other professionals without the parent's permission. The release of information forms that the parent is asked to sign should be thoroughly explained and filled out in the parent's presence, with enough detail written in to convey the message that the clinician takes confidentiality very seriously. Even when the signed release form gives the clinician freedom to exchange information with other parties, it is respectful to let the parent know when and why such a conversation will take place, to elucidate the parent's feelings about it, and to give the parent a summary of the exchange afterward.

Different Perceptions of the Best Interests of the Child

In voluntary therapeutic relationships, parents and clinician usually have a shared goal of improving the child's emotional experience and behavior. In mandatory treatment, parents and clinician often have sharply different opinions about the best interests of the child and may not start with a shared agenda. Clinicians are committed primarily to the child's long-term well-being and do not necessarily equate this goal with the preservation of the parent-child relationship. They may waver at different times between commitment to the primacy of the parent-child relationship, worries about the child's well-being in the parent's care, and preference for out-of-home placement and adoption. In contrast, parents ordinarily assume that the child should live with them and do not believe that their shortcomings as parents signify lack of competence to have custody of the child. When the clinician is unable to convey unambiguous support for their position, parents may be unable to tolerate the uncertainty. The resulting tension sets the stage for the reenactment of powerful and often polarizing conflicts between the parents and the clinician. When, as is often the case, the parent has little capacity for affect regulation and lashes out at the clinician in anguish and in rage, clinicians may resort to impulsive punitive measures using the rationalization that they are acting to protect the best interests of the child.

When clinicians feel the duty to recommend termination of parental rights in the best interests of the child, their attitude can make an enormous difference in protecting or damaging the parent's emotional integrity. Clinicians who remain aware of the parent's emotional experience and articulate the pain and tragedy of this recommendation may enable the parent to preserve some positive self-regard and avoid a spiraling self-destructive course following the loss. This situation is reflected in the example that follows.

Example: A Therapeutic Attitude toward an Abusive Parent

Mrs. Smith, a 35-year-old mother, lost her parental rights for her three young children due to her emotional abuse and neglect and her persistent inability to keep them safe from her partner's physical abuse. After 1 year of treatment, the therapist believed that the children continued to be at risk and submitted to the court a report recommending adoption of the children by their foster parents. The therapist told the mother about this recommendation and showed her a draft of the report for her input. After reading it, the mother said sadly: "It is hard to accept, but I just can't take care of them."

The mother's capacity for reflection and acceptance was hard won. A month earlier, the mother had locked her door when the CPS worker came to pick up the children to return them to their foster homes after a weekend home visit, and her partner threatened an armed confrontation if the police were called. The impasse ended when the mother said during an emergency phone consultation with the therapist that she would willingly relinquish her children if the therapist came to the house to pick them up. At some risk to himself but confident that the therapeutic relationship would hold, the therapist went to retrieve the children and the crisis was resolved peacefully.

Treatment with the mother, the partner, and the three children, ages 5, 3, and 1 year old, had started 1 year earlier, when the children had been placed with two different potentially adoptive foster families after bruises in the two older children were found by the child care provider soon after the youngest child's birth. All three children were immediately removed from the home. After some time in shelter care, the two older children were placed in one potentially adoptive foster home and the youngest child was placed in another. Although everybody involved would have preferred to place all the children together, no family willing to adopt three children so close in age was found. Ultimately, the painful decision was made that immediate stability of care was preferable to waiting for the optimal adoptive situation. The two older children and their adoptive parents received CPP treatment to help the children process the loss of their mother and sibling, the traumatic relationship with the mother's partner, to facilitate adjustment to their new home, and to help the adoptive parents understand the meaning of the children's behavior as reflections of the terrible circumstances they had gone through. The adoptive parents of the youngest child declined treatment on the grounds that the child did not show significant symptoms.

Three months after the crisis, the mother called the clinician from a different state to ask about her children, and with the clinician's encouragement she sent them letters and pictures. These materials were used in the treatment to reassure the children that their mother was well, that she continued to love them, and that she wanted them to grow up with parents who would not scare them or hurt them. During the telephone call, the mother let the clinician know that she had undergone a tubal ligation in recognition that she could not be an adequate mother for a child.

This outcome, simultaneously sad and optimal under the circumstances, was greatly facilitated by the clinician's remarkable ability to hold different frames of reference as an explicit component of the treatment. Specifically, the therapist kept the mother accountable for

her children's safety while empathizing with the psychological obstacles that prevented her from giving them adequate care. In describing his experience of providing treatment to this mother and her children, the clinician spoke about his strenuous efforts to suppress his impulse to berate the mother for her shortcomings. The mother's ability to relinquish her abused children and to take action to not have additional children speaks to the powerful mutative role of an authentic therapeutic relationship, where the clinician can integrate acknowledgement of the destructive facets of the parent's personality with compassion for the pain underlying the parent's inability to protect her children.

Challenges of Child–Parent Reunification

CPP is often the mandated treatment for the parent and child in two situations: maintaining reunification after a child is returned to the parent's care, and working toward reunification of a child placed in foster care. Clinical illustrations of each of these two situations are presented next. Although the chapter cannot do justice to the infinite variations presented by families that collide with the different facets of the child protection and legal systems, we hope that the two examples will illustrate key issues that can be generalized across individual family configurations. Space limitations prevent us from describing all the facets of treatment. Instead, we present highlights that demonstrate the overall approach as well as specific applications of CPP clinical modalities as they become relevant to the treatment of children and families in the CPS system.

In-Home Dependency: Sustaining Reunification after Foster Home Placement

CPP to maintain reunification focuses on the following goals: (1) recognizing the developmental changes in the child and the life changes in the parents that occurred during the separation; (2) understanding the implications of these changes for restoring a sense of belonging; (3) establishing daily routines that promote predictability and trust; and (4) identifying early signs that the problems that led to the child's removal may be reoccurring in order to take effective preventive action. These goals are pursued simultaneously, and often the same intervention addresses more than one goal. For example, developmental guidance to establish a predictable daily routine may restore a feeling of belonging between parent and child by building on habits that were established before the separation. As in other clinical situations, all the intervention

modalities may be used at different times and in different combinations. Here we describe the treatment that followed a young girl's reunification with her mother after she had been in foster care for 1 year due to her mother's alcohol abuse and child neglect.

Example

Presenting Problem

Marietta Brown was a 3-year, 4-month-old African American child who was removed from her mother's care after Mrs. Brown, age 25, forgot to pick her up from child care and was found in the street talking incoherently to herself. Mrs. Brown was taken to the hospital for observation, diagnosed with an alcohol abuse problem and depression, and released after 48 hours with a referral to a substance abuse program. The CPS worker reported that during the year preceding foster care placement, Mrs. Brown had become progressively more erratic in her behavior, often arriving late to pick up Marietta from day care and at times looking disheveled and somewhat incoherent. She became antagonistic and raised her voice when the child care providers reminded her of the importance of punctuality at pickup time. At those times Marietta was clearly distressed, moving between the mother and the child care provider as if trying to mediate between them. The day care director reported the situation to CPS when Marietta arrived at school looking unkempt and her mother did not come to pick her up by the time the center was closing. Marietta spent 2 weeks in an emergency shelter and was then transferred to a foster home that kept her for 6 weeks before the foster mother gave a 7-day notice that she could not continue to care for Marietta because the child soiled herself, had frequent tantrums, and woke up crying during the night. Marietta was transferred to the home of an experienced, patient, and loving foster mother who made her an integral part of her large family, including two grandchildren who were also toddlers and who visited frequently. Marietta stayed with this foster mother for the remaining 10 months of her out-of-home placement. By the time reunification with her mother occurred when she was 3 years, 4 months old, Marietta had experienced four separations from primary caregivers: the initial removal from her mother plus placement in three foster care homes, and she had not been in her mother's care since she was 28 months old.

Mrs. Brown had fought in court to have her child returned immediately after the initial removal. She adamantly denied alcohol abuse, but she was court-ordered to participate in alcohol treatment and job training programs and to undergo random alcohol tests as conditions

for reunification. Mrs. Brown had initially failed to pursue these court requirements and only began to do so when the 6-month court hearing was approaching. The period of reunification was extended for an additional 6 months in spite of the CPS worker's objections because Mrs. Brown's attorney mounted a vigorous defense of his client. With her lawyer's encouragement and unstinting support, Mrs. Brown successfully completed the reunification requirements and had Marietta returned to her.

During the year that Marietta was in foster care, Mrs. Brown had been granted supervised visits with her twice a week for 3 hours at a time. The visits were erratic at first due to Mrs. Brown's unreliable attendance, but they became quite regular once she started to consistently attend alcohol treatment. The lack of regularity of the early visits was likely to have compounded Marietta's distress at being separated from her mother and intensified the tantrums, crying, and sleeping problems that led the second foster mother to relinquish her care. Even after her everyday behavior stabilized markedly when she was placed with her supportive third foster mother, Marietta's visits with her mother were difficult because she did not want to either leave her foster mother's care or separate from her mother at the end of the visit. She had tantrums before leaving the foster home to visit her mother, clung to her mother and cried when it was time to say goodbye at the end of the visit, and was oppositional and moody for the day after her return. Her behavior was saying, essentially: "I don't know who loves me or where I belong. When I am with my foster mother I feel cared for and I don't want to lose her. I am afraid if I am not with her I will never see her again. When I am with my mom I feel again the good feelings I had when she took good care of me, and I don't want to give that up and let her go because I don't know if I will ever see her again." The CPS worker worried that Marietta's behavior could lead to Mrs. Brown's relapse if it became a source of stress for her, and she made the referral for CPP shortly before reunification.

Initial Assessment

Although it would have been optimal to conduct the assessment and begin treatment prior to reunification, our program had a waiting list at the time of referral and the first assessment session took place 3 weeks after Marietta had returned home. It was clear from the outset that Mrs. Brown was not welcoming of this new treatment expectation from the legal system. Although treatment was not mandated by the court, Marietta was still a dependent of the court and she could be placed back in foster care if the CPS worker found issue with Mrs. Brown's behavior.

The initial session was an individual meeting with Mrs. Brown in order to learn about her perception of her situation and her child's needs and to inform her about the treatment model. She arrived for her appointment 20 minutes late and said curtly that the bus was late. The clinician commented that the public transportation system was awful and added that she was sorry that the mother had to wait in the cold rain that was falling outside. Mrs. Brown did not respond and remained monosyllabic as the clinician tried to draw her out by asking her about what she wanted for herself and Marietta. Finally, the clinician addressed directly what she thought might be the mother's frame of mind by saying: "It occurs to me that you and Marietta are just getting to know each other all over again after being apart for so long. I am thinking that maybe the last thing you need is for someone to be looking over your shoulder while you are getting used to being a full-time mother again."

This statement used a mild self-effacing approach to mirror Mrs. Brown's predetermined negative experience of the clinician without exacerbating it. Mrs. Brown shrugged her shoulders, and said that she had doubts about treatment programs. The clinician answered that she respected her doubts and added that it would be up to Mrs. Brown to decide whether she wanted to be involved in treatment. Mrs. Brown then talked bitterly about the system taking children from their mothers. The clinician said sympathetically that mothers are the most important thing that children have, and that the work she did was geared toward doing everything possible to keep mothers and children together. Mrs. Brown replied: "Doctors spread your life around." Asked to elaborate, Mrs. Brown replied that she had seen a psychiatrist during her initial evaluation at the alcohol treatment program who kept writing notes while she talked but did not show her what he wrote. She attributed Marietta's extended foster care placement to the content of these notes, and said: "Doctors should tell you what they are thinking instead of talking about you behind your back." The clinician understood this statement as a veiled expression of Mrs. Brown's expectation that she would do the same and moved immediately to correct the incipient negative attribution by saying that she agreed that personal matters should be kept as much as possible between the two people involved, adding: "For example, if you decide that you want to continue meeting with me and I speak with your social worker, I will not tell her private things that you tell me. I will only say the things that you agree I can tell. The only time that, according to the law, I have to act without your permission is if Marietta is in danger, but even then I will do my best to tell you first." Mrs. Brown asked: "What kind of danger?" The clinician replied: "Danger that is too big for me or you alone to deal with. But even then, I will always try first to talk about it with you." She then

used this opportunity to show Mrs. Brown the release of information forms and to explain their function. Mrs. Brown was clearly relieved by the clinician's candor in disclosing her legal obligations while also stressing her commitment to confidentiality, and she agreed to fill out the forms to allow the clinician to speak with the CPS worker and with Marietta's pediatrician and child care provider.

