CHAPTER SIX

Attachment and Trauma

An Integrated Approach to Treating Young Children Exposed to Family Violence

AMY L. BUSCH and ALICIA F. LIEBERMAN

Young children instinctively rely on their caregivers for protection from danger (Bowlby, 1969/1982). When children experience a traumatic event during their early years, their trust in their attachment figures' ability to protect them is drastically challenged. Traumatic experiences shatter the "protective shield" (Freud, 1920/1955) that parents normatively provide for their children, threatening the core of the attachment relationship. Frightening events also can dysregulate the parent–child relationship by triggering posttraumatic stress reactions in both the child and the adult, hindering the child's ability to seek comfort from the parent and the parent's reciprocal ability to provide reassurance. The deleterious impact of traumatic events on attachment extends beyond infancy into the preschool years.

At the same time, children's ability to recover from traumatic experiences is influenced by the quality of their attachments. A child with secure attachment relationships is likely to trust that others will be available in times of need and that he or she is worthy of their help, and these

attitudes may facilitate the child's readiness and ability to seek assistance. Conversely, a child with insecure attachments may be more vulnerable to trauma because the child lacks the inner resources and the emotional support needed to cope with overwhelming circumstances (Belsky & Fearon, 2002; Toth & Cicchetti, 1996). A "dual lens" that integrates both attachment and trauma theory is necessary in clinical situations to help restore the developmental momentum of traumatized young children (Lieberman & Amaya-Jackson, 2005; Lieberman & Van Horn, 2005).

The following example illustrates a child's emotional stance toward her father after she witnessed his violence toward her mother:

> Maria, age 5, was drawing a picture of her family. The clinician asked Maria to tell her about the drawing, and Maria answered, "This is me, this is my mommy, and this is my brother." The clinician said, "I see. But what about your father—he's not in the picture?" The little girl replied, "Sometimes I forget about my daddy because he was mean to my mommy."

Why might this little girl want to "forget" about her father? Maria and her younger brother, Anthony, age 3, had witnessed several incidents of domestic violence between their parents. In omitting her father from her family drawing, Maria may have been showing her desire to avoid the memories of her father's frightening behavior, just as she wanted to avoid him while the violence was taking place. Avoidance has been identified both as an indicator of insecure attachment (Ainsworth, Blehar, Waters, & Wall, 1978) and as a symptom of posttraumatic stress disorder (PTSD) in adults as well as in young children (American Psychiatric Association, 1994; Zero to Three, 2005).

In this chapter, we recommend that clinicians use a combined attachment and trauma framework when intervening with children who have experienced domestic violence and other traumatic life events. We begin by identifying domestic violence as a traumatic stressor that affects children's attachment relationships with their caregivers, both directly and through potential posttraumatic stress responses in children and caregivers. We then discuss how the quality of children's attachment relationships can moderate the impact of trauma on their mental health. In the second half of the chapter, we present the case of Maria, Anthony, and their mother to highlight how clinicians might use an integrated attachment and trauma framework in assessing and intervening with traumatized young children and their caregivers.

DOMESTIC VIOLENCE: TRAUMA WITHIN THE ATTACHMENT–CAREGIVING SYSTEM

Domestic violence is a prime example of a situation in which attachment and trauma are inextricably linked for a child. The basic premise of attachment theory is that children have a biological predisposition to seek out their caregivers for protection from danger (Bowlby, 1969/1982). Their caregivers' pattern of responsiveness teaches children the degree to which they can consistently rely on their caregivers to relieve their fears and ensure their safety. Children whose caregivers generally are responsive to their distress tend to develop secure attachment relationships, while children whose caregivers are neglectful, rejecting, or inconsistently responsive to their vulnerability tend to develop insecure attachment relationships with them (Ainsworth et al., 1978).

In some circumstances, caregivers may be more than neglectful or unresponsive, they actually may appear frightening to a young child. Young children who fear their caregivers are faced with "fright without solution"—the paradox that their potential source of protection is also their source of fear (Hesse & Main, 2000). As a result, children's attachment relationships with these caregivers may become disorganized. In the Strange Situation procedure (Ainsworth et al., 1978), disorganized infants display contradictory approach and avoidance behaviors, appear unnaturally still or frozen, or show other signs of disorientation when interacting with their caregivers. By age 6, disorganized attachment appears to take the form of controlling behavior with caregivers. Some controlling children are punitive, commanding their parents to do things, while others seem excessively caregiving of their parents (Main & Cassidy, 1988). Their caregivers, in turn, often appear helpless within the parent–child relationship (e.g., Lyons-Ruth, Bronfman, & Atwood, 1999).

Domestic violence is a strong risk factor for disorganized attachment in early childhood (Zeanah et al., 1999). An attachment perspective suggests several reasons for this association. First, witnessing domestic violence between caregivers shatters the child's trust that the parent will not cause pain and injury and will protect the child from danger. Seeing one's caregiver harmed or injured may be overwhelmingly terrifying for a young child, and that fear may become linked with the child's mental representation of either the perpetrator or the victim of the violence (Lieberman, 2004; Lieberman & Amaya-Jackson, 2005). This fear of the caregiver may then disorganize the attachment relationship with that person.

