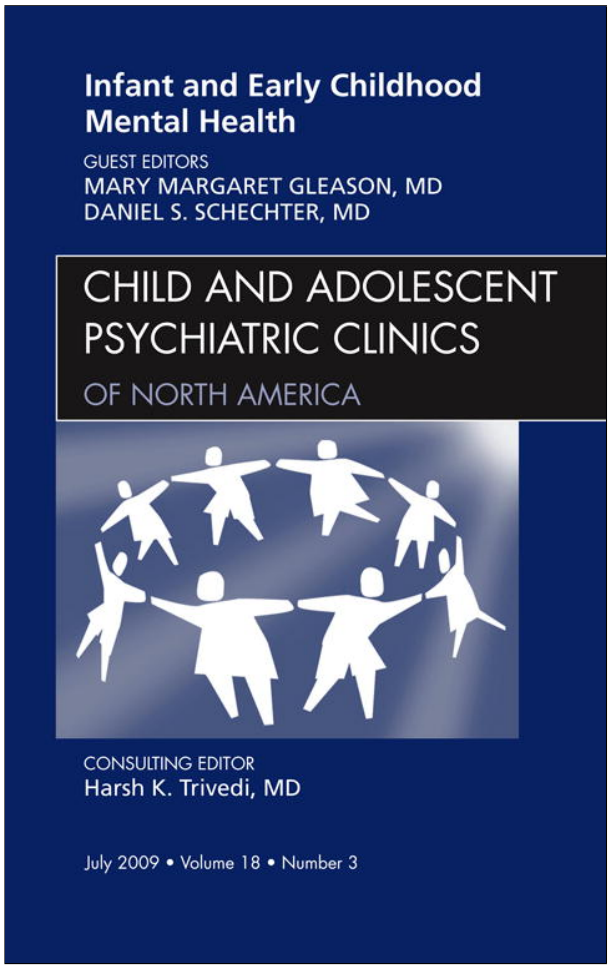

Giving Voice to the Unsayable: Repairing the Effects of Trauma in Infancy and Early Childhood

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KEYWORDS

- Infancy and early childhood trauma
- Child-parent psychotherapy • Traumatic stress
- Intergenerational transmission • Evidence-based treatment

The impact of traumatic events on infants, toddlers, and preschoolers is a well-documented phenomenon, which, in spite of its gravity, has failed to galvanize the actions demanded by the scope of the problem, either in terms of clinical attention or in the form of broad and sustained public policy initiatives. In spite of pervasive evidence to the contrary, there is a widespread misconception among mental health professionals and the public at large that young children are immune to trauma, because they are too cognitively immature to understand, remember, and be affected in other than transitory ways by acts of violence, accidents, intrusive medical procedures, witnessing accidental injury or death, and other traumatic events. The research on early trauma establishes conclusively that, although there are marked individual differences in how children in the first 5 years of life respond to and recover from trauma, they consistently show negative biologic, emotional, social, and cognitive sequelae after enduring traumatic events (see[1] for a review). This evidence lends particular urgency to the development, evaluation, and implementation of approaches to prevention and treatment, which are both empirically supported and can be effectively adapted to

Support: The writing of this manuscript was made possible by the generous support of the SAMHSA National Child Traumatic Stress Network and the Irving B. Harris Foundation.

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Child Adolesc Psychiatric Clin N Am 18 (2009) 707–720
doi:10.1016/j.chc.2009.02.007 **childpsych.theclinics.com**
1056-4993/09/$ – see front matter

mental health community programs and other service systems that serve traumatized children and their families. This article describes the clinical applications and community dissemination of child-parent psychotherapy (CPP), a relationship-based trauma treatment for young children and their families, which has substantial empiric evidence of efficacy in decreasing symptoms of traumatic stress and restoring young children's normative developmental trajectories (see Lieberman and colleagues[2] for a review).

EARLY EXPOSURE TO TRAUMATIC EVENTS: A CONTEXTUAL FRAME FOR INTERVENTION

The statistics about the prevalence of traumatic events in early childhood are staggering, yet mental health professionals do not, as a rule, receive training in age-appropriate assessment and treatment for children in the birth–5 years age range. There is a profound gap between the prevalence of early trauma and the recognition of this phenomenon in the field of mental health. Among abused children, 40% are younger than 6 years of age.[3] Children in the first year of life account for 44% of abuse-related fatalities, and 78% of the fatalities are children younger than 3 years of age.[4,5] Children younger than 5 years of age are at greater risk of hospitalization and death than older children as the result of drowning, burns, falls, chocking, and poisoning.[6] The immediate postpartum period is particularly vulnerable: one-third of maltreated infants younger than 1 year are injured in the first week of life.[7] Contextual violence is also prevalent in young children's environments. Children younger than 5 years of age are disproportionately represented in homes with domestic violence, and exposure to domestic violence in the first 6 months of life is a significant predictor of child neglect through 5 years of age.[8,9] Some subgroups are at greater risk than others as a result of the cumulative effect of numerous risk factors.[10] A nationally representative sample of children aged 2 to 9 years showed that those at highest risk for victimization were in families exposed to multiple stresses, including single-parent and step-parent households as well as ethnic minority and low-income groups.[11]