This was the beginning of the assessment process, which revealed an extensive story of foster care placement during Mrs. Brown's childhood as a result of her mother's alcoholism and her father's abandonment of the family. The assessment also showed a history of alcohol use by Mrs. Brown starting when she was 13 years old, although she minimized its severity. Mrs. Brown's thought processes were somewhat disorganized, raising concerns of possible organicity. On the other hand, she had held a job as a short-order cook for the past 6 months, was attending regular Alcoholics Anonymous (AA) meetings in her neighborhood, had a good relationship with her AA sponsor, and regularly attended church, where she had some friends.

Marietta's assessment showed a child of age-appropriate cognitive development but with some expressive and receptive language difficulties. She had a permanently worried facial expression, and her movements were slow and tentative. She demanded little during the day and often watched instead of participating in what other children were doing in day care. Her worries emerged at bedtime and during separations from Mrs. Brown, when she cried and clung to her mother and was difficult to soothe. She was not showing the temper tantrums that had been a major feature of her behavior during the initial stages of her foster care placement. Tantrums are most normative during the toddler period, and it is possible that Marietta was now capable of showing frustration and anger through words and refusal to comply, two strategies that are more age-appropriate for preschoolers. However, Marietta's language delays, worried expression, and slow movements led the clinician to hypothesize that the child's anger had gone underground for fear that expressing it might lead to yet another loss of her mother. Marietta had chosen emotional withdrawal as a safer alternative than rage in the fight-or-flight dilemma she faced in maintaining a relationship with a mother who had been unreliably available to her both physically and emotionally.

Highlights of Treatment

The treatment involved weekly home visits in the early evenings due to the mother's work schedule. Mrs. Brown's agreement to enter treatment focused on Marietta's sleeping problems and separation anxiety. Marietta's bedtime was Mrs. Brown's primary concern because the child

wanted to stay up with her until late at night, while Mrs. Brown wanted to have time alone and private time with her boyfriend when he visited about twice a week and over weekends.

Addressing Negative Maternal Attributions

In the second treatment session, the clinician asked about bedtime routines, and Mrs. Brown replied: "What routines?" In the conversation that followed, the clinician explained that small children are scared of being alone in the dark, and that they are helped when their mothers do the same thing night after night as a way of making them feel safe, such as singing or saying a prayer. Mrs. Brown rejected the notion that Marietta needed help going to sleep and described her as "manipulative" and "wanting to have her way." She wanted the child to go to sleep without protest when the mother said so and to stay asleep through the night, without having to say a prayer, sing her to sleep, or reassure her that Mrs. Brown would be there to take care of her while she was asleep. The clinician answered that this would be ideal and that bedtime routines can be very cumbersome for a mother. She then added that perhaps Marietta would need some time to learn to sleep by herself because she was just getting used to being back home after spending an entire year away from her mother.

The clinician's intervention, while accurate, represented an empathic lapse on her part because it triggered Mrs. Brown's guilt about Marietta's foster care placement. She became immediately defensive and, raising her voice, said: "She is a smart girl. Her teacher said that she can do puzzles and count to 5. You yourself told me she is learning well. She is not having trouble being back and she knows how to go to sleep by herself." She then turned the TV on and started watching sullenly. During this exchange, Marietta sat silently at some distance, moving some toys around while watching the adults with her worried expression. The clinician told her gently: "Marietta, your mommy and I are talking about your sleeping. We are trying to find ways that you will sleep well at night so that you can rest and your mom can rest." In translating for Marietta what was happening between the adults, the clinician tried to make her feel included and to soften the adversarial tone of her conversation with the mother by focusing on their shared goal rather than on their disagreement about the means to reach it. She also included the mother's need to rest in her explanation as a gesture to the mother that she cared also for her and not only for the child.

After a silence during which Mrs. Brown continued to watch TV, the clinician said: "You know, I apologize if I sounded bossy when I told you about sleeping routines. That was not my intention." Mrs. Brown

gave a small smile but continued to watch TV. The clinician watched with her, saying nothing. Mrs. Brown then laughed and said: "That's funny. I have to do that with people all the time." She then went on to say that her friends, like the clinician, tried to convince her that Marietta was different from how the mother saw her. The clinician asked her what she thought of that. Mrs. Brown replied: "You think you know Marietta, and in many ways you do, but you don't see her manipulative side. Nobody does, because Marietta just lets them see what she wants them to see. I am the only one who sees the true Marietta."

There was a short silence during which the clinician struggled with her wish to sharply disagree with Mrs. Brown. She said instead: "Yeah, I guess I do see her differently. As hard as I try, I don't see her as manipulative because to me she looks a lot like other children her age who I know, but I do see how you feel very strongly about her being that way." Mrs. Brown then told a confusing story about Marietta getting up in the middle of the night, going to the freezer, helping herself to the mother's favorite ice cream, and leaving a mess of melted ice cream all over the fridge which Mrs. Brown found the next morning when she woke up. Mrs. Brown reported that she did not say anything to Marietta, but as punishment she did not let her have candy at the store the next day. She added: "Marietta knew why I didn't give her candy without my having to tell her, because she did not put up a fuss like she usually does. She knew she deserved it." Turning to Marietta, she said: "I knew you could listen to me," and Marietta smiled at her. By now, the clinician felt that this story might confirm her earlier suspicion of a possible organic thought disturbance in the mother, and she could not find an appropriate way to respond. Marietta was playing with the doctor kit, and the clinician joined her in checking the stuffed animals as the mother watched. The session ended in this unresolved note.

In reflecting on the session, the clinician concluded that Mrs. Brown's distorted attribution of Marietta as manipulative was too entrenched to address directly. She decided instead to focus on specific behaviors and interactions that would offer the opportunity to build up age-appropriate explanations for the child's behavior as a counterbalance for the rigid distortions in Mrs. Brown's perceptions of her child. The following vignette is from a later session and illustrates how the therapist implemented her plan.

While helping Marietta with a puzzle, Mrs. Brown said that she was going to school that night to sign up for a class. Marietta grabbed her jacket, saying that she wanted to go with her. Mrs. Brown said "no," and Marietta started to cry. Mrs. Brown said: "See how she manipulates? Look at those crocodile tears. She isn't really crying." The clinician said: "You are facing her back. She looks pretty sad to me—there

are tears running down her face.” Marietta continued to sob, and her crying increased in intensity. The clinician made a sympathetic face to her but did not dare to intervene for fear of antagonizing Mrs. Brown and setting up a polarized situation where Marietta would turn preferentially to the clinician in situations of stress. Marietta’s crying increased in intensity. She said “I want to go to school with my mommy.” Mrs. Brown turned away from the child and said nothing for about 30 seconds. She then told the clinician: “She thinks I am going to *her* school.” The clinician, impressed by Mrs. Brown’s insight, exclaimed: “You are right! I didn’t realize that. Do you think she would understand if you explain it to her?” The mother asked: “Explain what?” Suppressing her irritation, the clinician answered patiently that perhaps Marietta would be less upset if she understood that her mom was going to a grown-up school and was told who would stay with her and when her mom would be back. Marietta cried louder, and Mrs. Brown continued to look away, saying nothing.

The clinician’s narrative notes describe what happened next in the following words: “It seemed like 15 minutes had passed, but it was probably only 15 seconds. This made me think of the theory of relativity because I had such a hard time waiting to see what would happen.” Marietta approached the clinician, who pulled her on her lap and said: “I know you are very sad that your mommy can’t take you with her. She is going to *her* school, not to your school, and she can’t take you with her. But you will stay with your auntie, and your mom will be back before you go to sleep.” Mrs. Brown picked up on the explanation and repeated it while Marietta looked at her.

The clinician wrote in her notes what happened next:

I nudged Marietta toward her mother, who touched Marietta’s hair and smiled at her a little, and Marietta stopped crying. She returned to the puzzle much less enthusiastically than before. She then went to the bathroom. While she was gone, I asked Mrs. Brown if Marietta often cries like that when she leaves. Mrs. Brown said “Yes, all the time. She is oversensitive.” I asked her if perhaps she could be oversensitive because of her earlier experience being separated for such a long time from her mommy. Mrs. Brown said: “Maybe.” I said that I found that in situations when mom and child have been separated, it is often necessary to really almost overexplain the reason for absences or separations—even seemingly short and simple separations like her going to sign up for a class tonight. I said that kids who had long separation experiences seem to be more oversensitive than kids who haven’t, and I asked her what she thought of that. Did she think this might be true of Marietta? To my relief, she said that it makes a lot of sense and went on to describe other difficult separations. She then asked me if perhaps bedtime was hard for Marietta because when she was drinking,

Mrs. Brown would just leave in the middle of the night, and because they shared a bed, Marietta could tell when she was gone. She became silent while looking at me. I was amazed by this double revelation: her telling me that she drank after those months of denial and her telling me that she left Marietta alone during the night. I tried to stay cool and I asked her if she was wondering whether perhaps bedtime was hard now because Marietta worries that if she goes to sleep, her mother will leave again. She said yes. I commented that Marietta had understood the explanation that her mom was going to her school that night and would be back. I said that Marietta would be really relieved if the mom assured her she would not go out at night when Marietta was asleep.

The session ended with the clinician giving the mother a ride to the school. The notes say: “Marietta was a bit teary at saying goodbye, but she was distracted by her auntie, who is very loving with her. Mrs. Brown told her: ‘I am going to school now. I will be back soon,’ and Marietta waved her goodbye with her auntie’s help.”

This session illustrates the process of inner change for Mrs. Brown, Marietta, and their relationship. In the second session, Mrs. Brown had been unable to accept the clinician’s suggestion that Marietta’s difficulties going to sleep might be related to her separation from the mother during her foster home placement. In this session, approximately 2 months later, Mrs. Brown spontaneously linked her child’s bedtime distress with the revelation that she used to leave her in the middle of the night to go drinking. This self-disclosure followed the clinician’s steady and ultimately successful focus on reassuring Marietta about her mother’s departure to go to school. The clinician’s careful balance between waiting for the mother to soothe her child and taking the initiative to do so herself is worth noting. Sometimes the clinician must tolerate children’s distress in the moment (as when 15 seconds feel like 15 minutes!) for the long-term goal of building a partnership with the mother that will last after the treatment ends. In this case, the clinician gave Mrs. Brown opportunities to respond to Marietta’s crying but intervened herself when the child approached her in order to show both child and mother that it is necessary to respond to bids for help.

Early Signs of a Relapse

Similar interventions were a routine part of the treatment for the following 3 months, with slow but steady progress in Marietta’s bedtime and separation distress in response to Mrs. Brown’s increased receptiveness to her signals of need. This promising treatment pattern was interrupted when Mrs. Brown began to seem less emotionally present during the sessions, then started calling intermittently to cancel sessions on the

grounds that she had to work, and finally was not at home on several occasions for the scheduled home visits. The clinician tried without success to identify whether she had done anything that might offend the mother, and she started to wonder whether something had gone awry in the mother's private life. A call to the child care provider revealed that Marietta continued to attend regularly. The following session took place after a 3-week treatment interruption, as reported in the clinician's narrative notes.