There also may be indirect pathways to disorganized attachment among children who have witnessed domestic violence. For example, mothers' lack of resolution regarding past trauma on the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996) has being linked to disorganized attachment in their infants (van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). In our own sample of battered mothers, 53% were classified on the AAI as having unresolved loss or abuse (Busch & Lieberman, 2006). Mothers who remain unresolved regarding their own past traumatic experiences tend to appear frightened or frightening when interacting with their young children (Schuengel, Bakermans-Kranenburg, & van IJzendoorn, 1999). For example, some unresolved mothers loom aggressively at their infants while playing, while others freeze or seem to enter dissociative-like states during parent–child interactions (Hesse & Main, 2000). These frightening parental behaviors are associated with disorganized attachment in children.

There is also evidence that battered women are at higher risk of abusing their own children (Osofsky, 2003), and maltreatment has been directly linked to disorganized attachment (van IJzendoorn et al., 1999). Of course, these two parenting paths toward disorganized attachment are not mutually exclusive: given the intergenerational transmission of childhood abuse, it is likely that mothers who maltreat their infants were themselves abused as children and remain unresolved regarding those experiences. Thus, in addition to directly abusing their children, these mothers may display the more subtle, frightening behaviors associated with unresolved loss or abuse.

The Contribution of a Trauma Lens: Posttraumatic Stress Responses in Child and Caregiver

By using a trauma lens, clinicians may identify an additional pathway to disorganized child–parent relationships, beyond those identified in the attachment literature. Witnessing domestic violence may constitute a traumatic stressor for a child, defined as "direct experience, witnessing, or confrontation with an event or events that involve actual or threatened death or serious injury to the child or others, or a threat to the psychological or physical integrity of the child or others" (Zero to Three, 2005, p. 19). As a result of this traumatic experience, children may develop PTSD. A diagnosis of PTSD is appropriate when, following trauma, children display symptoms that are sufficiently intense and pervasive to interfere with their development and that persist for at least 1 month (Zero to Three, 2005). There are three main diagnostic criteria for PTSD in children:

1. *Reexperiencing the traumatic event*, as evidenced by posttraumatic play, repeated nightmares, distress at exposure to reminders of the event.
2. *Numbing of responsiveness or interference with developmental momentum*, manifested by restricted range of affect, diminished interest in play, efforts to avoid activities, places, or people linked to the trauma.
3. *Increased arousal*, including sleep difficulties, attention problems, hypervigilance, exaggerated startle response, increased irritability or temper tantrums.

In addition to these three symptom clusters, other behaviors are considered associated features of PTSD in children, such as the loss of previously acquired developmental skills, aggression toward others, new fears such as separation anxiety, and age-inappropriate sexual behaviors.

PTSD rates are as high as 40% among child witnesses of domestic violence (Chemtob & Carlson, 2004), and children appear to have more severe PTSD symptoms in response to witnessing domestic violence than to frightening events not involving threats to their attachment figures (Scheeringa & Zeanah, 1995). However, parents are often unaware of the effects that trauma can have on a young child, because of guilt over their own involvement in the traumatic event, their mistaken belief that young children are too immature to notice or understand the experience, or their own posttraumatic stress reactions (Lieberman & Van Horn, 2005; Pynoos, Steinberg, & Piacentini, 1999). As a result, parents may misinterpret children's trauma symptoms as oppositional behavior, attention-deficit/hyperactivity disorder, or lack of love on the children's part. This can lead to mutual alienation, miscommunication, a failure to protect, and eventual disorganization of the attachment system (Lieberman, 2004; Lieberman & Amaya-Jackson, 2005; Lyons-Ruth & Jacobvitz, 1999). This may partly explain why some infants appear securely attached to their caregivers but also display momentarily disorganized behavior with them. At least some of these infants may have had a history of responsive caregiving that became disrupted when a traumatic experience, such as domestic violence, injected new fear into the child–parent relationship.

Using a Dual Lens in Conceptualizing Children's Symptoms Following Trauma

Clinicians may note that some of the markers and correlates of disorganized/controlling attachment behavior in infancy and preschool years are similar to the features of PTSD in children, such as frozen postures, dissociation, aggression, affect dysregulation, cognitive delays, and physiological alterations (for reviews of this research, see Lyons-Ruth & Jacobvitz, 1999; van IJzendoorn et al., 1999). Although to our knowledge, there has been no systematic empirical investigation of this issue to date, theoretical and clinical work suggests that these two constructs may be related (Lieberman, 2004; Lieberman & Amaya-Jackson, 2005). Problems with exploration and learning are associated with both disorganized attachment relationships and posttraumatic stress responses in children. If a caregiver is frightening (i.e., the domestic violence perpetrator) or frightened and helpless (i.e., the victim), then the child may experience fewer of the supportive interactions that normally facilitate learning. In addition, children who must accommodate to the emotional demands of relating to a frightening or helpless parent may deploy their cognitive and emotional resources away from exploration of the environment and learning and toward monitoring of the parent's behavior (Moss, St-Laurent, & Parent, 1999). From a trauma perspective, children's developmental progress can be interrupted when they experience extreme fear during the same period that new developmental milestones are being achieved (Pynoos et al., 1999). Children exposed to high levels of domestic violence tend to score significantly lower on intelligence tests than nonexposed children (Koenen, Moffitt, Caspi, Taylor, & Purcell, 2003). PTSD symptoms, particularly high levels of arousal, may be the mechanism that explains some of these cognitive effects (Stamper & Lieberman, 2006).