These figures provide a frame for designing assessment and treatment models, because exposure to traumatic events has grave mental health repercussions for infants and young children. Clinicians must be prepared to ask specific questions about trauma exposure to provide appropriate intervention. For example, in a pediatric sample of 305 children aged 2 to 5 years, 42% of the 2-year-olds and 52.5% of the entire sample had experienced at least one severe traumatic stressor, and there was a strong association between the number of traumatic events and the likelihood of an emotional or behavioral disorder according to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV), which was documented in 17.4% of the children.[12]

The importance of adopting diagnostic criteria specifically geared to the developmental characteristics of infants and toddlers is highlighted by findings that using the standard DSM-IV criteria yielded a posttraumatic stress disorder (PTSD) diagnosis in only 13% of severely traumatized infants and toddlers, whereas using developmentally appropriate alternative criteria led to the diagnosis of PTSD in 69% of the sample.[13] Using the same alternative criteria with preschoolers referred to treatment as the result of exposure to domestic violence and physical maltreatment, Lieberman and colleagues[14] found that the diagnosis was met by 45% of the sample. It is important of point out, however, that children exposed to traumatic stressors may be in need of treatment even in the absence of a formal diagnosis, because the psychological impact of traumatic events often derails the child's normative acquisition of developmental capacities, with long-term consequences for emotional, social, and cognitive competence.[15,16]

Assessment and treatment of traumatic stress in young children must be geared to identifying and addressing environmental risk factors. It is now widely accepted that

child development is best understood using an ecological-transactional model that encompasses the biologic characteristics of the child in the context of family, community, and cultural protective and risk factors.[17,18] For children exposed to chronic sources of adversity and cumulative traumatic stressors, the combined effect of multiple risk factors and scarcity of protective resources has far-ranging effects on mental health and overall functioning.[16,19] Contextual factors were identified in the DSM-IV field trials as having a major effect on the extent of psychological damage. Primary predictors of the child's functioning are the child's age at first traumatization, the frequency of traumatic experiences, and the extent to which caregivers were implicated in the traumatic event.[20] The parents' psychological status and responsiveness to the child significantly influence the child's functioning and ability to recover from the impact of traumatic events.[17,21–23] Unless clinicians are alert to these findings, they might focus narrowly on the traumatized child's symptoms and miss the ecological context that triggers and sustains these symptoms. These findings highlight both the need for prompt clinical attention to early trauma and the importance of incorporating the child's primary caregivers into the treatment.

IDENTIFYING TRAUMATIC STRESS IN INFANCY AND EARLY CHILDHOOD

Assessment and treatment must also attend to how the child's developmental capacities influence her response to trauma.[16,24] The expression of traumatic stress in infants, toddlers, and preschoolers is shaped by the rapid pace of development in the first 5 years of life, including the acquisition and consolidation of patterns of attachment, affect regulation, discrete emotions, independent locomotion, and language. Students of trauma going back to Freud[25] pointed out that early trauma involves a shattering of the young child's "protective shield" represented by the parents' care and nurturance. The young child's developmentally appropriate expectation that the parent will be available as an effective protector is violated by the experience of trauma, with possible long-term ramifications for the capacity to place trust in intimate relationships. Fraiberg[26] observed that preverbal infants use fighting, freezing, and avoidance to defend against the overwhelming emotions elicited by perceived danger. Toddlers in the second year of life may also show aggression against the parents as perceived aggressors or failed protectors. They may also turn aggression against the self in an effort to deflect their anger away from the all-important attachment figure who failed to protect them, as shown for example in biting or hitting themselves, banging their head, pulling their hair, holding their breath, and engaging in reckless and self-endangering behavior. These behaviors can be misinterpreted as expressions of the child's constitutional regulatory problems in the absence of a clinical lens that incorporates systematic assessment for the possibility of trauma.

Careful clinical observations of very young children have not yet yielded a widely accepted diagnostic classification relevant to them. In planning assessment and treatment, clinicians should be aware of the finding that the DSM-IV category of PTSD resulted in a high number of false negatives when applied to young children.[13] In an effort to develop a more useful diagnostic instrument for infancy and early childhood, the DC: 0-3 classification[27] maintained the three PTSD symptom clusters defined in the DSM IV (reexperiencing, withdrawal, and hyperarousal) but made the category more relevant to the first 5 years of life by adopting the following changes: (1) calling the condition traumatic stress disorder to highlight the role of ongoing traumatic events in the child's life, such as recurrent physical abuse, sexual abuse, and domestic violence; (2) including threat to the *psychological* (not only physical) integrity of the child or others in the definition of a traumatic event; (3) giving specific examples

of age-appropriate behavior, such as posttraumatic play, loss of previously acquired developmental skills, play constriction, and sleeping problems; (4) adding a fourth cluster comprising symptoms not present before the traumatic event, such as new fears, somatic symptoms, separation anxiety, aggression, or sexualized behavior; and (5) requiring that the child display only one symptom in each of the symptom clusters. In its recent revision, DC: 0-3R[28] adopted the DSM-IV nomenclature of PTSD to make the diagnostic language consistent across the age spectrum and opted to categorize new symptoms as an associated feature of the disorder rather than as a fourth cluster. Although DC: 0-3R offers clinicians the best available instrument for diagnosis in infancy and early childhood, the diagnostic criteria will undoubtedly continue to change as new research data emerge. An example is the current interest in developmental trauma disorder as a distinct diagnostic category to conceptualize the pervasive disorganization of core competencies that characterizes the psychiatric effects of chronic, cumulative trauma.