When I came in, Mrs. Brown and Marietta were sitting at the table looking at newspaper ads together. They were sitting in their down jackets, and I said I wasn't sure if they were coming or going. Mrs. Brown said they had just arrived, and continued to show the ads to Marietta. I asked if I could sit down and sat next to Marietta, who gave me a huge smile and ran to bring the puzzle we had been working on the last time I was there. She and I sat on the floor and started assembling the puzzle while Mrs. Brown continued to look at the paper. She answered briefly and without elaboration when I commented that it had been a while since our last meeting and I was glad to see them again. After a while, I said that I felt that something had changed between us and I couldn't quite get a hold of what it was. She asked me what I meant and said that to her everything seemed the same. I said that it felt different somehow—that before she would come and join Marietta and myself on the floor, but that for the past few visits I felt like I was intruding—that she wanted to clean, to eat, to read her mail. She replied that she likes to do those things after a long day at work and picking up Marietta. I said that I could see that, but that it seemed odd that it hadn't happened before—additionally, she had missed some sessions and not called me, and these things make me feel that there is something going on. I said: "One thing I wonder is perhaps it feels that I can't be of help any longer, that my suggestions don't seem to be working, that I see Marietta, like your friends see Marietta, differently than you do, and that maybe what I have to say isn't meaningful to you." She put down the paper and said that just because we see Marietta differently doesn't mean that sometimes I don't come up with some helpful things. She then launched into problems she was having with her boyfriend, and went on for quite a while about how she was struggling with him. She said that he seemed less interested in the relationship than before and they bicker a lot, giving several examples. I listened sympathetically and commented that it's hard to muster the energy for everyday life when one's love life is not going well. She said that it was helpful to talk about the problems that she is having with him, that I am a good listener, and that in the past she found that when we talk about him, she is less likely to do something bad to him that will only make things worse. Saying this, she came to join Marietta and me on the floor. It had been several weeks since we had worked on a puzzle, and both the mother and I expressed surprise and pleasure at how well Marietta was doing and how much she had improved. Marietta smiled

broadly. When the puzzle was put together, Mrs. Brown moved on to her usual “what is this” game to get Marietta to tell her the names of things, but it felt lighter and less pressured than other times. Marietta was able to answer all of her mother’s questions, and I commented that Marietta looked proud of herself and liked to please her mother. Mrs. Brown said: “You are finally getting it right, Marietta.” I said that was a hard puzzle and some of the words in the quiz were also hard, that many children would not know the answers. Marietta and Mrs. Brown had big smiles.

This session illustrates that the clinician’s attention to Mrs. Brown’s personal life facilitated the mother’s ability to pay attention to her child and derive pleasure from their interaction. However, this improvement did not last, and soon Mrs. Brown began to be erratic again in her attendance to treatment. One day, when the clinician phoned her in midmorning to leave a message on the assumption that she was at work, Mrs. Brown answered the phone with blurred speech and sounding confused. The clinician surmised that she had relapsed to using alcohol. This presented her with a clinical dilemma: whether or not to share this suspicion with the CPS worker. Timing was of the essence because, if all went well, dependency would be dismissed the following month. Reporting Mrs. Brown’s possible relapse might lead instead to an extension of postreunification services and might endanger the reunification itself. Thinking quickly, the clinician asked Mrs. Brown to come for an individual meeting at her office 2 days later. She did not raise the question of a relapse on the phone, but said the meeting was needed to make plans for the court hearing to dismiss dependency the next month. Mrs. Brown agreed to attend.

A Crisis

During the individual meeting, the clinician described the pattern of missed appointments of the previous few months, Mrs. Brown’s difficulties with her boyfriend, and her not being at work during a weekday, and added: “You and I have been pretty open with each other, and I promised you when we started meeting that I would not do things behind your back. I have to tell you that I am worried that you are drinking again.” Mrs. Brown denied this at first, but her denials were halfhearted. The clinician said: “I realize how difficult this is for you because of course you are worried that Marietta will be put back in foster care if you are drinking again.” Mrs. Brown admitted that she had been drinking “a little” and that she had a fight with her AA sponsor and stopped going to the meetings. The clinician said that it was hard to stop drinking for good without relapsing after beginning to drink at age 13. Mrs. Brown started to cry. The clinician asked if

her religious faith might be of help at this difficult time. Mrs. Brown said that she was too much of a sinner for Jesus to help her, and she had stopped going to church. Her crying intensified. The clinician said: "Jesus loves the worst sinners and wants them to repent and follow him." The mother asked: "Are you a born again Christian?" The clinician replied: "I am not, but I have a lot of respect for those who are. Is it a problem for you that I am not?" The mother answered: "Not really. You are not black either, but you try hard to help me." This was the first time that the religious and ethnic differences between this African American mother and Latina clinician had been spoken about directly. The clinician commented: "I am an immigrant and I know how hard it is to feel like one belongs, but your people suffered from slavery and racism in a way that nobody else can feel in their own flesh in the same way." Mrs. Brown answered: "My grandma saw a man being lynched when she was little and grew up in the South. She says she never forgot it." The clinician answered: "I believe it. How do you think it affected you?" The mother shrugged her shoulders and said she did not know. The clinician said: "Sometimes suffering goes underground and comes up in ways that we don't recognize but that hurt us." The mother said: "Like drinking." This led to a conversation about the intergenerational pattern of drinking in her family.

The new awareness of the long and entrenched pattern of alcoholism in Mrs. Brown's family alarmed the clinician, who realized that the drinking problem would only grow worse if unaddressed. She said to the mother: "You need help from all those who want the best for you and for Marietta. Remember when I told you that the only time I would tell things to your worker without your permission is if I thought that Marietta was in danger and the danger was too big for you and me alone? This is one of those times." Mrs. Brown's mood changed abruptly and she said angrily: "I knew I could not trust you. Now they will take her away from me again." The clinician answered: "You can trust me because I want the best for you and for Marietta even when you are hurting yourself. You need help from the outside right now to remember that alcohol is still a problem for you."

The long conversation that followed was geared at preparing Mrs. Brown for the call to her CPS worker. The clinician gave her the option to call herself in the clinician's presence. Mrs. Brown left a message for her worker saying that she was drinking again, followed by a message from the clinician stating that she was available to speak with the worker. In the week that followed, multiple phone conversations yielded the plan to ask for an extension of child in-home dependency for another 6 months, with the mother's renewed attendance to her alcohol rehabilitation program and AA meetings and renewed monitoring of random alcohol tests, in addition to continued CPP treatment.

After this crisis, Mrs. Brown was unavailable for several weeks to meet with the clinician, but she attended her alcohol treatment programs. The clinician continued to call regularly, leaving messages that she was keeping the time for the home visits available but needed to hear from the mother that she would be there. One day, on an impulse, the clinician dropped by the home unannounced and found Mrs. Brown there, alone because Marietta was in child care. She had lost her job but was attending a job training program as part of her alcohol treatment. The clinician said she was happy to find her at home because she was hoping that they could continue their work together to help Marietta. She added that Marietta was very lucky to have a mother who was trying so hard not to give in to alcohol like Mrs. Brown's mother had done. This statement proved a turning point in the treatment, leading to a tearful recollection of physical and sexual abuse both while in her mother's care and during her stays at foster homes. The clinician said: "That is why I had to tell your worker that you were drinking again. I know that alcohol can be stronger than you, and I didn't want you to blame yourself if anything happened to Marietta." As they talked, Mrs. Brown declined the suggestion of individual treatment to address her abuse history on the grounds that she could not repeat to yet another person the terrible things that had happened to her. She said that the group therapy that was part of the alcohol treatment program gave her a chance to talk, and that she could talk to the clinician if she needed to. This therapeutic reconciliation led to an agreement to have weekly telephone check-ins in addition to the joint child-parent session to provide support in between sessions and to determine whether Mrs. Brown needed time for herself with the clinician. Individual sessions with Mrs. Brown took place about once a month in addition to the child-parent sessions.

The relapse and the crisis that followed had a salutary effect on Mrs. Brown's capacity to make use of the treatment. Her boyfriend, who used methamphetamine and who had been a precipitant to her relapse, disappeared from the scene, leaving her feeling abandoned and depressed but with a new awareness of her attraction to substance abusers. Church was a potent source of support at this time, and she spoke often about Jesus appearing in her dreams telling her to hold on. She also had dreams of demons suffocating her, something that she linked with the clinician's guidance to some of the bodily feelings she had when she was sexually abused as a child.

Treatment continued for 3 years, with one additional relapse following a breakup with another boyfriend. This relapse did not necessitate a referral to CPS because Marietta's auntie came to live with them until Mrs. Brown restabilized. What had started as mandated treatment became voluntary treatment, with Mrs. Brown's attendance actually

improving after she regained legal custody of her child. The intervention strategies described in the early phases of treatment continued to be applied throughout the treatment because they were found to be effective in promoting developmental progress in Marietta and in motivating Mrs. Brown's engagement in treatment.

By the end of treatment, Mrs. Brown had been working steadily for 8 months and Marietta was doing well in kindergarten. Mrs. Brown continued to wish for a steady boyfriend. She was sad but philosophical about her love relationships being short-lived, and she never left Marietta alone with her boyfriends because, as she put it: "after what happened to me, I don't trust nobody with my little girl." Mrs. Brown had stopped referring to the child as "manipulative." She now occasionally called her "uppity" but did so with a chuckle that denoted the pleasure and pride she had learned to feel toward her child. Mrs. Brown will continue to be at risk for relapses to alcohol use and for distortions of thinking at times of great stress. The hope is that the strengths that she and Marietta acquired during treatment will protect them during the challenges they will undoubtedly continue to face.

Out-of-Home Placement: Treatment toward Reunification of Child and Mother

The challenges of treatment toward reunification differ in major ways from those presented by treatment to consolidate reunification or prevent foster care placement. The ongoing separation of foster placement simultaneously heightens the anxiety that the child and the parent have about their relationship and attenuates their presence in each other's lives. It is difficult to learn to parent a specific child and to be parented by a specific person without daily practice to build mutual meanings and expectations. This practice is precisely what is missing when the child and the parent are not living together but meet for limited periods of time, often in artificial settings such as visiting rooms where they cannot join together in the routines of everyday life. The following example illustrates some of the challenges involved in deciding when reunification is indicated and the clinical strategies used to foster the emotional growth of the child-parent relationship.

Example

Presenting Problem

Ashley was 3 years old when she was removed from her mother's care after the pediatrician noticed that the child's weight was not adequate

for her height, she did not have the appropriate vaccinations, and she was quite dirty. The pediatrician noted that the mother was vague in describing the child's feeding schedule and seemed uninterested in the pediatrician's efforts to engage her in helping the child gain weight. The pediatrician suspected maternal substance abuse and made a referral to CPS.

The investigation revealed that the mother, Ms. Sander, a 23-year-old white woman, had been using methamphetamine for the past year. The referral for reunification services was made when Ashley was 4 years old and had been in foster care placement from the time of her removal with a middle-class, white lesbian couple in their late 30s who wanted to adopt her. Ms. Sander had been visiting Ashley on a regular basis from the time of the child's removal and had successfully completed a drug treatment program, but had been unable to obtain reunification because she did not have a steady job and had changed apartments several times without apparent reason. Ms. Sander was furious at this state of affairs, arguing that "being unemployed was not a crime" and no reason to keep her daughter from her. She felt deeply ambivalent toward the women who were taking care of Ashley—simultaneously grateful for their good care of her daughter while she was in residential drug treatment and resentful because she believed that Ashley would already be living with her were it not for this couple's wish to adopt the child. In spite of this, she got along well with her CPS worker, who felt torn between sympathy for this mother's predicament and her concern that Ms. Sander's inability to keep a job was emblematic of her lack of readiness to be a full-time mother in spite of her clear commitment to maintain a relationship with her child.