The Quality of Attachment Influences Children's Response to Trauma

Although domestic violence and other traumatic events can affect the quality of attachment, the attachment system also can influence a child's response to trauma. Lyons-Ruth and colleagues (Lyons-Ruth et al., 1999) have proposed a "relationship-diathesis" model in which recovery from trauma depends on both the nature of the trauma, such as its suddenness, intensity, developmental timing, and involvement of attachment figures, and the quality of the child's attachment relationships. Consistent with this model, support from caregivers appears to mitigate the negative impact of trauma on children and improve their ability to resolve PTSD symptoms (Cohen, Mannarino, Berliner, & Deblinger, 2000; Cook et al., 2005). Secure attachment relationships also appear protective in the face of cumulative stressors including maternal depression, marital problems, and poverty (Belsky & Fearon, 2000), and are linked to better regulation of physiological stress responses (see Schuder & Lyons-Ruth, 2004, for a review). These findings highlight the important role that the caregiving relationship plays in young children's ability to manage both psychological and physiological responses to trauma, and they suggest that by enhancing the quality of the attachment relationship, clinicians might improve children's ability to cope with traumatic life events. In the following section, we discuss the use of a relationship-focused intervention model to help children recover from traumatic experiences.

USING THE ATTACHMENT RELATIONSHIP TO FACILITATE CHILDREN'S RECOVERY FROM TRAUMA

The interplay of attachment and trauma suggests that intervention for infants, toddlers, and preschoolers who have experienced domestic violence and other traumatic events logically follows a child–parent model. Child–parent psychotherapy (CPP) is founded on the basic premises of attachment and psychodynamic theories, which posit that the parent–child relationship is central to shaping personality development in the early years, and that effective intervention for young children's social-emotional difficulties should focus on this attachment–caregiving system (Lieberman & Van Horn, 2005). When working with families who have experienced family violence or another trauma, the child–parent psychotherapist approaches that trauma as an experience that has profound effects on the child, the mother, and their relationship. While CPP may be conducted with any primary caregiver (mother, father, grandparent, adoptive parent, etc.), we will refer to the caregiver as the mother for purposes of this chapter.

Assessing Trauma and Attachment–Caregiving Relationships in the Family

The first step in CPP involves assessing the child, the mother, and the quality of their relationship. Prior to beginning treatment, the clinician meets the mother alone to learn about her child's history of trauma and psychological symptoms. Knowing as many details as possible about the trauma guides the clinician in choosing appropriate toys for the treatment, and it helps the clinician make connections between the child's play and his or her actual experience during the therapy.

We also recommend that the clinician assess the mother's history of trauma and her symptoms because the mother is a crucial member of the treatment and mothers' mental health directly impacts their ability to care for their children (e.g., Lieberman, Van Horn, & Ozer, 2005). In addition, because parents' ways of thinking about their own childhood experiences influences their parenting of their children (see Hesse, 1999, for a review of this research), we recommend assessing the mother's attachment history. Although we have used the AAI (George, Kaplan, & Main, 1996) in our treatment outcome research, clinicians also may use clinical interviews to assess mothers' childhood experiences and to identify defensive patterns, such as idealization, projection, and isolation of affect, that may characterize parents' psychological functioning and influence their perceptions of their children.

The therapeutic focus of CPP is the relationship between the child and caregiver. The clinician listens closely to the way that the mother describes her relationship with her child during the assessment phase, looking for helpful ports of entry for intervention during treatment. In the final part of the assessment, mother and child are observed playing together using toys, games, and puzzles provided by the clinician. They then participate in a separation and reunion task that is based on the Strange Situation but adapted to the child's age (Ainsworth et al., 1978; Crowell, Feldman, & Ginsberg, 1988). This part of the assessment provides information on a number of domains of the parent–child relationship, such as their capacity to find pleasure in each other, the child's compliance with parental direction, the parent's ability to follow the child's lead in play, how the parent and child manage the potentially stressful experience of separation in an unfamiliar environment (the clinic playroom), and how the child uses the parent for security upon return.