THE RELATIONAL IMPACT OF TRAUMATIC STRESS

Traumatic events occurring in infancy and early childhood tend to affect every member of the family regardless of the nature of the event. Accidents such as car collisions, dog bites, falls, burns, and near-drownings occur frequently in the first years of life and may leave both the child and the parents with enduring fears and anticipatory anxiety. Adult caregivers may blame themselves or each other for their failure to protect the child. These emotions may trigger a cascade of changes in the parent-child relationship, with mutually reinforcing negative feelings and difficulty repairing lapses in empathy.

Most children and parents recover from these challenges and use the experience to become more consciously alert to realistic danger. For those who are unable to do so, the traumatic event can mark a turning point for the worse in their ability to trust themselves and each other. The security of attachment may be affected in the aftermath of trauma, particularly when there is chronic exposure to danger. From this perspective, patterns of disorganized attachment may be an overlooked expression of the child's traumatic stress response, which denotes fear of the parent as the source of maltreatment or uncertainty about the parent's capacity to protect from danger.[29] For example, when there is family violence, there is a significant relationship between the child's traumatic experiences and the mother's symptoms of PTSD.[30] This finding complements the findings by Scheeringa and Zeanah[31] that young children show higher symptoms of PTSD when they witness their mother being the victim of domestic violence than when the child himself or herself was the victim of abuse. Taken together, these two sets of findings suggest that the mother and the young child are each deeply traumatized by the trauma of the other. This relational impact of child trauma is the foundation for focusing on the child-parent relationship as the most expedient vehicle toward the child's recovery. For traumatized young children, a simultaneous clinical focus on attachment issues and on traumatic responses holds the greatest promise for improvement.

CPP AS A RELATIONSHIP-BASED APPROACH TO EARLY TRAUMA TREATMENT

CPP is based on the premise that the most effective and long-lasting means of supporting and restoring the mental health of traumatized young children is to enable the child and the parents to accomplish the following goals:

(1) Create a common language to describe what happened; (2) regulate the overwhelming affects associated with the experience; (3) enhance the parents' capacity

to respond in developmentally appropriate ways to the child's basic needs for protection, nurturance, and socialization; and (4) restore trust in the parent's ability to protect the child from external and internal danger.[32]

Clinical focus on the parent-child relationship as the quintessential mutative factor in treatment for infants and toddlers dates back to the pioneering work of Fraiberg,[33] whose careful clinical studies illustrated the intergenerational transmission of psychopathology when the baby becomes the representative of figures from the parent's past who were associated with now unrecognized fear, anger, and unfulfilled longings. Fraiberg created a treatment approach called *infant-parent psychotherapy* to guide parents of children aged birth–3 years to the early sources of their conflicted feelings toward the child, and she stated that as a result of this process, the ''baby is liberated, as it were, from the distortions and displaced affects which have engulfed him in the parental neurosis.''[33] Intimate relationships are particularly colored by the metaphorical ''angels in the nursery'' of having felt unconditionally loved and protected while growing up[34] and the ''ghosts in the nursery'' of early experiences of loneliness, rejection, and terror.[35,36] The past lives on in a multiplicity of guises, including perceptions of the present and expectations of the future that carry the imprint of what was already experienced in the formative stages of one's life.

The concept of the baby as a transference object who evokes unresolved parental conflicts is also a core element of trauma-focused CPP. Parental negative attributions to the child are often the manifestation of a process of projective identification in which the child becomes the recipient of unconscious wishes, fears, and fantasies that were rooted in early traumatic experiences but that the parents cannot acknowledge as a part of their own self. These unconscious processes lead the parent to become selectively attuned to child behaviors that can be interpreted as confirming the parent's attributions. The meanings that the parent attributes to the child become the substrate for childrearing attitudes and behaviors that bring pressure on the child to align his or her behavior in conformity to the parent's attributions.[35] Harsh physical maltreatment and abuse can result when the parent's negative perceptions are enacted in outbursts of rage, which may be justified by the parent as efforts to discipline the child.

Clinical Example

A child-mother dyad was referred for treatment after the childcare provider found bruises on the 15 month-old's bottom. The child protection worker who investigated the possibility of abuse described the child as ''out of control,'' ''impossible to stop,'' and ''recklessly throwing himself on the floor and running off'' when frustrated. She made a referral for treatment after accepting the mother's explanation that he was bruised when he fell while trying to climb on the dining room table to reach his bottle. During the initial assessment, the mother described her 15-month-old son as ''diabolical,'' ''impossible to control,'' ''reckless,'' and ''suicidal.'' As she spoke, the child hit the cat and tried to climb on the windowsill of the family's fourth-floor apartment. The mother did nothing to stop the child's behavior but pointed to it as an example of the accuracy of her perceptions. As treatment unfolded, this mother described horrific episodes of maltreatment by her psychotic mother as she was growing up. In her mind, her son had become the representative both of her ''diabolical'' mother and of the repressed self-destructive aspects of herself that were shaped by her mother's abuse. The son, in turn, dutifully enacted his mother's expectations in an effort to please his mother by becoming the uncontrollable, aggressive, suicidal child that she was pressuring him to be.