Assessment Findings and Treatment Plan

Ashley was a beautiful child, the product of a casual relationship between her mother and her father, who disappeared from the mother's life soon after she found out that she was pregnant. Visits to the home of her foster mothers, Ms. Carpenter and Ms. Lovell, showed that Ashley was attached to them, showed a range of affect in their presence, and turned to them for help when she needed or wanted something. Ms. Lovell was clearly Ashley's preferred attachment figure, but she seemed comfortable and happy with both women.

The assessment of Ashley's relationship with her biological mother showed a much more ambivalent relationship. Ashley alternated between wanting to be in close proximity and physical contact with her mother and turning away from her, rebuffing the mother's approaches, and slapping the mother when Ms. Sander was not immediately responsive to

her. At the time of the referral, the court ordered two overnights a week between Ashley and Ms. Sander in an effort to accelerate reunification. For the 3 months prior to this new schedule, she had spent 3 days a week with her mother but no overnights. By her foster mothers' report, Ashley cried and clung to them when she was brought to Ms. Sander's apartment for her overnight visit and had become more aggressive and oppositional since this new schedule began. They also reported that once a month or so Ms. Sander called at the last moment to say that she could not pick up Ashley that week, leading them to worry that she was still using drugs. By Ms. Sander's report, Ashley ate well and slept well when she was with her, and said "no" and tried to hide behind an armchair when Ms. Sander told her that Ms. Lovell was on her way to pick her up. She indignantly denied ongoing drug use, explaining that her earnest search for a well-paying job and for stable housing interfered with her regular visits with Ashley.

Following the assessment, the clinician found herself deeply unresolved about what course of action she could ethically endorse. At first glance, it was clear that Ashley's future would be easier and more secure staying where she was, both because her relationship with her foster mothers was less conflicted and because of the physical well-being and educational opportunities that these women's socioeconomic standing could provide for her. On the other hand, Ashley had an intense although ambivalent relationship with her mother, which might result in lasting psychological harm if it were terminated. The relationship between the foster mothers and Ms. Sander was of such ambivalence that it seemed unlikely that they could agree to an arrangement that would keep all of them in Ashley's life in some equivalent of a joint custody arrangement. The likelihood was that if Ms. Sander regained full custody of Ashley, she would not allow the child to visit the foster mothers. Conversely, it was unlikely that the foster mothers would maintain a long-term commitment to involve Ms. Sander in Ashley's life if they adopted the child. Compounding the clinician's uncertainty about the best course of action was that Ms. Sander clearly loved her daughter and appeared to have successfully overcome her drug use in order to get her back. Ashley was her major incentive in her efforts to obtain stable housing, work, and go to school, although she admitted to difficulties in doing so which she attributed to recurrent feelings of hopelessness.

After much soul-searching, the clinician decided that the ethical course of action was to do her utmost to facilitate reunification between mother and child on the grounds of the intense emotional relationship that existed between them and the mother's efforts to overcome the obstacles to providing adequate care for her child. She also decided

to systematically focus on improving the communication and mutual acceptance between Ms. Sander and the foster mothers. Ms. Sander was regularly attending individual psychotherapy and had an excellent relationship with her therapist. This was a major support for the CPP focus on the relationship between mother and child.

Highlights of Treatment

In the first child–mother session, Ashley demonstrated to the clinician the appropriateness of her decision. Among other toys, the clinician had provided baby and adult animals, including hippos, elephants, and zebras. Ashley took the baby hippo, elephant, and zebra and placed them inside an enclosed pen, saying: “They don’t have mommies.” The adult counterparts were outside the pen. She then took the baby hippo out of the fence, saying in a small voice: “I am lost.” She then built a bridge-like structure linking the baby and mother hippo, and made the baby hippo cross the bridge to be close to its mother. This capacity for symbolic play bode well for Ashley’s capacity to make use of treatment, as did the clarity of her sense of being lost and her wish to reestablish a connection with her mother.

Competing Attachments and Diffusion of Ashley’s Sense of Self

The theme of Ashley not having a home was shared both by her mother and her foster mothers, but each of them had a different interpretation of what this meant. On the phone with the clinician, Ms. Lovell said: “Ashley does not have a home. She does not know where she belongs. Since the overnights started, she has lost the spring in her step and is worried about being out of our sight. She becomes withdrawn and emotionally constricted whenever we talk to her about her mother.” As she listened, the clinician heard Ashley saying: “I don’t have a home,” and the foster mother confirmed that Ashley was standing next to her as she spoke. This exchange showed the clinician the extent to which Ashley was internalizing Ms. Lovell’s description of her plight. Ms. Sander, on the other hand, had the following opinion: “Ashley knows she belongs with me, but they give her all these toys and pretty clothes and I can’t compete.”

To assuage the competitiveness between the biological mother and the foster mothers, the clinician structured the sessions to promote communication among them. Ms. Lovell brought Ashley to the sessions with Ms. Sander and spent the first 15 minutes with mother and child talking about Ashley’s week. After she left, the therapist met with Ashley and her mother for 45 minutes. After Ms. Lovell picked Ashley up at

the end of the session, Ms. Sander stayed for an individual 30-minute session with the clinician to review what had transpired during the joint session and discuss issues relevant to the mother's life and the reunification process. This schedule highlights the usefulness of moving beyond the "50-minute hour" when clinically indicated. The structure of the sessions increased the biological mother's and the foster mother's understanding of what each of them meant to Ashley and heightened their empathy for the child's worry about their not getting along.

There were stressful moments as well. In one session, for example, Ms. Sander asked Ms. Lovell to register Ashley in a day care center in the mother's neighborhood to facilitate transportation once reunification took place. This request was in line with the court order. Ms. Lovell replied: "We'll see." When meeting alone with the clinician afterward, Ms. Sander expressed her anger at being undermined in her reunification efforts. In her mind, Ms. Lovell's "we'll see" comment showed how consistently the court orders were thwarted by the foster mothers and their lawyer. She added, in an exasperated tone of voice: "I can't have them in my life until Ashley is 18!" She talked about her wish to "cut them off" from Ashley's life, but she immediately contradicted herself, saying that she could not do so with a clear conscience because of what they meant to Ashley. The clinician praised Ms. Sander for her ability to keep Ashley's feelings in mind in the midst of her understandable frustration about the situation. She then rehearsed with her ways of reminding Ms. Lovell about the need to register Ashley at the day care center in the mother's neighborhood without engaging in an altercation.

This situation illustrates the concept of "unmaking of a mother" that is one of the iatrogenic consequences of involvement in the child protective system, which demands that parents demonstrate their competence to care for their children while taking away their authority to do so (St. John et al., unpublished manuscript). These contradictory expectations stem from the concerns leading to the child's foster care placement in the first place—namely, the parent's inability to keep the child safe. In the case of Ms. Sander, her unstable housing, frequent job changes, and inconsistent visitation were major factors in the foster parents' ongoing hopes to adopt Ashley.

Ms. Sander's difficulties with everyday living were a major presence in the joint sessions with her daughter. She was often preoccupied with how to reconcile the multiple goals she had set for herself. She wanted Ashley to live with her, but she was currently working as a waitress and her work schedule was unpredictable and often involved night hours. She was also going to school to complete her GED, a goal she considered indispensable toward overcoming poverty. During the sessions, she was often distracted and teary as she discussed these topics. The clinician

guided her to redirect her thoughts away from the overwhelming accumulation of circumstances and toward discrete, concrete steps that she could take to manage her daily routine. She also reminded Ms. Sander that she was only 23 years old, and that many of the challenges she was facing were characteristic of her developmental stage. These interventions helped in the moment, but Ms. Sander struggled constantly with fear of the future. The individual psychotherapy sessions were not sufficient to contain and modulate Ms. Sander's despair.

Helping the Mother Keep the Child in Mind

The clinician was acutely aware of the fact that Ashley was often a secondary presence in the sessions because the focus was often on the mother's plight. The child cooperated by playing quietly with the dolls and the animals as the clinician struggled to find bridges between mother's and child's experience. Ashley's behavior fit the profile of an attachment disorder involving role reversal in caregiving, with the child showing precocious competence in caring for herself and for the mother (Lieberman & Zeanah, 1995). The clinician berated herself for contributing to this state of affairs by "forgetting" the child during the sessions because of her empathy for the mother's pain, and she made conscious efforts to remain aware of what Ashley was doing and how she was expressing her feelings during the sessions.

Three months into the treatment, Ms. Sander started crying loudly as she told the clinician that her individual therapist was relocating to another state in order to care for his ailing mother. She put her head between her hands and sobbed uncontrollably. Ashley laughed as she looked at her mother. The mother continued sobbing. Ashley froze, then walked slowly toward her mother and touched her hair. Ms. Sander looked up at her, and Ashley touched her mother's cheeks, saying softly: "Tears." The mother hugged her and said: "I am sad that we don't live together." Mother and child held each other tightly. After a few moments, Ashley went to the papers and crayon and started scribbling on a page, which she then brought to her mother, who took it and said "Thanks." This was repeated several times, with Ashley ceremoniously bringing her drawings to her mother one by one and the mother saying: "Thanks" after each one. Ashley then wanted to play with the baby and mother animals, and brought the baby and mother hippo to her mother. Ms. Sander looked distracted and sad and was unable to make the mother hippo take care of the baby hippo. Ashley stood by in a desultory way. The clinician took the baby and mother hippo and said: "Your mommy is thinking of grown-up things right now, Ashley. You and I can play with the mommy and baby hippos until your mommy

can join us.” This statement seemed to stir Ms. Sander, who took the toy animals from the clinician and put both of them inside the pen, saying: “The mommy and baby hippo are together.” Ashley put the giraffe and the zebra inside the pen, and then quickly took them out saying: “They don’t go here.” The clinician commented: “It’s hard to know who belongs where,” putting in words her understanding that the giraffe and zebra represented the foster mothers and that Ashley was trying to resolve in her play the question of who belonged together. She said, “Ashley, sometimes you want to be with your mom and sometimes you want to be with Mamma Beth and Mamma Casey.” Ashley ignored her. The therapist picked up the book *The Invisible String*, which describes the ways that people who love each other stay connected in spite of separation, and said to the mother: “This book can help with how you are both feeling.” As the mother read, Ashley listened with rapt attention and then asked her mother to read it again.” At the end of the session, Ashley gave her mother the drawings and said: “For you.” Ms. Sander replied: “I will keep them and we’ll look at them together when you come over.”

This promise was not fulfilled. The loss of her individual therapist proved to have major consequences for Ms. Sander, who suddenly stopped seeing or calling Ashley altogether and did not return the clinician’s calls. This interlude lasted for 3 weeks. During this period the foster mother stayed in telephone contact with the clinician and brought Ashley for two individual sessions. The clinician kept in touch with the CPS worker, who suspected that Ms. Sander had reverted to using methamphetamine.

Locating Feelings in the Body

During the individual sessions with Ashley, the clinician spoke about her mommy not coming to see her and put the child’s feelings of sadness and anger into words. During the first individual session, the clinician said: “I know that your mommy is not coming to see you.” Ashley nodded briefly and then moved on to pretend that the mother hippo was sick, making loud noises of farting and throwing up. For the first time in the treatment she shed her demure demeanor and took pleasure in actively making the mother hippo defecate and vomit. The clinician understood this play as a condensation of Ashley’s worry about her mother’s well-being and her accumulated anger at her mother, which she had not been able to express in Ms. Sander’s presence for fear of losing her. The clinician was not quite sure whether to side with Ashley’s worry or with her newly found ability to express anger and decided to simply mimic Ashley’s noises while saying: “The mommy hippo is pooping and

throwing up a lot.” Ashley was delighted with the clinician’s noises, and said: “Louder.” The clinician complied, and Ashley smiled. She laughed out loud when the clinician made faces and commented on the bad smell. After a while, the clinician started to ask what could be done to help the mommy hippo feel better, but Ashley was clearly uninterested in joining in this effort. Suddenly the clinician thought that perhaps Ashley was also displaying her own visceral feelings in response to her mother’s absence, and said: “What about the baby hippo?” Ashley ignored the comment. The clinician said: “The baby hippo is waiting until her mommy is well again.” Ashley’s play continued unchanged until the end of the session, with the clinician joining her and intermittently asking questions to check whether Ashley was ready to add new angles to her play. The session ended with Ashley in a spirited frame of mind, saying to Ms. Lovell: “We pooped!” This session was a graphic demonstration of the primary site of strong emotions in the body and the beneficial effect of allowing their expression in the safety of the therapeutic relationship.