Attachment and Trauma-Focused Goals of Child–Parent Psychotherapy

The primary goal of CPP with traumatized children is to promote and restore developmental progress by helping the child and the parent create a joint narrative of the traumatic event, to place the trauma in the larger context of living, and to find ways of relating and communicating that promote safety, trust, and enjoyment of age-appropriate pursuits (Lieberman & Van Horn, 2005, p. 7). Interventions may take various forms, but they generally have the following aims: (1) increasing reciprocity in the parent–child relationship by helping children and mothers understand one another's perspectives and correcting distortions in their mental representations of themselves, each other, and their relationship; (2) improving emotion regulation in both children and mothers in order to reduce internalizing and externalizing behaviors; and (3) addressing both children's and mothers' posttraumatic stress symptoms by identifying trauma triggers, normalizing traumatic responses, and learning to respond realistically to new threats. The treatment described below illustrates the clinical application of these principles, highlighting the use of a dual attachment and trauma framework.

THE CRUZ FAMILY: A CASE STUDY OF THE RECIPROCAL IMPACT OF ATTACHMENT AND TRAUMA

Mrs. Cruz and her children were referred to our program by a friend who knew that she was a victim of domestic violence and that her children had witnessed the abuse. Mr. and Mrs. Cruz were both second-generation Mexican Americans whose grandparents had immigrated to the United States. Both parents spoke English in the home and considered themselves Hispanic Americans who where well acculturated to the United States. The therapist in this case was European American. Cultural issues, whether implicitly or explicitly articulated, are part of every clinical encounter. However, we do not refer to specific interventions addressing cultural values in this case because despite having different cultural backgrounds, the therapist and the mother had shared goals for treatment and there were no instances in which cultural differences appeared to interfere with treatment progress.

During the assessment period, Mrs. Cruz reported that, over a period of 6 months, her husband had yelled at, pushed, and slapped her several times when he was high on drugs and alcohol. Anthony was 18 months old and Maria was 3 years old when the violence began. Mrs. Cruz thought that Maria probably was less aware of her father's violence than Anthony because Maria usually was in day care when it occurred. In contrast, Anthony had witnessed nearly all of the domestic violence in the home. In the last and most severe episode, Anthony walked into the living room and saw his father looming over his mother with his hands around her throat. When Mr. Cruz saw Anthony watching from the doorway, he ran out of the house. After Mrs. Cruz called the police, Mr. Cruz was arrested and spent some time in jail. He also received substance abuse treatment. After a 1-year separation, during which he had had only phone contact with his children, Mr. Cruz begged his wife to let him return to the home, telling her that he was no longer using drugs or alcohol and that he would never raise a hand to her again. Mrs. Cruz was eager to have her family back together and accepted her husband back into their home. As promised, Mr. Cruz had remained clean and sober and had not been aggressive to her since their reunion. Mrs. Cruz reported that her husband was very apologetic and committed to repairing his relationship with his wife and children. Mrs. Cruz denied that she or her husband had ever maltreated or neglected the children, and there were no child protective service reports.

Anthony's Traumatic Stress Symptoms

Since witnessing his father's violence toward his mother, Anthony (age 3) had been having nightmares, had regressed to wetting his bed, had difficulty going to sleep, was easily distractible, and had become more aggressive toward his sister. He also had difficulty tolerating frustration. He repeatedly banged his head on the floor and cried when asked to gather his toys or end his play. Mrs. Cruz also reported that Anthony's speech was difficult to understand and seemed delayed in comparison to his peers. In the home, Anthony frequently showed fear of his father. For example, whenever Anthony saw his mother and father arguing about household issues, he would cry out, "Don't hurt my mommy!" Anthony otherwise avoided his father at home. The frequency and intensity of these responses led the clinician to make a diagnosis of PTSD.

Anthony's Attachment Relationships

As mentioned above, Anthony often appeared fearful for his mother's safety in the home. Mrs. Cruz reported that he was extremely protective and caring toward her. She recalled a time when she was upset and he reached out his hand to gently stroke her cheek, as though their roles were reversed and he was caring for her.

The observations made during the assessment were consistent with Mrs. Cruz's reports. In one session, Anthony used the toy cooking utensils to prepare a meal, fed his mother tenderly, and urged her to eat all her food. However, when it was time to clean up, Anthony suddenly fell to the floor and began sobbing inconsolably. His mother attempted to comfort him but he continued to cry for several minutes. Mrs. Cruz appeared unsure of how to console him. Later, during a brief separation from his mother, Anthony retreated to a corner of the playroom and sat on the floor with a sad expression on his face. He said softly, "Mommy" but showed no other signs of searching for her. Upon Mrs. Cruz's return to the room, he turned his back to her and ran to the pile of toys on the floor.

Although Anthony's intense distress during the clean-up episode clearly indicated problems with affect regulation, his inability to obtain comfort from his mother and his mother's inability to soothe him also suggested some dysregulation of the attachment–caregiving system. Anthony's play and separation–reunion behavior contained elements of controlling–caregiving, ambivalent, and avoidant patterns of attachment. His relationship with his father was not directly assessed, but it appeared from Mrs. Cruz's reports that Anthony was fearful and avoidant of him, suggesting possible disorganization of the child's attachment to his father as a result of the violence that Anthony had witnessed and the yearlong separation that followed. Bowlby (1973) described the highly avoidant behavior displayed by toddlers following prolonged separations from their primary caregivers as "detachment." Anthony may have been distancing himself from his father because he was experiencing both fear of and detachment from him.