During a session 1 month into the treatment, the clinician asked the mother whether she ever found herself doing to her son the same things that her mother had done to her. The mother at first denied this possibility. The clinician gently persisted, explaining that her query was prompted by the intense frustration that the mother often showed in her interactions with the child. Very slowly and hesitantly, the mother disclosed that she sometimes lost control of herself and could not stop hitting the child, although she always managed to hit him over his clothes in order not to leave marks. The bruises that prompted the referral to Child Protective Services occurred when the child was in the bathtub and started splashing water on the mother's new cashmere sweater. The mother had interpreted this behavior as a purposeful effort to ruin her beautiful new garment and was flooded by a feeling that she was trapped in a relationship with this ''monster'' who gave her ''no peace.'' As she spoke, the mother started crying, and the clinician asked her what the tears meant. The mother said, ''I want to be a good mother. I don't want to be a monster like my mother.'' The equation linking her own mother, herself, and her child to the identity of the ''monster'' became clear and would become a key motif in the treatment that ensued. While the mother described this event, her son stood at a distance, looking at her with wide eyes and a sober expression. The clinician said to the mother, ''He is listening very seriously. What you are saying is very important to him.'' There was a silence. The clinician turned to the child and said, ''Your mommy is telling me that she hit you. That is very scary.'' The child nodded solemnly, staying firmly in his place. The clinician added, ''Your mommy doesn't want to scare you. She is sorry that she hurt you.'' The child stood still. Turning to the mother, the clinician said, ''Can you tell him that yourself?.'' In a shaky voice, the mother told the child that she was sorry that she hit him and would not do that again. It was notable that the mother and child continued to keep their distance from each other. The promise of safety was too incipient to be trusted–either by the mother or by the child.

Child trauma at the hands of the parent, as in this case, often emerges only after careful observation of the child-parent interactions and exploration of the parent's attributions to the child. One of the consequences of uncovering child abuse is that the clinician is legally mandated to make a referral to Child Protective Services. The clinician explained this obligation to the mother, who became both angry at the clinician and terrified that the child would be placed in foster care. The clinician told the mother that, although she could not predict what measures the agency would take, she would recommend against foster care placement, because the mother had voluntarily disclosed that she hit the child and was participating in treatment. The clinician also suggested that the mother herself make the call to Child Protective Services in the clinician's presence and coached the mother in what to say. This approach had a productive outcome. The mother felt some sense of control by making the call herself. The child protective worker accepted the clinician's recommendation against foster care and instead maintained the case open under a ''family preservation'' category that would enable the worker to visit the family monthly and monitor for abuse during a period of at least 6 months. Although the mother expressed anger at the clinician for making the referral, she also acknowledged that she felt as if a burden had been taken off her shoulders as a result of not having to keep secret this deeply shameful part of herself.

In the treatment of this mother-son dyad, the clinician made extensive use of clinical strategies that linked the mother's relentlessly punitive and derogatory treatment of her child in the present with her own past as a terrified young girl who both internalized a profound sense of inner badness and was enraged by her mother's abuse. Her son's defiance triggered within her psyche memories of her early helplessness and

provoked aggression as a desperate effort at self-protection. The child had become, in the mother's mind, a new version of this persecutory figure that continued to hound her and would give her no peace.

Simultaneous attention to the influence of the past and the immediate demands of the present is one of the hallmarks of psychoanalytic relationship-based interventions as developed by Fraiberg and colleagues.[33,36,37,39] Insight-oriented interventions need to be supplemented with unstructured developmental guidance when the parent lacks age-appropriate childrearing information. The clinician helped the mother to understand the developmental meaning of her son's moment-to-moment behavior by explaining the normative motivations and anxieties of the first 2 years of life and helping her to learn protective responses to the child's aggression and self-injurious behavior. The core mutative factor, however, is seen as enabling the parents to correct their distorted perceptions of the child and to redirect the associated negative affects to their legitimate original recipients in the parents' childhood. In this sense, psychoanalytically oriented CPP is emblematic of Faulkner's dictum that "the past is never dead. It's not even past."[38]

Therapeutic focus on how the parent's past affects the child's trauma experience is most feasible during the child's preverbal period, when language, independent locomotion, and self-assertion are still incipient and the parents and clinician are not distracted by the verbal and mobile child's motivation for individual attention and active participation.[34,40] When the child has acquired language and symbolic skills, trauma treatment must incorporate the creation of a shared trauma narrative between child and parent, as described below.

CREATING A SHARED TRAUMA NARRATIVE BETWEEN CHILD AND PARENT

Present trauma and the child's age are two factors that call for significant clinical modifications that extend beyond attention to the parental reenactment with the child of experiences and conflicts from the past. When the child is the victim of traumatic events in the present, the claims of the parents' past must give space to accommodate the urgent demands of the present circumstances. This is particularly important after the first year of life, when toddlers and preschoolers can participate actively in the treatment by verbalizing and playing out their emotional distress. At present, CPP is an umbrella term that encompasses the age ranges covered by the terms *infant-parent psychotherapy*,[37,38] *toddler-parent psychotherapy*,[40–43] and *preschooler-parent psychotherapy.*[44] Trauma treatment for older toddlers and preschoolers involves a major clinical challenge, because the therapist must attend simultaneously to the child's individual experience of the trauma, to the parents' individual experiences and how their past is connected to the child's trauma, and to parental responses to the child that may alleviate or exacerbate the child's traumatic response.