The following individual session was more subdued, but Ashley was clearly still engrossed in the question of the mother hippo’s health. She allowed the clinician to use the doctor’s kit to see how the mother was doing, and pronounced her “well.” When the clinician broached the topic of her mother not being in the session and not visiting her, Ashley came close to the clinician and said: “You’ll be my mommy?” This was a surprising question because of Ashley’s love for her foster mothers, who were ostensibly serving as primary attachment figures for her. The clinician, although taken aback, responded: “No, I am not your mommy. You have your Mommy Eve (her name for her mother), and you have Mommy Beth (her name for her primary caregiver) and Casey (her name for the foster mother’s partner). I am your feeling doctor.” Ashley turned to the building blocks and started making a tower, which collapsed after reaching a certain height. She squealed with laughter, and then started building it again. The clinician sat by her side, making comments but not intervening directly in the building process. Ashley built the tower and watched it collapse three times. The fourth time, when the tower did not fall on its own, she kicked it and laughed when it fell down. The clinician said: “You know you can build it up again even when it falls down.” Ashley started building it again, then interrupted the play midway and said to the clinician: “Read me a story.” The clinician chose “The Invisible String” as a bridge to her absent mother, and as when her mother was reading it, Ashley listened with rapt attention. The clinician said: “You are thinking of your mommy and your mommy is thinking of you.” Ashley asked directly: “Where’s my mommy?” The clinician, who did not know the answer to this question, answered: “She is on

a trip, and we are waiting for her to come back.” She used this as a metaphor that transcended the concrete question of where the mother was, and the child seemed satisfied with it.

The Transmission of Loss

When Ms. Sander resurfaced, she said that after her therapist left, she went on a trip to her hometown to look for her alcoholic mother, whose home she had left at age 17 after the mother hit her during a drunken rage. She had never written or tried to contact her mother since that time, and now she feared that her mother was dead. After returning from this trip, which lasted 5 days, she broke up with her new boyfriend and stayed in her room, with the curtains drawn, for several days. She emerged to find that she had lost her job and was now looking for another job as a waitress. She denied that she had reverted to using methamphetamines during this period. However, the CPS worker considered this crisis serious enough to postpone reunification and informed the clinician that she could not recommend reunification at the next hearing, which would take place in 3 months. This reasonable position entailed a difficult question: For how long could Ashley be in limbo about her ultimate care? Was it better for her to terminate parental rights for Ms. Sander and have her adopted by her current caregivers, with the serious repercussions the loss of her mother would entail? Or to continue for an indefinite period of time in her uncertain current situation, until it became clearer whether Ms. Sander could become stable enough to regain custody of her? And if the latter, how long a period would be needed to demonstrate sufficient maternal stability given the known long-term effects of methamphetamine use?

Although Ms. Sander’s absence had been relatively brief from an adult’s point of view, it had confirmed both in Ashley’s mind and for the service providers that her responses to personal crises might endanger her child if they were living together. Particularly concerning was Ms. Sander’s lack of a single support person on whom she could count in her personal life. Every reliable adult for her was a member of the service system, and the precariousness of these relationships was demonstrated by the destabilizing impact of her therapist’s departure. It was understandable that his loss prompted Ms. Sander to go in search of her mother, perhaps in an effort to replace this surrogate attachment figure with “the real thing.” Not finding her confirmed the reality of a terrible void in Ms. Sander’s psychological landscape and plunged her into a period of mourning that included complete withdrawal from contact with her daughter and with the world and the possible use of drugs to alleviate her pain.

The hopeful note in this worrisome situation was the relatively short-lived nature of the crisis, although the questions remained: What would have happened to Ashley if she were living with her mother when this occurred? Would her presence serve as a safeguard that preserved Ms. Sander's ability to function in her everyday life, or would the child be endangered anew by the mother's impulsive actions? The clinician and CPS worker conferred about these questions, acknowledging that they had no answers. They were both grateful that Ashley could rely on the predictable love and availability of her foster mothers. The foster mothers and their lawyer, in turn, saw Ms. Sander's disappearance—understandably—as one more example of her inability to care reliably for her child.

In the first joint child–mother session after her return, Ms. Sander saw the book *The Invisible String* as she entered the playroom and commented: “That is a boring book.” The therapist asked: “What do you find boring about it?,” and the mother answered evasively that she did not know. The therapist felt torn between her wish to explore Ms. Sander's mourning of the losses of her mother and her individual therapist, which represented the breaking of the invisible string. But the therapist had Ashley's needs to uphold, and she said instead: “Ashley does not find it boring. We read it to help her feel connected with you while you were away.” She then addressed Ashley by saying: “Ashley, your mommy and I are talking about when she went bye-bye. The mommy hippo was sick and she pooped and threw up a lot.” Ms. Sander said: “I was sick too, Ashley. That is why I did not come visit you, but now I am okay again.” Ashley put the mother and baby hippo inside the pen, and then added all the other animals—mother and baby penguins, giraffes, elephants, and zebras. She looked at the menagerie and said: “They're all mommies and daddies.” She seemed to be expressing her sense that she could not rely on her mother's presence alone and that there was safety in numbers. She then took out some of the animals from the pen, saying: “These don't go here.” The clinician answered: “It's hard to know who lives with whom. Ashley sometimes lives with her mom and sometimes lives with Mom Beth and Casey.” Ashley repeated pensively “Beth and Casey.” The question of who belongs with whom had no easy answer for this child.

In her individual session with Ms. Sander, the clinician sympathized with the impact that the loss of her therapist had on her and linked it to the urgent need Ms. Sander felt to find her mother and the painful realization that she might never find her again. Ms. Sander expressed enormous guilt for not having attempted to find her mother sooner and said: “I will never forgive myself.” The clinician answered: “Those are very old feelings that started when you were a little girl and you thought

that you could take care of your mother. It's very sad that you don't know where she is or what happened to her, but it does not mean that it is your fault." Ms. Sander replied: "But it is my fault. If I had kept in touch with her, this wouldn't have happened." The clinician answered: "You carry so many burdens, and you expect so much of yourself. I think that at times it all feels so heavy that you need to check out to give yourself a break."

This comment introduced the topic of Ms. Sander's renewed use of methamphetamines, although she said it happened only once while she was away. The clinician told her that the effect of the drug lasted for a long time, often as much as 18 months after the last time it was used, and that it led to mood swings that could be almost unbearable at times. She urged her to reenter a substance abuse program and an ongoing support group. Ms. Sander said that she did not have time, and the clinician replied: "If you don't have time for that, it will endanger the time you spend on everything else. Look at what happened to your time with Ashley."

The treatment of Ms. Sander and Ashley is continuing. The mother is in individual psychotherapy with a new therapist who, in her mind, will never replace her old therapist but who is helping her to modulate her emotions and explore her traumatic past. The CPP sessions currently focus on helping Ashley put her relationship with her mother in the context of the rest of her life rather than as the core of her life. Her mother changed apartments yet again, a move that rendered moot the previous plan to enroll Ashley in a day care in her mother's old neighborhood. This had the advantage of keeping continuity of child care for Ashley, who attends her ongoing child care center for half the day and spends the rest of the time with Ms. Lovell. She no longer spends overnights with her mother but visits with her on Saturdays. While her final placement is uncertain, she has a predictable daily routine. The clinician, who is doing a 1-year internship, plans to continue offering CPP to Ashley and her mother for as long as needed by offering services pro bono after she starts private practice at the end of her training. There is a standing offer for individual treatment for Ashley in parallel for CPP, but Ms. Lovell and Ms. Shaw do not believe it is necessary. They believe that Ashley is doing well and can talk openly about her worries for her mother's well-being and her questions about where she belongs. These issues are likely to constitute the core existential issues for Ashley for the rest of her life regardless of what her ultimate placement will be. In the meantime, Ashley is loved and cared for by a number of attachment figures who are managing to maintain a civil relationship with each other on behalf of the child. Sometimes that is the most that one can ask for.

CPP with Foster Parents

CPP is also applicable to improve the child's relationship with foster parents. When reunification with the biological parents is unlikely, the foster parents may be the most immediate source of stability for the child. The child–foster parent relationship may be marred by the child's emotional difficulties and challenging behaviors, which are often more difficult to manage after the child returns from a visit with the biological parent. The relationship between the biological parent and the foster parent is often conflictful and becomes a source of anxiety for the child, who is torn between competing loyalties.

To decide what attachment figure to include in the treatment, the therapist and CPS worker must have a candid discussion of the CPS plans for the child and the likelihood of reunification with the biological parents. In the cases of Marietta and Ashley described in the earlier sections, reunification was the goal because there was reasonable hope that their biological mothers could overcome the considerable obstacles facing them and raise their daughters, and CPP focused on that goal. In other cases, it is equally clear that the biological parent is not capable of raising the child, and CPP is provided with the foster parent or adoptive parent to support and enhance their relationship with the child. In these situations, CPP therapeutic modalities are geared to cultivating the foster parents' attunement to the emotional meaning of the child's behavior. Treatment includes translating the child's and foster parent's behavior to each other and supportive strategies to address child behavior that seems rejecting and unmanageable but is in fact a self-protective effort to guard against the fear that the foster parents will be just as unreliable, punitive, and rejecting of the child as the parents and other adults have been. The ultimate goal of treatment with the foster parent or adoptive parent is to provide the child with attachment relationships and affective experiences that will create new somatic and affective memories and counterbalance the anxieties about abandonment and self-worth generated by their maltreatment.

CPP with foster parents can be useful even when the children in their care will be reunified with the biological parent. Many children are in a systemic limbo. They are awaiting reunification with the biological parent but in the interim (and often as a response to the combined adversities of maltreatment and placement uncertainty) they show unmanageable aggression, recklessness, lack of affection, and oppositional behavior. These behaviors make the child difficult to care for and routinely trigger the dreaded "7-day notice" that foster parents use to notify the CPS worker that they want the child immediately removed from their home. The prevention of changes in foster care placement

offers a compelling argument to offer CPP to foster parents even in cases in which the ultimate goal is reunification because placement disruptions harm the child's emotional health and make the eventual reunification more precarious.

The case formulation and treatment plan when both the biological parent and the foster parent are in ongoing relationships with the child consist of enabling the foster parent and the biological parent to form a working alliance with each other on behalf of the child. The clinician works with the biological parent and with the foster parent to help them appreciate the essential place that each of them has in the child's life. The clinician translates the child's play and behavior both to the biological parent and to the foster parent and speaks for the child and to the child about the complex array of feelings generated by the competing attachments and conflicting loyalties. The treatment plan also involves specific steps to enable the foster parent to participate constructively in the reunification.

When the child is placed in a kinship home where the foster parent is also a relative, the emotional issues between the biological parent and the foster parent are made more complex by the long history of their relationship. Kinship placements are preferred by policy or law in many states and are often made without attention to the family competitiveness that may be generated as a result. A relative may (or may not) represent the best hope for continuity for the child and may (or may not) feel genuine care and moral obligation to care for the child. Even in the best of circumstances, the same relative may also harbor anger, competitiveness, and jealousy toward the child's biological parent. These feelings may have their roots not only in the parent's current behavior and inability to care safely for the child but also in childhood relationships and generational family patterns. The therapist can serve as an emotional mediator between the relative and the parent, helping them to sort out what belongs in the present and what belongs in the past. When good system collaboration is in place, the therapist can also help the CPS worker understand the conflicting feelings involved and avoid a polarizing stance that holds the risk of rash decisions in deciding what is best for the child.