Maria's Traumatic Stress Symptoms

Mrs. Cruz reported that, for the past year and a half, Maria (age 5) had had difficulty falling asleep at night, often woke up from nightmares, and was exhausted during the day. She was quick to startle and often seemed "on edge." She also was disrespectful and aggressive toward

both her mother and father. Maria seemed to be experiencing increased arousal and possibly some reexperiencing of the violence, but she did not show signs of numbing or interference with her developmental momentum and did not receive a PTSD diagnosis.

Maria's Attachment Relationships

During her play session with her mother, Maria chose to play a board game, and she created her own set of rules for the game that she demanded her mother follow. She became angry at one point when her mother misunderstood her instructions. Mrs. Cruz joined her daughter's play but appeared somewhat passive and tired during the session.

During the separation and reunion episode, Maria did not appear distressed by her mother's departure from the room and continued to play with the toys, looking up briefly when her mother returned and demanding, "Sit down and play with me!" Maria appeared somewhat punitively controlling toward her mother, behavior that was consistent with Mrs. Cruz's description of her as obstinate and difficult to manage. From Mrs. Cruz's reports, Maria often was avoidant of her father in the home.

Mrs. Cruz's Trauma History and Posttraumatic Stress Symptoms

Mrs. Cruz reported that she had witnessed her own father physically abuse her mother throughout her childhood. She remembered one time when her father pushed her mother into some shelves, shattering her mother's treasured dishes inside. Mrs. Cruz said that she had married her husband at a young age to escape her abusive home. Although her marriage had been good for the first several years, her husband began to drink heavily after he lost his job and the domestic violence started soon after that. From the assessment, the clinician determined that Mrs. Cruz met criteria for PTSD. She experienced panic attacks in response to memories of the violence, had difficulty sleeping at night, and avoided any mention of domestic violence on the television or in the newspaper.

Mrs. Cruz's Attachment History

Mrs. Cruz described her father as absent and distant throughout her childhood. When he was present, he was often critical of her. She denied that her father had ever physically abused her, but she stated that he

sometimes spanked her when she had "broken his rules." Mrs. Cruz's mother often worked long hours to support the family. She seemed timid when in the home and Mrs. Cruz described her as "unavailable." In contrast, Mrs. Cruz's relationship with her grandmother appeared close and loving. Mrs. Cruz had clear and loving memories of cooking with her grandmother in the kitchen and being soothed by her when she was ill.

Although Mrs. Cruz's state of mind regarding attachment was not formally assessed with the AAI, her presentation seemed consistent with that of "earned security" (Roisman, Padrón, Sroufe, & Egeland, 2002). She described her difficult childhood experiences coherently and in a balanced way, expressing understanding toward her parents and gratitude toward her grandmother, who was still living. It appeared that, for Mrs. Cruz, her grandmother was an "angel," willing and able to chase away the "ghosts" of parenting abuse and indifference when they appeared (Fraiberg, Adelson, & Shapiro, 1975; Lieberman, Padrón, Van Horn, & Harris, 2005). In working with traumatized families, an essential goal is to help parents identify beneficial influences in their pasts in order to help them draw on these benevolent figures to enhance their relationships with their children.

Mrs. Cruz's Caregiving Relationships with Her Children

Mrs. Cruz reported that she enjoyed being a mother, and that she had valued staying at home with her children to care for them. She reported that prior to the violence, she had spent hours each day playing with the children, taking them on outings to the park, and reading to them. While they continued to do some of these activities together, she felt that her children no longer listened to her and had become difficult to control. Mrs. Cruz reported that she often "walked away" from conflicts with her children because she felt overwhelmed by their disagreements.

At the end of the assessment, Mrs. Cruz reported, like many victims of domestic violence, that she had never before discussed her difficult life experiences with another person and that she felt relieved by being able to tell some of her life story to the clinician. The clinician assured Mrs. Cruz that her symptoms were expectable given her frightening experiences, provided information about PTSD, and reframed Mrs. Cruz's anxiety as an understandable response to her abusive experiences and to her fear that her husband might become violent again. Mrs. Cruz declined the clinician's offer of a referral for individual psychotherapy on the grounds that

she had little spare time and no consistent child care. Nonetheless, after five individual meetings with the clinician during the assessment phase, Mrs. Cruz reported a decrease in her symptoms, suggesting that the assessment of a parent's functioning, within the context of a supportive relationship, can have positive intervention effects in itself.