As a general rule, trauma-focused CPP with verbal children shifts clinical priorities away from linking the parent's past with the child's present experience of trauma and becomes more focused on giving the child a safe emotional space to name and process the traumatic experience. The clinician attends to the moment-to-moment interactions between parent and child to address the specific emotional meanings that parent and child have for each other around issues of trust and protection from danger.

As is the case with preverbal young children, therapeutic sessions are jointly attended by the parent and the child. When more than one parent needs clinical attention and is willing to participate in treatment, the format is expanded to include the child and both parents. Similarly, when siblings are close in age and have clinical needs that can be

addressed simultaneously, two or more children may attend sessions jointly. Treatment traditionally involves weekly 1-hour sessions lasting approximately 1 year, but these parameters can vary depending on clinical needs and program resources. Treatment can be conducted in the home, office, or community settings convenient for the family, such as childcare center or family resource center. Individual sessions with the parent are introduced when attention to the parent's individual experience is necessary to promote improvement in the child. Individual sessions for parent and/or child may also be used as adjuncts or substitutes to the joint child-parent sessions when the joint sessions are not conducive to improvement in the child's mental health or the parent's capacity to provide appropriate caregiving.[33]

The urge to avoid thinking, feeling, and speaking about the trauma compounds the clinical challenge of treating traumatized young children who are capable of verbalizing the traumatic event or enacting it in play. When the parent gives the child the implicit or explicit message that the traumatic event must remain a secret—not only to outsiders but also within the family and within the self—the trauma as an *unsayable* event puts the child in the untenable position of "knowing what you are not supposed to know and feeling what you are not supposed to feel."[45] CPP has the goal of making the trauma *knowable* and *sayable* as a shared child-parent experience in which the parent becomes capable of acknowledging the reality of the events and the legitimacy of the child's resulting terror, anger, and broken trust. The emotional connection made possible by this recognition enables the clinical process to place the trauma in perspective and to move on to build protection, nurturance, and pleasure in everyday life. The clinician acts as an emotional translator between child and parent, communicating to the parent the developmental or symbolic meaning of the child's behavior and trying to establish bridges between the often discordant developmental agendas and affective needs of traumatized children and their parents.[33] Treatment manuals are used to organize and clarify the premises of intervention and provide clinical examples for the use of specific therapeutic modalities.[46,47]

Treatment begins with an initial assessment that may comprise four or five sessions and includes individual sessions with the parent(s) to learn about the nature of the traumatic event(s), the family circumstances, the psychological functioning of the parents, and the child's functioning before the traumatic events and in their aftermath. It is very useful to administer a trauma-screening inventory, because parents tend to consciously or unconsciously omit or minimize the traumatic experiences endured by the child. The sessions with the parent also provide an opportunity to plan how the parent will explain to the child the reasons for the treatment. In this process, the clinician models for the parent a way of talking about the trauma directly but tactfully, using words that the child can understand. The child usually joins the assessment process in the third session. When there is reason for concern about the child's cognitive functioning, a structured cognitive assessment is conducted. Alternatively, the session involves unstructured play with a combination of toys that are evocative of the specific traumatic event (eg, ambulance, police car, doctor's kit, a family of dolls matching the family's composition and ethnicity), wild and farm animals, and toys associated with nurturing (eg, kitchen set). Early in the session, the clinician asks the child whether the parent explained the reason for the session and corroborates the parent's explanation. For example, the clinician might say, "Your mom told me that you got very scared when you saw your dad hitting her, and now you are sad and angry because he does not live with you any more." This description of the traumatic circumstances is followed by an explanation that the mother is bringing the child to treatment as a way of helping with the feelings and behaviors that are troubling the child. From the beginning, the clinician normalizes the negative feelings created by the

traumatic events and instills hope that the child and the parent will together find ways to feel better.

CPP intervention modalities include the following: (1) using play, physical contact, and language to help regulate the expression of affects associated with stress and trauma and promote developmental progress; (2) unstructured, reflective developmental guidance; (3) modeling protective behavior; (4) insight-oriented interpretation; (5) addressing traumatic reminders; (6) retrieving and creating benevolent memories; (7) emotional support; and (8) attention to reality through crisis intervention, case management, and concrete assistance. Through the use of these modalities, the therapist cultivates during the sessions an emotional climate in which frightening memories can be retrieved safely and painful affect can be tolerated, because there is understanding and support.

