CHAPTER 1

N

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 (Greenspan & 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 (Weinfield, 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.

Guilford Publications
72 Spring Street
New York, NY 10012
212-431-9800
800-365-7006
www.guilford.com