An Attachment- and Trauma-Informed Case Formulation

The clinician drew on both attachment and trauma theory in her conceptualization of the Cruz family's struggles. The assessment suggested that, prior to the domestic violence, the children's relationships with their mother had been positive and their attachments to her may have been secure. The clinician hypothesized that the family's relationship difficulties were related to the children's fear of their father following the domestic violence and their mistrust in their mother's ability to protect them. Their mistrust was compounded by Mrs. Cruz's struggle to care for the children while suffering from her own traumatic stress symptoms. It appeared that, in response to Mrs. Cruz's helplessness and fear, the children were responding with controlling behavior. The clinician identified these mother–child relationship patterns as suggestive of disorganization of the attachment–caregiving system (Lyons-Ruth et al., 1999; Solomon & George, 1999). Anthony may have been experiencing more distress than his sister following the violence not only because he had witnessed more of the abuse, but also because he was younger and more dependent on his parents for his sense of safety in the world (Lieberman & Van Horn, 2005). These hypotheses guided the clinician's interventions during treatment.

Treatment Sessions

CPP is usually conducted in weekly home- or clinic-based sessions lasting approximately 1 hour. The clinician and Mrs. Cruz decided to meet in the clinic rather than in the family's home because although Mr. Cruz was supportive of the children receiving treatment, he chose not to be part of the therapy. The clinician and Mrs. Cruz agreed that the treatment would be conducted with both children simultaneously because both children were symptomatic and relatively close in age and developmental stage and because Mrs. Cruz had limited time available for treatment.

Mrs. Cruz, Anthony, and Maria attended 40 sessions of CPP over the course of 1 year. There were many facets to their treatment, and the clinician drew on psychoanalytic theory, social learning theory, cognitive-behavioral therapy, and other approaches using the integrative model of CPP (Lieberman & Van Horn, 2005). However, for the purposes of this discussion, we focus on those aspects of the treatment that highlight the interplay between attachment and trauma. In presenting the clinical vignettes, we explain how the use of a dual lens can elucidate clinical issues and guide specific interventions within the therapy.

On Knowing What You Are Not Supposed to Know . . .

Prior to beginning treatment, the clinician asked Mrs. Cruz what the children understood about why they were coming in for therapy. Mrs. Cruz responded that she had never talked to the children about the therapy, nor had she ever discussed their father's violence with them. She said, "They didn't know he went to jail for a month for hitting me. I told Anthony and Maria that their father had gone to visit friends and was going to be away for a while." However, when the clinician inquired further, Mrs. Cruz admitted that the children may have overheard her and Mr. Cruz talk about his incarceration after he returned home.

The clinician explained to Mrs. Cruz the importance of acknowledging the violence to her children and telling them that they would be coming to see someone to help them talk about the frightening things that they had seen at home. Mrs. Cruz asked the clinician to help her do this. At the first session with Maria, Anthony, and their mother, the clinician said, "Your mom is bringing you here because she knows that I'm someone who helps children and their parents with the scary things that happened to them and how they feel about them." Immediately, Maria asked, "Like when Daddy gets angry and I get scared?" The clinician replied, "Yes, like when your daddy gets angry and then you get scared." Anthony responded differently, saying, "My Daddy's home now. My Daddy came back." His mother said to the clinician, "He says that a lot—he still cries out for his father when he wakes from his nap." The clinician replied, "It seems like it's still hard for Anthony to believe that his father is really home." Turning to Anthony, she said: "Your dad was gone for a long time, but now he is home and he doesn't want to go away again."

Maria's quick acknowledgment of her father's anger and her own fear highlighted her always-present awareness of her father's violence,

which was particularly notable because her mother believed that she had been sheltered from the frightening episodes. Even when violence stops, the emotional sequelae for children continue. The little girl's words suggested that even very young children can get relief from acknowledging the frightening events that bring them into treatment.

Anthony's response suggested that for this little boy, the separation from his father was an additional stressor that had yet to be acknowledged within the family. Perhaps for this reason, his trust in his father's return home was still tenuous. Anthony's words also highlighted the coexistence of longing and fear in his relationship with his father. Acknowledging the ambivalence that children may feel toward a violent caregiver helps to normalize their often confusing internal responses.

Mrs. Cruz's long-standing silence regarding the violence is common among battered mothers. Parents often deny the occurrence of violence either because of shame about the abuse, a desire to forget, or a hope that children will remain unaffected. For Mrs. Cruz, Anthony, and Maria, the domestic violence and Mr. Cruz's subsequent absence from the home had been the proverbial "elephants in the room," looming large but never acknowledged.

As Bowlby (1979) described in his seminal paper "On Knowing What You Are Not Supposed to Know and Feeling What You Are Not Supposed to Feel," the denial of a child's reality can have lasting harmful effects. When very young children witness frightening events, such as violence between their parents, the death of a loved one, or community violence, they rely on their attachment figures to help them make sense of their experiences and to help them cope with their feelings. Too often, though, the attachment figure is unable to assist the child in this process because he or she may be traumatized by the same event or may be responding to memories of past frightening experiences. Many of the parents who seek treatment for recent traumas have never talked with their children about other difficult life events such as a death or divorce. As a result, traumatic experiences often are layered upon one another silently and without acknowledgment. This can impair children's relationships with their caregivers and impede their recovery from trauma.

One of the primary goals of CPP for families who have experienced trauma is to enable them to "speak about the unspeakable." For very young children, this might be through play. For older children who have more developed language, talking about the traumatic event may be more appropriate.