Clinical Example

A father and his 4-year-old daughter were referred for treatment by Family Court after the child witnessed the father hitting his wife, who was also the child's stepmother. The child had become sad and withdrawn, started wetting the bed at night, and woke up crying several times every night. The preschool teacher reported that she seemed preoccupied and listless and had started calling her peers by abusive names. The father had acknowledged the incident, which he justified as the result of excessive drinking. He agreed to the Court's stipulation that he participate in treatment for alcohol abuse, anger management, and CPP. During the initial assessment, the father and clinician planned how he would explain to the child the reason for the treatment. The father spontaneously came up with the idea that he would tell the child that he had made a bad mistake when he hit his wife, that he was drinking too much, and that he was trying hard to learn not to hit, because he wanted everybody in the family to be safe.

In the initial session following the assessment, the father started out by saying that they had had a very nice week and everything was going fine. The clinician turned to the child and said, ''Daddy told me the other day that a lot of things happened in your family.'' The child nodded and said, ''Daddy went to jail on Saturday.'' Surprised, the clinician asked, ''How come?'' The child answered, ''He was beating up my brother.'' (This brother was the 14-year-old son of the stepmother). The clinician responded, ''That is very scary!'' The child nodded in agreement and added, ''I was scared. My stomach hurt. And daddy was mean because my cousin was crying and daddy yelled at him and told him he was a crybaby.'' The clinician looked questioningly at the father, who turned to the child and said, ''I am sorry I did that.'' The clinician asked what happened. There was a silence, which was interrupted by the child saying, ''Daddy was drinking.'' The clinician replied, ''It sounds like daddy becomes mean when he drinks. How do you feel when that happens?'' The child answered, ''I feel sad.'' The therapist answered, ''Yes, I can understand that. It is sad that you have to worry so much because daddy drinks and gets angry. It makes you cry even at night when you are sleeping.'' The father told the child, ''I am very sorry I made you sad. Your brother and I were texting each other and I apologized to him. I am sorry I was mean. Will you accept my apology?'' The child nodded and asked to play with the jail toys. She found a doll to represent the father and set up the jail while the father spoke to the therapist, giving her the business card for the social worker who had been assigned to the case. He then turned to the child and said, ''The social worker told me that drinking is a sickness. I have to get well, and I am going to a class to help me get better.'' The child nodded and started playing with the jail. She took the father doll, put its arms behind its back, and said, ''This is what the policeman did

to daddy.'' The father took the doll and put it in the jail cell, saying, ''And then this is what happened. They put me in a little room like this and I stayed there all night.'' The therapist asked, ''How were you feeling then?'' The father looked at the child and said, ''I was thinking that I really missed my kids. I missed your brother, I missed you, and I missed mommy.'' The child said, ''Daddy told the policemen that they smelled like pigs.'' The therapist asked the child if she knew what that meant. The child answered, ''No, but I don't think that it's very nice.'' The father looked sheepish. The child added, ''And then daddy got in trouble at church. He grabbed the pastor's shirt.'' The father explained that he had gotten angry when the pastor told him not to drink and grabbed his shirt; the pastor asked him to leave and not come back until he could talk without becoming aggressive. The therapist asked what happened then. The father said that his wife and the children were very upset about what happened in church, and he had called the pastor and apologized. Turning to the child, the therapist said, ''It sounds like everyone gets sad and upset when daddy drinks and gets mean. What can we do to get rid of mean daddy?'' The child said, ''No, we can't get rid of daddy.'' The therapist answered, ''No, we won't get rid of the nice daddy. That is the daddy who is sitting here. But there is also a mean daddy who scares you and makes everybody sad.'' The child answered, ''There is only one daddy.'' The therapist, realizing that the child was right, answered, ''Yes, you are right. There is only one daddy. He sometimes is nice and sometimes is mean.'' The child nodded. The father looked very embarrassed. The therapist added, ''It sounds like daddy gets very mean and scary when he drinks.'' The child nodded. She then asked to play with the play dough, and father and child spent the rest of the session making play dough figures that represented the family members. At the end of the session, the therapist said, ''You talked about really important things today.'' The father said, ''I have a lot of homework to do.'' The clinician agreed and turned to the child saying, ''Your dad is telling us that he really heard what you were saying.'' The child gave a little smile and took the father's hand as they left the room.

This session illustrates the extraordinary ability of young children to describe in detail frightening events when they are given permission to do so. One strength of this father was his ability to listen to his child and to show remorse, although he was somewhat facile in his contrition. The session also illustrates a potential pitfall of treatment when the therapist wants to offer simplistic solutions, as when she talked about ''getting rid'' of the ''mean daddy.'' The child's refusal to go along with this untenable plan led the therapist to a more accurate (if sadder) acknowledgment that the same father held two mutually incompatible facets and needed to be accountable for the frighteningly aggressive parts of himself. This initial session laid the foundation for a clear-eyed focus on the challenges that he faced in living up to the promise of recovery that he made to his daughter.

EMPIRICAL EVIDENCE OF EFFICACY

CPP efficacy has been documented in five separate randomized, control trials with high-risk infants, toddlers, and preschoolers. The samples include anxiously attached toddlers of newly immigrated Latina mothers with histories of exposure to violence,[48] toddlers of middle-class depressed mothers,[42] maltreated infants in the child welfare system,[49] maltreated preschoolers in the child welfare system,[44] and preschoolers who witnessed domestic violence against the mother in addition to other violence-related traumatic stressors.[14] Outcome findings include reductions in child and maternal psychiatric symptoms; more positive child attributions of parents, themselves, and relationships; improvement in quality of child-mother relationship and

measures of security of attachment; and improvements in child cognitive functioning. CPP is currently under review by the Substance Abuse and Mental Health Services Administration for inclusion in the National Registry of Evidence-based Practices.