CPP clinicians serving children in the CPS system bear heavy emotional burdens. They may feel intense empathy for the maltreated child as well as rapidly shifting feelings of rage and compassion for the maltreating parent as well as indignation and impatience at systems that often compound the family's problems through insufficiency and inefficiency. Vicarious traumatization leading to clinician burnout and to the parallel process of ineffective treatment is a real and ever-present risk in this work. The therapist may feel drained by the effort to uphold a clear

commitment to the child's best interests while cognizant of compelling arguments that support the interests of other players in the child's life. Self-care and the ongoing striving for internal balance are essential in this work, although these qualities may also be difficult to uphold in the face of external and internal demands.

Systemic Problems: The Contagion of Dysfunctionality

In presenting the cases of Marietta and Ashley, we deliberately chose two situations in which there is no easy or predictable "happy end" because they reflect the uncertain outcome for many children in the CPS system. Both cases had also an unusual number of protective factors, including the presence of reliable supports in the child's life (Marietta's auntie, Ashley's foster mothers). There were relatively few of the extraneous system issues that so often derail the child's progress, ranging from diametrically different points of view between therapist and CPS worker to court orders that follow the letter of the law rather than the best interests of the child. At the cost of sacrificing the complexity inherent in many CPS cases, we chose to focus on cases that allowed the focus to remain on CPP treatment with the child and the parent rather than on collateral efforts to manage the dysfunctions of the system.

For the two children described previously, their uncertain future mirrors the current state of the foster care system nationally. The profound problems plaguing the service systems addressing the needs of maltreated children and their families are well known. There are not enough professionals and paraprofessionals trained to meet the needs of traumatized children and their families. There is a dearth of partnerships between and among child-serving agencies. The size and scope of the programs serving traumatized children and their families are not commensurate to the need (Harris et al., 2006).

These systemic deficits result in frequent errors of omission and commission. Errors of omission involve failure to identify and address child abuse and neglect before the child is seriously harmed. Errors of commission result from punitive action toward the parents and from developmentally harmful measures toward children in the legal system. Most glaringly, indefinite stays of young children in foster care and multiple changes in the child's foster care placement are not the exception but the rule.

There are multiple and overlapping reasons for this system dysfunctionality, but they have in common a pervasive societal failure to allocate the necessary resources to address the needs of maltreated children and their families. The majority of these children are poor and belong to

underserved racial and ethnic minority groups, suggesting that social class biases and racial discrimination, however unconscious, may be interwoven with this state of affairs. For example, a recent report by the Annie Casey Foundation showed that African American children are more frequently placed in foster care under the same circumstances than children of other ethnicities (Casey Family Programs, 2005).

Service providers often blame families for their problems as a way of protecting themselves from the hopelessness and sense of ineffectiveness that stem from chronic insufficiency of funds, training, and system coordination. Parents are seen instead as the culprits for their failure to take effective action on behalf of their children. This blaming of parents reflects the fact that service providers across systems are not sufficiently trained about the reverberating long-term consequences of traumatic stress, including the intergenerational transmission of responses to trauma in the forms of aggression, depression, substance abuse, and failure to pursue an education or keep a job. Without this knowledge, service system providers can easily become hopeless in the face of enormous unmet need.

A feeling of futility about their ability to help is a common index of vicarious traumatization among service providers. The resulting lack of effectiveness compounds the negative effects of insufficient numbers of providers trained to identify and address traumatic responses (Harris et al., 2007). The concrete manifestations of this situation are so commonplace as to be taken for granted, but they are profoundly harmful to children. Inexperienced interns provide treatment for children and parents with severe psychiatric and social problems with little supervision. Short-term treatment is offered to address chronic problems that call for long-term comprehensive intervention. There are frequent changes in CPS caseworkers as the family moves through the system. Foster parents do not receive the training and support that they need, are not accorded authority as representatives of the child, and often feel simultaneously neglected and exploited by the child protection system. CPS workers, in turn, are often critical of the quality of care provided by foster parents. Psychological evaluations of the parent and the child are routinely so generic that they are essentially useless as guides for case planning. Therapists often decline to provide clinical information that is essential for child placement decisions on the grounds that doing so would violate clinical confidentiality. The relationships among city attorneys, parent attorneys, and child attorneys are often bitterly adversarial. Judges are not as a rule knowledgeable about young children's emotional needs. There is no institutional forum organized around the best interests of the child where the different parties can spend the time

necessary to learn about the multiple facets of the situation and work toward consensus.

The lack of adequate system resources and the resulting inability of service providers to act effectively generate a mutually reinforcing contagion of dysfunctionality across families and systems. The maladaptive behaviors of parents and children are exacerbated by the service providers' mistakes in identifying problems and implementing solutions. The result is an escalating sequence of emotionally damaging parallel processes that may pervade the interactions among the different players in the system. This process often results in a polarization of opinions, with different service providers holding diametrically opposing views about the course of action that is in the best interests of the child. Each of these opinions often represents a legitimate facet of the situation but is insufficient on its own because it overlooks other equally legitimate points of view. Decisions made in this adversarial emotional climate may do long-term damage to the child because there is a failure to reconcile opposing perspectives into an integrated approach. There is an urgent need to bring to scale the systems of care providing the services that prevent maltreatment and ameliorate its sequelae once it has occurred.

Coordinating Services across Other Systems of Care

CPS is the system of last resort in keeping children safe. First-line service providers, including pediatric care providers and child care providers, play important roles in providing developmental guidance to parents and monitoring the child's healthy development. When the child's well-being is at risk, first-line service providers have additional key roles in identification and referral. Depending on the immediacy and severity of the child's needs, pediatric care and child care providers may expand their involvement from occasional developmental guidance to ongoing support with chronic difficulties, referral to appropriate intervention programs, and in extreme cases, referral to CPS when maltreatment is identified or suspected.

Primary service providers should optimally engage in collaboration with other service systems in cases of stress and trauma in order to provide valuable information and prevent fragmentation of services. However, role definition and system constraints tend to prevent pediatric care and child care providers from actively engaging in coordinated services with the mental health system. It behooves the mental health clinician to take the initiative in creating this coordination of services, which should become standard "best practice" in mental health services for infants and young children.

A variety of approaches can be used to coordinate services, depending on the presenting problem and the needs that emerge during treatment. Coordination of services can start from the initial contacts with the family. Establishing a protocol of routinely asking the parents for signed release of information forms during the assessment enables the clinician to contact pediatric care providers, child care providers, and other professionals for information relevant to the treatment plan. Information about health status and regularity of pediatric care should be included as a standard component of the treatment plan for babies and young children. Similarly, on-site observations in the child care setting during the assessment period enable the clinician to obtain a more comprehensive understanding both of the child's functioning and of the quality of care.

Coordination of services should optimally continue throughout treatment. Exchanging information with the pediatric care provider can enhance health care by enabling the clinician to address relevant health issues on an ongoing basis. When the child's behavior presents problems in the child care setting, encouraging a circle of communication that involves the parent, caregiver, child, and clinician can be a powerful aid in the child's improvement. This circle of communication enables the therapist to address in the treatment the experiences that the child has in the child care setting and to share with the child care provider the understanding of the child's behavior and the intervention strategies that are found effective during treatment for possible implementation in the group setting.

Additional service systems—police, child protective systems, and the courts—come into play in situations of domestic violence, suspected or confirmed child maltreatment, and child custody disputes between the parents. As examined in the cases described earlier, the child and the parents then become entangled in a complex web of institutional expectations and mandates that can affect every aspect of everyday life. Models of collaboration between mental health providers and police (Marans, Murphy, Casey, Berkowitz, & Berkman, 2006) and mental health providers and the courts (Osofsky & Lederman, 2006) demonstrate that interdisciplinary collaboration is both feasible and effective (Harris et al., 2006). Bringing them up to scale in response to the urgent needs of maltreated children remains a test of the public will to protect our children and our future.

CHAPTER 10



Closing Thoughts

Taking Perspective

The time will come
When, with elation,
You will greet yourself arriving
At your own door, in your own mirror,
And each will smile at the other's welcome,

And say, sit here. Eat.
You will love again the stranger who was your self.
—DEREK WALCOTT, “Love after Love” (1986)

Alienation from ourselves and from those we love is at the core of suffering, whether we understand it using the concepts of mental illness or existential malaise. One of the joys of working with young children and their parents is witnessing the meeting of the minds and hearts that happens when parents discover the richness of their children's inner lives and in this process they welcome back long-banished parts of themselves. One mother articulated this experience for many other families when she said about her 3-year-old daughter, “I didn't know who I was, so she didn't know who *she* was. She would be so needy that she got on my nerves. Now when I feel like pushing her away I take a moment to breathe and I remind myself that I too am needy sometimes. When I can pay her attention, she knows I am there for her and it makes me feel like I know what I'm doing.” Recognizing her own sense of need helped

this mother connect with her daughter's inner experience and nourish herself with a feeling of self-worth while attending to the child.

This vignette from an individual mother and child receives empirical support from the group findings of a randomized trial. Preschoolers who witnessed domestic violence perpetrated on their mothers by their fathers showed statistically significant improvement in behavior problems, PTSD symptoms, and PTSD diagnosis when treated with CPP compared with a control group receiving intensive case management and individual treatment for the child and/or the mother in community mental health programs. Mothers in both groups had high levels of PTSD symptoms before the beginning of treatment. At the end of treatment, the CPP group mothers showed statistically significant declines in avoidance symptoms and a trend toward greater improvement in global psychiatric distress when compared with mothers in the control group (Lieberman, Van Horn, & Ghosh Ippen, 2005). This maternal symptom improvement was unexpected for two reasons: CPP focuses on the child-parent relationship but does not specifically target the mothers' individual symptoms, and in the control group two-thirds of the mothers received individual psychotherapy in addition to the individualized case management provided to all control group mothers by a skilled clinician. In this context, the differential individual improvement of CPP group mothers suggests that their relationship with their children and their child's healthy functioning have a powerful mutative effect on women's mental health as individuals.

The most intriguing findings, however, were obtained at follow-up 6 months after the termination of treatment. At this measurement point, children in the CPP group maintained the improvements they had shown at the end of treatment when compared to the control group. In addition, CPP group mothers continued to improve, as demonstrated by their significantly lower scores in global psychiatric distress when compared with control group mothers 6 months after the end of treatment (Lieberman et al., 2006). It is possible that the CPP mothers' continued improvement resulted from their newfound ability to process rather than avoid their traumatic experiences with their children and from their satisfaction in the stability of their children's improved functioning. If this is the case, these mothers' enhanced mental health might become a mechanism to support the child's ongoing healthy development. Although other studies have not incorporated a systematic assessment of maternal mental health, this randomized trial is one of several studies documenting the efficacy of a therapeutic focus on the child-parent relationships on child mental health, quality of attachment, and parenting attitudes and behavior (for reviews, see Berlin, Zeanah, & Lieberman, *in press*; Lieberman, Ghosh Ippen, & Marans, *in press*; Sameroff, McDonough, & Rosenblum, 2004).

Empirically Supported Treatment: Do Group Findings Address Individual Needs?

The growing empirical evidence in support of relationship-based treatment for mental health problems of infancy and early childhood is deeply satisfying for clinicians, clinical researchers, public policymakers, and anyone who wants a sound scientific foundation for psychotherapy models. At the same time, the lively debate about the value and limitations of evidence-based treatment bears witness to the ongoing salience of a major question: how to reconcile treatment that is individually tailored to the needs of the child with adherence to manualized interventions that demonstrated efficacy in randomized trials.