Danger and Safety within the Attachment Relationship

The dual themes of danger and safety predominate in CPP with families who have experienced trauma. A prerequisite for treatment is the establishment of safety both in real life and in the therapeutic setting. Children who witness violence suffer a disruption of their "secure base" (Bowlby, 1969/1982) and distrust their caregiver's ability to keep them safe. Parents often are unaware of their children's lingering fear. The therapist's role is to name and normalize these fears while helping the parents to take effective actions to increase safety in the home.

In the case of the Cruz family, this intervention included regularly assessing Mrs. Cruz's feelings of security in her relationship and the creation of a safety plan for her and her children that Mrs. Cruz agreed to follow if she ever felt threatened by her husband again. For Anthony and Maria, however, the issue of safety was more complicated because their mother had decided to allow their previously violent father back into the home. Although their father was no longer aggressive and he was trying to repair his relationship with his wife and children, his past violence continued to shape the children's feelings and behavior. The therapist's role was to facilitate a discussion of the children's fears while helping them put them in the perspective of current safety to the extent that this was realistic and accurate.

In the second treatment session, the clinician addressed the children's fears by saying: "Your mommy brought you here so that you could talk about the scary things you saw, the times you saw your daddy hit your mommy," the clinician said. "You have scary memories, but it's also tricky because your mommy feels that your dad is safe now, and that is why he's living with you again." Mrs. Cruz said, "Daddy wouldn't be in the house if I didn't feel it was safe." Maria then said, "Sometimes daddy says scary things." The clinician asked the child about these "scary things," and Maria responded, "Sometimes he talks angry. It scares me when I hear mommy cry—I don't want mommy to get hurt." Her mother looked very sad. The clinician then asked Mrs. Cruz how she felt to hear this from her child, and she replied, "It's really hard to hear it, because my role is to protect them." Mrs. Cruz and the clinician then talked about how Mrs. Cruz might bring her husband into this discussion, and how, as a couple, they could find ways to reassure the children that, even though their parents sometimes argued, their home was now safe.

In this session, Mrs. Cruz showed great insightfulness regarding her children's reliance on her for protection from harm and fear. The clinician built on this insight to help Mrs. Cruz promote security within the children's attachment relationships with their parents, by acknowledging the past trauma and striving to provide them with a sense of safety regarding their future.

A Child's Helplessness: Linking to Past Trauma within the Attachment Relationship

As he had during the assessment, Anthony continued to have difficultly with transitions at home, at school, and in the therapeutic setting. For example, whenever it was time to end a treatment session, he immediately began to cry and threw himself on the ground, sobbing loudly. Mrs. Cruz appeared embarrassed and frustrated during these episodes. Exasperated, she would threaten to take away a favorite toy when they returned home. This usually failed to end Anthony's crying. In session 5, the clinician said to Anthony, "Saying good-bye is so hard for you. It makes you feel so upset." Anthony looked up at the clinician but said nothing. "It seems as though it's hard for him to leave places—home, here, even day care," the clinician observed to Mrs. Cruz. Mrs. Cruz said that he did get frustrated easily: "He likes to have things just so, like his carrots not touching his meat." The clinician said, "It seems as though he likes to have some control over things—that's natural for little kids—and especially for him, because things have not felt in control at home at times, right?" Mrs. Cruz said she had never thought about it that way before. The clinician suggested that they might help Anthony anticipate his good-byes by pointing out to him when their time was almost up. She also began bringing in a large timer to each session that allowed Anthony to see how much time was left in session. At home and at school, Mrs. Cruz made an effort to help talk with Anthony about transitions before they occurred, and his tantrums decreased substantially.

In this example, the clinician implemented a two-pronged intervention to help Anthony cope with the ending of sessions and other transitions in his life. First, she interpreted his difficulty with situations that felt out of his control—such as the ending of therapy sessions—as a reaction to the helplessness that he had felt witnessing the conflict and violence between his parents. This approach targeted Mrs. Cruz's negative attributions toward her son and reframed the child's behavior as an understandable response to his past frightening experiences with his attachment figures.

Mrs. Cruz then appeared more tolerant and understanding of her child, and this changed attitude in turn improved her ability to soothe him when he was distressed. Anthony's posttraumatic and disorganized symptoms decreased in tandem with the improvement in the quality of the parent–child relationship. The clinician also suggested concrete changes that Mrs. Cruz could make in helping Anthony anticipate transitions in the future, and she modeled effective action by bringing in a new clock that would appeal to a child at his developmental stage.