SUMMARY

The treatment of traumatic stress in infants and young children calls for careful evaluation of the individual manifestations of the child's traumatic response and the family and environmental factors involved. Acknowledging the concrete reality and emotional sequelae of the trauma is the primary building block of treatment. The capacity of children and parents to tolerate talking and playing about the trauma varies widely. Some children are confidently ready to speak about what happened; others take a long time to do so. Similarly, parents vary widely in their ability to open themselves to their child's emotional experience. Although clinical timing and tone are always important in therapeutic interventions, therapists working with traumatized young children should cultivate a readiness to speak about the trauma using manageable words that address the concrete characteristics of the traumatic event in ways that the child can understand. The therapist's courage in giving voice to previously unspeakable experiences enables the child and the parent to give themselves and each other permission to know what must be known and to feel what is legitimate to feel.

REFERENCES

1. Van Horn P, Lieberman AF. Psychological impact and treatment of children exposed to domestic violence. In: Jenny C, editor. Medical evidence in child maltreatment. New York: Elsevier; 2009.
2. Lieberman AF, Ghosh Ippen C, Marans S. Psychodynamic treatment of child trauma. In: Foa EB, Matthews Friedman JA, Cohen A, et al, editors. Effective treatments for PTSD: practice guidelines from the international society for traumatic stress studies. 2nd edition. New York: Guilford Press; 2008. p. 370–87.
3. Administration for Children and Families, U.S. Department of Health and Human Services. Child maltreatment 2004. Available at: http://www.acf.hhs.gov/programs/cb/pubs/cm04/chapterthree.htm#ten. Accessed January 28, 2009.
4. National Clearinghouse on Child Abuse Neglect Information. Child abuse and neglect fatalities: statistics and interventions, 2006. Available at: http://www.childwelfare.gov/pubs/factsheets/fatality.cfm. Accessed January 15, 2009.
5. Administration for Childen and Families, U.S. Department of Health and Human Services. Child welfare information gateway, child abuse and neglect fatalities: statistics and interventions. Available at: http://www.childwelfare.gov/pubs/factsheets/fatality.cfm. Accessed January 28, 2009.
6. Grossman DC. The history of injury control and the epidemiology of child and adolescent injuries. In: Behrman RE, editor. The future of children. Los Altos, CA: David and Lucile Packard Foundation; 2000. p. 4–22.
7. Centers for Disease Control and Prevention. Nonfatal maltreatment of infants – United States, October 2005–September 2006. Morb Mortal Wkly Rep 2008;57:336–9.
8. Fantuzzo JW, Fusco RA. Children's direct exposure to types of domestic violence crime: a population-based investigation. J Fam Viol 2007;22:543–52.
9. McGuigan WM, Pratt CL. The predictive impact of domestic violence on three types of child maltreatment. Child Abuse Negl 2001;25:869–83.
10. Sameroff AJ, Fiese BH. Transactional regulation: the developmental ecology of early intervention. In: Shonkoff JP, Meisels SJ, editors. Handbook of early childhood intervention. 2nd edition. New York: Cambridge University Press; 2000. p. 135–59.

11. Turner HA, Finkelhor D, Ormond R. The effect of lifetime victimization on the mental health of children and adolescents. Soc Sci Med 2006;62:13–27.
12. Egger H, Angold A. Stressful life events and PTSD in preschool children. Paper presented at: Annual Meeting of the American Academy of Child and Adolescent Psychiatry; 2004; Washington DC.
13. Scheeringa MS, Zeanah CH, Drell MJ, et al. Two approaches to the diagnosis of posttraumatic stress disorder in infancy and early childhood. J Am Acad Child Adolesc Psychiatry 1995;34:191–200.
14. Lieberman AF, Van Horn P, Ghosh Ippen C. Towards evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. J Am Acad Child Adolesc Psychiatry 2005;44:1241–8.
15. Carrion VG, Weems CF, Reiss AI. Stress predicts brain changes in children: A pilot longitudinal study on youth stress, PTSD, and the hippocampus. Pediatrics 2007;119:509–16.
16. Pynoos RS, Steinberg AM, Piacentini JC. A developmental psychopathology model of childhood traumatic stress and intersection with anxiety disorders. Biol Psychiatry 1999;46:1542–54.
17. Cicchetti D, Lynch A. Toward an ecological/transactional model of community violence and child maltreatment: consequences for children's development. Psychiatry 1993;56:96–118.
18. Sameroff AJ. Models of development and developmental risk. In: Zeanah CH Jr, editor. Handbook of infant mental health. New York: Guilford Press; 1995. p. 659–95.
19. Rutter M. Poverty and child mental health: Natural experiments and social causation. JAMA 2003;290(15):2063–4.
20. van Der Kolk B, Pelcovitz D, Rosh S, et al. Dissociation, somatization, and affect dysregulation: The complexity of adaptation to trauma. Am J Psychiatry 1996; 153:83–93.
21. Laor N, Wolmer L, Cohen D. Mothers' functioning and children's symptoms 5 years after a SCUD missile attack. Am J Psychiatry 2001;58:1020–6.
22. Linares LO, Heeren T, Bronfman E, et al. A mediational model for the impact of exposure to community violence on early child behavior problems. Child Dev 2001;72:639–52.
23. Schechter DS, Coates SW, Kaminer T, et al. Distorted maternal mental representations and atypical behavior in a clinical sample of violence-exposed mothers and their toddlers. J Trauma Dissociation 2008;9(2):123–47.
24. Marans S, Adelman A. Experiencing violence in a developmental context. In: Osofsky JD, editor. Children in a violent society. New York: Guilford Press; 1997. p. 202–22.
25. Freud S. Inhibitions, symptoms and anxiety. In: Strachey J, editor. and trans. The standard edition of the complete psychological works of Sigmund Freud. Vol. 4. London: Hogarth Press; 1926;1959:87–156.
26. Fraiberg S. Pathological defenses in infancy. Psychoanal Q 1982;5:612–34.
27. Zero To Three/National Center for Clinical Infant Programs. Diagnostic classification 0-3: diagnostic classification of mental health and developmental disorders of infancy and early childhood. Arlington, VA: Zero to Three/National Center for Clinical Infant Programs; 1994.
28. Zero To Three/National Center for Clinical Infant Programs. Diagnostic classification 0-3: diagnostic classification of mental health and developmental disorders of infancy and early childhood. Rev. ed. Washington, DC: Zero to Three Press; 2005.