This question has particular urgency in light of the growing cultural diversity of the U.S. population, where each family has its own varied configuration of ethnicity, religion, socioeconomic status, immigration, and acculturation experiences. Each of these configurations has implications for the family's sense of belonging and safety versus alienation and fear as they move within and across the different social institutions, and the parents' attitudes toward childrearing and toward treatment are deeply affected by their sociological conditions. How can the clinician do justice to the individuality within this diversity and at the same time implement the principles of intervention supported by empirical evidence that is often derived from a sample with different characteristics? Do clinicians risk missing what is uniquely curative for an individual child and family because, in applying standard intervention principles, they may overlook what holds the deepest meaning for them? These are not rhetorical questions. A skilled therapist from an immigrant group with a long tradition of spiritual healing practices asked in an anguished voice while learning a manualized treatment approach: "But can I still use the spiritual practices of my people?"

Such a question would not need to be asked if it were widely recognized that all successful psychotherapies share many common factors and that efficacy, as reported in research trials, is not equivalent to clinical effectiveness in everyday practice (Roth & Fonagy, 2005). The superior performance of a treatment approach in a laboratory trial does not guarantee that the treatment will result in clinical improvement when applied in a community-based clinical setting. For example, a meta-analytic comparison of treatment outcomes showed a much larger impact when treatment was conducted in a research setting than when it was conducted in a clinical setting (Weisz, Donenberg, Han, & Weiss, 1995). This finding might be due to the rigorous training, supervision, and monitoring of therapist adherence that are routine during clinical trials but mostly absent in nonacademic clinical settings. In addition, researcher allegiance to the treatment being tested is an important

contributor to treatment effects, to the extent that in some studies the significance of treatment effects disappears when researcher allegiance is controlled for. There is a dearth of independent studies of a variety of different approaches, so that a definitive list of empirically supported therapies remains premature (Roth & Fonagy, 2005).

These considerations apply to the use of treatment manuals because many manuals are developed for research purposes rather than with the average clinician in mind. This fact might explain research findings showing that the efficacy of trainees went down when their adherence to specific therapeutic techniques went up, whether for psychodynamic psychotherapy (Strupp, Butler, & Rosser, 1988) or cognitive therapy (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). At their best, manuals are a distillation of clinical experience accrued over many years. When their application becomes formulaic, manuals can unwittingly stifle creativity and foreclose the kind of clinical discovery that comes from daring to experiment when the tried and true turns out not to be so true.

Polarizations of opinion and practice can be bridged by enlarging our field of vision to include the roles played by different conceptual perspectives, social priorities, and cultural values on decisions with the potential to affect public policy about mental health services. Roth and Fonagy (1996) recommend a formulation where clinical practice guidelines are informed conjointly by research evidence and clinical consensus. In this framework, promising new therapies would be formally researched to establish efficacy and would also be field-tested in large samples in natural service systems. This dual approach would resolve potential conflicts among researchers, clinicians, and funders; ensure that the scientific method is applied with an eye to its relevance for public policy; and promote a climate where evidence-based practice is increasingly equated with best practice because clinicians outside research institutions find it compatible with their clients' needs.

These considerations guide the efforts to train CPP practitioners and to disseminate CPP as a treatment approach that can be adapted to a range of clinical settings and diverse sectors of the population. Current CPP manuals address young children's exposure to family violence (Lieberman & Van Horn, 2005) and traumatic bereavement among young children who lost a parent to death (Lieberman et al., 2003). These manuals describe the theoretical framework and research findings relevant to the clinical problem being addressed, identify domains of intervention (e.g., child fearfulness, child aggression, parental threats, and parental physical punishment), describe a range of therapeutic strategies within each domain, and offer clinical vignettes from actual narrative notes as illustrations of how each strategy can be implemented. The purpose of this unstructured but systematic manualized format is

not to prescribe what the therapist must do but rather to help clinicians expand and enrich their clinical reasoning by offering a range of alternatives that they can implement or adapt according to their understanding of the family and the specific features of the present clinical moment. In the present book, our goal was to expand and deepen the material covered in the manuals by addressing a broader range of stresses and by presenting extended case examples to illustrate treatment implementation across different clinical circumstances.

Clinical supervision is an essential training component in learning to implement treatment, whether it is manualized or not, because the written word cannot encompass the myriad variations of human experience. Oral transmission of knowledge is a time-honored practice in all traditions, and psychotherapy is not an exception. Clinical supervision offers the opportunity to learn from a more experienced practitioner, to process the clinician's emotional responses to the child and the parents, to reflect on the success or failure of different interventions, and to take perspective. As one trainee commented, "I always think of a good intervention after I do a bad one." Thinking and feeling along with the clinical supervisor facilitate and expedite the learning process and increase the chances of treatment success.

Commonalities across Treatment

The ultimate goal of all treatment is to support developmental progress by helping the child function well in the emotional, social, and cognitive domains—in other words, attaining or restoring affective self-regulation, safely reciprocal interpersonal relationships, and readiness to explore and learn without recklessness or crippling fear. Addressing the specific problem of traumatic exposure, Marmar, Foy, Kagan, and Pynoos (1993) outlined some of the pathways shared by all forms of treatment in attaining these treatment goals. CPP has adapted these pathways to the specific clinical needs of stressed and traumatized young children and their parents. These pathways include:

- *Responding realistically to danger.* Traumatic stress alters the accurate perception of danger, leading to underestimating threat in ways that increase the likelihood of revictimization or overestimating threat to the extent that age-appropriate functioning is curtailed by fear and emotional withdrawal. Treatment includes identifying realistic threat and practicing adaptive ways of coping with it.
- *Differentiating between remembering and reliving.* Traumatic triggers take the person back to the traumatic moment, flooding

consciousness with sensations that make the person respond as if the trauma were occurring again. Treatment gives the person the tools to gain mastery over the experience of reliving by building safety in the present and practicing strategies for differentiating remembered danger and present responses to internal and external triggers.

- *Normalizing the traumatic response.* Traumatized children and adults are frightened of the overpowering intensity and pervasiveness of their feelings and responses. Treatment offers relief by helping them understand that these responses are predictable, understandable reactions to overwhelming events and are shared by many others in similar circumstances.
- *Placing the trauma in perspective.* Treatment helps to expand the person's self-definition. Although the trauma may be a profoundly transformational life event, the person is not defined only by it but is able to see his life as a rich tapestry of interests, activities, relationships, and talents that help to restore developmental progress.

The Parents' Role

CPP makes the child–parent relationship the organizing focus of the treatment, but parental involvement is also a key element of best practice across treatments, a position adopted by the “Practice Parameters for the Assessment and Treatment of Children and Adolescents with Post-traumatic Stress Disorder” (Cohen & Work Group on Quality Issues, 1998). Whether or not parents are the perpetrators, stress and trauma can transform the child's developmentally appropriate perception of the parent as a reliable protector and may introduce mistrust and alienation in the child–parent relationship. Parents are often traumatized, directly or vicariously, by the same events that traumatized their children. When the parent and the child are simultaneously present during a traumatic event, their concern for each other's well-being compounds the personal impact of the trauma because they are worried both about themselves *and* the other, and the behavior of each may serve as a traumatic trigger for the other. Even when parents were not present during the traumatic event, knowing that one's child was endangered or hurt can be a devastating experience that induces guilt and self-blame and is often accompanied by avoidance, emotional withdrawal, anger, and pervasive affective dysregulation. The parents' ability to manage these intense emotions has a profound influence on their ability to help their child.

There can be serious clinical repercussions when the parent is not included in the treatment. Parents may feel irrelevant, devalued, and

blamed, responses that may compound parental self-blame and generate competitiveness, envy of the child's closeness with the therapist, worry about what the child may disclose, and efforts to undermine the treatment. When parents are not included, a valuable opportunity may also be lost to magnify and extend the beneficial effects of treatment. The primary relationships of the child are not with the therapist but with the parents, who will remain the most influential figures in the child's life long after the end of treatment. Clinical attention to the parents' effectiveness and to the emotional quality of the child-parent relationship will have a greater chance of long-term beneficial effects because the child needs the parent's collaboration to implement adaptive ways of relating and responding to stress in daily life. When the parents are also the perpetrators of the trauma, their participation in the treatment when this participation does not endanger the child can help to change entrenched negative attributions and mutually reinforcing negative behaviors. At the same time, variations in the therapeutic focus on the child-parent relationship are necessary when the parents cannot overcome the internal and external obstacles that impede their ability to collaborate toward their child's improvement.

Context as a Substrate for Treatment Success

Just as the institutional context in which a treatment is implemented can influence its success, the ecological context in which the child and the family live deeply affects the nature of their mental health problems and the feasibility of different approaches to treatment. Overlooking the power of a protective environment to ameliorate the child's response to a deeply upsetting event can lead the clinician to underestimate the self-righting tendencies of the child and the family and to overtreat. Single events routinely defined as stressful or traumatic do not necessarily have lasting damaging effects on the child's mental health if the event occurs in the context of an overall supportive environment, the parents are available to reassure the child by putting the event in perspective, and the child has a reasonably sound capacity to tolerate and cope with anxiety and fear. Most parents are appropriately distraught by the potential impact of a traumatic event, but perturbations do not by themselves predict disorder. To protect the child's developmental momentum and psychological health, it may be sufficient to provide good-enough parents with psychoeducation to enable them to observe their child and to implement "psychological first aid" as needed.

The value of this modulated approach to intervention is illustrated by the response of a 3-year-old boy who had been swept by an ocean wave while standing at the edge of the water. He remained unconscious

for several hours before coming back to consciousness. The day before the near-drowning, this little boy had received a puppy as a gift and was overjoyed with his new friend. He and the puppy had been frolicking together on the beach when the wave swept over them. After regaining consciousness, the first word that the boy said was “puppy,” followed immediately by “mommy” and “daddy.” As his devoted parents, grandparents, and other family members monitored the child closely during the ensuing 4 weeks, they could find no signs of traumatic response. He enacted his falling on the sand and said he was scared when he could not get up and could not breathe, but he was satisfied with the parents’ explanations of what happened and, although he displayed some manageable anxiety about going back to the beach, he slept well and showed no fear of the bath water, no increased aggression or negativity, no dysregulation of emotion or biological rhythms, and none of the other symptoms usually associated with a traumatic experience in young children. He continued to show great affection for the puppy, who had not been harmed. The parents and the clinician concluded that the well-regulated temperamental qualities of this child, coupled with his loving family and supportive environment, had protected him from experiencing the near-drowning as a traumatic event.

During the period of observation, the parents stayed in touch intermittently with the clinician through e-mail and over the phone and received a combination of emotional support, developmental guidance, and psychoeducation about trauma responses. This brief long-distance intervention enabled the parents to contain their anxiety and self-blame so that these feelings did not get transmitted to the child. The most powerful contributor to their own emotional recovery, however, was the image of their child whispering “puppy ... Mommy ... Daddy...” when he first recovered consciousness. This response gave the parents powerful confirmation of their importance to the child and relieved their guilt. The parents and the clinician entertained the perhaps wishful idea that as he lay unconscious, the boy may have had sustaining mental images of his joyful playing with the dog that explained his calling out for the puppy and for his mom and dad as the first thing he did on regaining consciousness.

This example illustrates that resilience consists of a transactional process where the child’s individual characteristics are supported by protective factors in the environment. A child growing up in a maltreating family and dangerous neighborhood would be less likely to have similar access to predominantly protective expectations when confronted with comparable circumstances. Best practice needs to include an assessment not only of the child’s individual characteristics but also of the strengths and vulnerabilities of the child’s ecological context. The treatment plan,

in turn, has to incorporate efforts to change the pathogenic features of the child's environment, often by enlisting the involvement of other relevant social institutions.