29. Lieberman AF, Amaya-Jackson L. Reciprocal influences of attachment and trauma: using a dual lens in the assessment and treatment of infants, toddlers, and preschoolers. In: Berlin LJ, Ziv Y, Amaya-Jackson L, editors. Enhancing early attachments: theory, research, intervention, and policy. New York: Guilford Press; 2005. p. 100–24.
30. Schechter DS, Zygmunt A, Coates SW, et al. Caregiver traumatization adversely impacts young children's mental representations on the MacArthur Story-Stem Battery. Attch Hum Dev 2005;9(3):187–205.
31. Scheeringa MS, Zeanah C. Symptom expression and trauma variables in children under 48 months of age. Infant Ment Health J 1995;16:259–70.
32. Lieberman AF, Van Horn P. Psychotherapy with infants and young children: repairing the effects of stress and trauma on early attachment. New York: Guilford Press; 2008.
33. Fraiberg SH. Clinical studies in infant mental health: the first year of life. New York: Basic Books; 1980.
34. Fraiberg S, Adelson E, Shapiro V. Ghosts in the nursery. A psychoanalytic approach to the problems of impaired infant-mother relationships. J Am Acad Child Psychiatry 1975;14(3):387–421.
35. Lieberman AF. Negative maternal attributions: effects on toddlers' sense of self. Psychoanalytic Inquiry 1999;19(5):737–56.
36. Lieberman AF, Silverman R, Pawl JH. Infant-parent psychotherapy: core concepts and current approaches. In: Zeanah ZH Jr, editor. Handbook of infant mental health. 2nd edition. New York: Guilford Press; 2000. p. 472–84.
37. Lieberman AF, Padrón E, Van Horn P, et al. Angels in the nursery: The intergenerational transmission of benevolent parental influences. Infant Ment Health J 2005;26:211–38.
38. Faulkner W. Requiem for a nun. New York: Random House; 1951.
39. Lieberman AF. Infant-parent psychotherapy with toddlers. Dev Psychopathol 1992;4:559–75.
40. Cicchetti D, Rogosch FA, Toth SL. The efficacy of toddler-parent psychotherapy for fostering cognitive development in offspring of depressed mothers. J Abnorm Child Psychol 2000;28:135–48.
41. Cicchetti D, Toth SL, Rogosch FA. The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers. Attach Hum Dev 1999;1:34–66.
42. Toth SL, Rogosch FA, Manly JT, et al. The efficacy of toddler-parent psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: A randomized preventive trial. J Consult Clin Psychol 2006;74(6):1006–16.
43. Toth SL, Maughan A, Manly JT, et al. The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. Dev Psychopathol 2002;14(4):877–908.
44. Bowlby J. A secure base: parent-child attachment and healthy human development. New York: Basic Books Inc; 1988.
45. Lieberman AF, Compton N, Van Horn P, et al. Losing a parent to death: guidelines for the treatment of traumatic bereavement in infancy and early childhood. Washington, DC: Zero to Three Press; 2002.
46. Lieberman AF, Van Horn P. Don't hit my mommy! A manual for child-parent psychotherapy with young witnesses of family violence. Washington, DC: Zero to Three Press; 2005.

47. Lieberman AF, Weston D, Pawl JH. Preventive intervention and outcome with anxiously attached dyads. Child Dev 1991;62:199–209.
48. Cicchetti D, Rogosch FA, Toth SL. Fostering secure attachment in infants in maltreating families through preventive interventions. Dev Psychopathol 2006;18(3): 623–49.
49. Lieberman AF, Ghosh Ippen C, Van Horn P. Child-parent psychotherapy: six month follow-up of a randomized control trial. J Am Acad Child Adolesc Psychiatry 2006;45:913–8.