Treatment of Single versus Cumulative Stress and Trauma

A single traumatic occurrence generates a multiplicity of traumatic moments that include visual, auditory, olfactory, and kinesthetic perceptions; visceral responses; and ongoing appraisals of external and internal threats. For this reason, even a single traumatic experience is extraordinarily complex and can have long-lasting repercussions in many domains of functioning. It is now widely accepted that the assessment and treatment of single trauma should include (1) ascertaining the objective characteristics of the trauma and the subjective experiences it elicited; (2) elucidating and addressing the external and internal cues that serve as proximal trauma reminders; and (3) elucidating and addressing the secondary stresses and associated adversities that result from the traumatic event, all in the context of the child's individual characteristics and ecological circumstances. The cornerstone of best practice in the assessment and treatment of child trauma is direct exploration with the child and the parent of the traumatic event and its impact, using their respective reports to uncover potential inaccuracies and omissions and to enlist the parents as indispensable allies in the child's treatment (Pynoos et al., 1999).

The recommendation to thoroughly ascertain the objective and subjective parameters of the traumatic event needs revision for situations of cumulative trauma. Exposure to multiple, often overlapping traumatic events is among the most frequent trauma configuration in community clinical settings. For example, in our clinical research with preschoolers who witnessed domestic violence, their mothers experienced on the average 13 traumatic events in their lifetimes, with a range from 8 to 23 such events. Among their children, 40% had been physically abused in addition to witnessing domestic violence, and many others had also been sexually abused, placed in a foster home, and exposed to neighborhood and community violence or other traumas. For these families, it continues to be critically important to encourage an open discussion of adverse events by asking specifically about traumatic stressors and their impact on the child and on the parents. At the same time, it can easily become emotionally overwhelming and therefore clinically counterproductive to focus the assessment and treatment on itemizing each of the many traumatic events, let alone linking each event with the myriad traumatic responses and secondary responses that it gener-

ated. Clinical reasoning dictates an approach where the mental health provider determines therapeutic priorities according to the emotional salience of the different stressful experiences, with the understanding that sometimes children's and parents' dysregulation, negative expectations, and impaired coping are tied more to lifetime patterns of pain and loss than they are to discrete traumatic events, however terrifying those single events may have been.

Small children have what has been called "a short sadness span," and they may turn quickly from directly addressing the stressful or traumatic event to playing out other themes in their lives. It would be a mistake to interpret this behavior only as avoidance or resistance to treatment. The children may be showing that they reached the limit of their tolerance for a painful topic and need to turn to other pursuits that promote well-being. A 4-year-old enacted the ebb and flow of trauma-related material when he showed his mother a toy knife and started an emotionally charged discussion about watching her threaten his father with a knife. After his mother reassured him that she regretted this episode and would never repeat it, the child said, "Put the knife away, mom. I am done with it for now." The theme had received closure for the moment, although it reappeared again in later sessions.

Addressing the multiple sequelae of cumulative trauma is among the most challenging demands for the therapist. The American Academy of Child and Adolescent Psychiatry's Practice Parameters document adopts the position that retelling the traumatic event constitutes an attempt at mastery of the traumatic experience and is a key component of trauma treatment. The authors caution, however, that therapists should not insist on conducting exposure activities if the child does not respond as expected. They state, "Persistent talking about traumatic memories with children who are very embarrassed or highly resistant may not be indicated and may in fact worsen symptoms. Indirect methods of addressing traumatic issues, such as art and play techniques, may be helpful in these situations" (Cohen & Work Group on Quality Issues, 1998, p. 168). The practice parameters also include the importance of pairing stress management techniques with direct discussion of the traumatic event. Therapists must beware of becoming traumatic triggers that mobilize the child's efforts to avoid them when they become associated with intrusive reminders of the traumatic event.

These recommendations highlight the role of clinical reasoning and clinical judgment in deciding when and how to apply specific therapeutic techniques. For toddlers and preschoolers, play, storybooks, and drawing are often the "royal road" to recovery from trauma because through them the child can gauge what is safe to feel and tell and the parents can gain some emotional distance to process the child's experience. Play,

literature, and art can serve as transitional forms of addressing the stressor, setting the stage for more explicit verbal exchanges when the child and the parent feel readier to confront what happened more directly. Children as young as 2, 3, and 4 years of age can learn stress management techniques such as breathing, yoga poses, and counting “one, two, three” to manage strong negative emotions. Decisions about when and how to use these modalities are at best the product of an active collaboration involving the clinician, the parent, and the child.

A major clinical challenge across treatment approaches in pursuing these therapeutic goals is to distinguish between therapeutic means and therapeutic goals. Best practice calls for a clear differentiation between these two concepts. What is the means to the end, and what is the end in itself? The example of *trauma narrative* is a case in point. Engaging in a narrative of the traumatic experience offers the means to connect raw sensory dysregulation with the capacity to reflect on the experience for the purpose of containing overpowering physical sensations and modulating their accompanying catastrophic emotions of helplessness and terror. The trauma narrative provides the reassuring symbolic frame of words, play, movement and/or art as means to achieve increased understanding, correct perceptual distortions, enhance reality testing, give meaning to the experience, communicate with others, and resume age-appropriate functioning. The trauma narrative does not serve its intended function when it does not result in these outcomes. There are children and adults who are breathtakingly articulate in describing traumatic events in words, art, and play but who are also severely compromised in their biological regulation, social relationships, or readiness to learn. When this happens, client and therapist need to seek alternative or complementary means to process the trauma. These alternatives may range from stress management techniques to psychodynamic exploration of the links between the traumatic experience and unresolved psychological conflicts.

The Limits of Psychotherapy: Acknowledging the Supraclinical

In conditions of poverty and lack of access to resources, all aspects of everyday life have the potential to exacerbate the emotional problems of children and their families. Risks of commission (violent neighborhoods, Immigration & Customs Enforcement [ICE] raids, repeated crises caused by lack of access to needed material resources) are compounded by risks of omission (lack of adequate housing, child care, education, employment, health care, and transportation).

These circumstances compromise the opportunities for healthy child development and diminish parental capacities to attend to their children's emotional needs because concrete survival needs make urgent claims on the parents' energy and resources. The overlap between poverty and psychopathology is well established, although the complexity of the factors that mediate and moderate the links between family income and child functioning renders a conceptualization of these processes quite daunting (Luthar, 1999; Rutter, 2003). One of the most dramatic consequences of poverty is that it increases the chances of traumatic exposure. For example, 20 per 1,000 women living in households with the lowest annual income (less than \$7,500) are victims of intimate partner violence, compared to 3 per 1,000 women living in households with an annual income above \$75,000 (Rennison & Welchans, 2000).

These findings are relevant to young children because they are the frequent witnesses of domestic violence between their parents and because there is a consistent overlap between domestic violence and child abuse (Osofsky, 2004b). The impact of poverty on mental health is also most noticeable in younger children (Lipman, Offord, & Boyle, 1996; National Research Council & Institute of Medicine, 2000). There is intriguing evidence that the association between poverty and child mental health problems can be reversed. The Great Smoky Mountains Study documented significant declines in conduct disorder and oppositional defiant disorders among American Indian and white children whose families moved out of poverty (Costello, Compton, Keeler, & Angold, 2003). This finding has important implications for social policy because it demonstrates the reality of social causation rather than a purely genetic interpretation of the roots of mental health disturbances.

The consequences of cumulative and pervasive traumatic exposure go beyond discrete psychiatric diagnoses and have far-reaching manifestations in the forms of physical and mental illness, school underachievement and failure, substance abuse, maltreatment, and criminal behavior (Harris et al., 2006). These conditions constitute a supraclinical problem that must be addressed by going beyond the child's individual clinical needs to enlist a range of coordinated services for the child and the family (Harris et al., 2007). Clinicians working with multiply stressed and traumatized children and their families owe it to themselves and to their clients to develop a consistent awareness of the limits of mental health treatment in toxic social conditions. The subliminal pressure to view responses to stress and trauma as residing primarily within the individual is evident, for example, in the use of diagnostic categories such as PTSD to label responses to ongoing traumatic events such as high rates of murders and violent assaults in a community. Treatments

of traumatic stress uphold the importance of “safety first” and advocate for an end to traumatogenic situations. What happens when the communitywide manifestations of danger do not end?

Clinician Self-Doubts, Clinician Self-Care

Clinicians are as a rule guided in their work by a profound desire to heal pain and bring emotional health to the children and families they treat. This is particularly the case for clinicians who work in the public service system, which does not offer the financial remunerations of the private sector and where large case loads, bureaucratic demands, limited space, and lack of access to reflective supervision and consultation are powerful disincentives. The therapist’s burden is compounded by the fact that many of the children and families seeking help from the public health system are beset by cumulative social stressors and dangerous conditions that transcend their private life situations and cry out for supraclinical solutions that therapists are helpless to provide.

Clinicians often blame themselves, the family, or the treatment method for the failure of psychotherapy when the supraclinical dimensions of the family’s plight are not clearly understood. Blame is a common attempt to cope with helplessness. The overwhelming nature of the problems and the relentless accumulation of crises wear down the clinician’s energy, motivation, and versatility. Parents who repeatedly fail to show up for sessions, whose concrete problems interfere with their attention to their child, or who fail to integrate what is achieved during the sessions into their relationship with the child outside treatment are frequently perceived by the clinician as disorganized, indifferent, or suffering from borderline, antisocial, or other personality disorders. While the diagnoses may fit their psychiatric definitions, the toxic effect of the external situations that help to engender and perpetuate them is not given its full due. A diagnostic nomenclature of societies, although nonexistent to date, would balance this lopsided focus on individual failures in the absence of adequate social supports. The evolving diagnoses of complex trauma disorder for adults and developmental trauma disorder for children attempt to incorporate an appreciation of the impact of external events on personality functioning. Understanding the social roots of many forms of psychiatric disturbance can be a powerful antidote to clinician demoralization and self-blame.

Self-care must go hand in hand with this understanding. Giving of oneself as a therapist needs to be balanced with practicing what we attempt to teach: cultivating inner life, attending to those we love, taking time to rest and play, and building support systems at work.

The proliferation of tightly prescriptive treatment manuals might be a response to clinician self-doubt in the face of the complexity of clinical pictures and the increasingly demanding workplace. As the therapeutic enterprise increasingly shifts its focus from understanding the meaning of behavior to bringing about rapid change, clinicians often become anxious when they are unsure about what to do in a specific clinical moment. At any point of the session, many ports of entry present themselves. Does one respond to the themes of the child's play? To the mother's bid for the therapist's attention? To the particular exchange between mother and child as they entered the room at the beginning of the session? Or should one wait and see what unfolds? Any and all of these alternatives might lead in productive directions, and choosing one port of entry necessarily entails not pursuing other possibilities at the same time. As a psychology intern observed, "Choosing one course of action means giving up 10 others." In making the choice, there is no substitute for empathic attunement to the emotional salience of certain patterns and the recurrence of particular themes. Clinical reasoning involves the thoughtful elucidation of a gestalt in the myriad of seemingly disparate and disconnected moments that make up the therapeutic hour. An inner secure base can be accrued by opening oneself to the ebb and flow of emotions in the child, in the parent, and in oneself; connecting the temporal sequences of behavior, interaction and emotion; and observing oneself as one observes and responds to the others. This internal compass will allow the clinician to tolerate the ambiguities and uncertainties of treatment and to trust the process of learning to know and to be known by the child and the family. The words of Jeree Pawl (1995) convey it best:

We learn over time that everything we think we know is a hypothesis; that we have ideas, but that we don't have truth.... When we know this, our attitude conveys it; and the child and family sense themselves as sources, not objects. In this context, they become aware of a mutual effort. They do not feel weighed, measured or judged. They do feel listened to, seen and appreciated.

We have come full circle. We began this chapter with the words of a young mother reflecting on the fact that knowing herself allowed her to know her daughter. We end it with the truth that we have no truth. We cannot know, but we can engage with children and parents in their quest for self-knowledge and self-understanding. Our best clinical efforts consist of leaving ourselves open to the ambiguities and uncertainties that are integral to that quest and conveying our steady presence with them in the journey.

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