Understanding Children's Hypervigilance: Protecting the Attachment Figure

In session 10, Mrs. Cruz mentioned to the clinician that her children were having trouble getting ready for school on time in the mornings. The clinician learned that both children were still tired when they woke each day. When asked about the children's sleep schedule, Mrs. Cruz reported that she usually left the television on all night in the children's room and that the children stayed up late watching shows. The clinician asked what made it difficult for Mrs. Cruz to turn off the television and help the children get to sleep earlier. Mrs. Cruz was evasive and vague in her answers. Finally, the clinician asked, "I wonder if I'm pushing this issue too much? I sense that you're not sure what you'd like to do about the television." Mrs. Cruz said that she *was* unsure what to do about it. She added that it didn't matter what she did, because "the kids would just turn the television back on if I turned it off." The clinician commented, "Somehow, it seems that the children have a lot of control of how things go at bedtime. I wonder why that might be?" Mrs. Cruz suddenly paused and looked stricken. "I think," she said softly, "that the children watched television late at night because that was when we used to fight the most."

Turning to the children, the clinician said, "I know you worry about your mommy getting hurt. Your mommy and I are wondering if you stay up late at night because you're worried about her." Maria nodded her head. "When I close my eyes," she said, "I see monsters." Anthony then exclaimed, "Monster daddy!" Their mother looked upset and asked the therapist, "Are they saying that their daddy's a monster?" The clinician replied, "I think that the children are telling us that they remember what happened, and that they're still scared by it." Mrs. Cruz responded, "I didn't know all this. I didn't know that Maria didn't want to sleep because she was afraid." The clinician said, "I think the children know

that you and their dad are trying to make their home safe for them, but they also are still worried that their dad might become violent again. I think they're looking for signs from you that they can relax and not worry so much. Maybe by turning off the TV and putting them to bed at an earlier hour you can help them learn that things are safer now." Mrs. Cruz responded with surprise and interest to this suggestion.

In this session, the clinician detected ambivalence and feelings of helplessness in Mrs. Cruz's approach to her children's bedtime routine. When traumatized mothers discuss their parenting, they often describe themselves as helpless and passive. Their children, in contrast, are either described as out of control and unmanageable or as extremely precocious and caring of the mother. These mothers seem to have abdicated caregiving of their children, and their children have inverted the parent–child role in response to this parenting vacuum (Lyons-Ruth et al., 1999; Solomon & George, 1999). When faced with evidence of this dysregulated attachment–caregiving pattern in the Cruz family, the clinician attempted to highlight for Mrs. Cruz her children's unresolved fear of their father, rooted in his past violence. At the same time, the clinician suggested to Mrs. Cruz ways that she might be able to provide structure and reassurance to decrease her own and her children's feelings of helplessness. Following this intervention, Mrs. Cruz was able to turn off the television at night, and she was surprised that the children went to bed without protest. The ease with which the children adapted to this new routine suggested that they actually may have been relieved and comforted when their mother finally set limits on their bedtime in order to foster their well-being.

Aggression within the Attachment Relationship: A Trauma Trigger for Mother

In session 17, Mrs. Cruz entered the therapy room with a frown on her face. She looked tired and pale. The children, in contrast, ran happily into the room and began to look for some of their favorite toys. Almost immediately, Mrs. Cruz began to complain that her daughter had been "bad" this week—Maria was defiant, controlling, and manipulative, she said. The clinician tried to explore this further and included the children in the discussion. She said, "Your mom seems upset about how things are going at home. She's telling me, Maria, that you aren't getting along very well and that she doesn't know what to do right now." Maria looked at the clinician briefly but continued to play with some toy trucks on the floor. Her mother said, "Maria, we're talking to you. Listen!" Maria suddenly looked up at her mother and raised her hand as though to strike her. Mrs. Cruz froze where she was sitting and said nothing. At that moment, Anthony walked near Maria, stepping on her shoe. Maria burst into tears and crawled into her mother's lap as though she were an infant seeking comfort. Mrs. Cruz held Maria and rocked her gently. Both mother and daughter seemed relieved. The clinician, sensing that mother and child had quickly moved on from their conflict, asked if they could return to what had been bothering them. She said, "I think something happened a few moments ago that is important to talk about. I wonder if Maria is crying, not because her foot was stepped on, but because of what happened between the two of you before that. It seemed like you were talking about how upset you were with Maria this week. And then you got angry with her when she didn't respond to my question. Then Maria got so angry and upset that she felt the urge to hit you." The little girl looked at the clinician and nodded, crawling deeper into her mother's lap. The clinician turned to the mother and both children and said, "But hitting people is wrong. Your daddy hit your mommy in the past, and that was very scary. Now it's scary for your mom to see Maria want to hit her, because she remembers that frightening time with your dad."

This interaction between Maria and Mrs. Cruz can be viewed through the dual lens of trauma and attachment theory. Examining it from the perspective of trauma, Maria's threatened violence toward her mother might be understood as identification with the aggressor, her father. Mrs. Cruz's frozen response suggested that Maria's raised hand may have triggered memories of her husband's violence. Attachment theory suggests that Maria was using violence as a way of exerting control in the face of her mother's helplessness, a pattern that would be consistent with the identified trajectory from infant disorganization to controlling behavior at school age (Solomon & George, 1999). The clinician used these hypotheses in attempting to intervene to break the negative cycle she observed between mother and child. She interpreted Mrs. Cruz's reaction as a traumatic stress response, making the link to the father's violence as a way of explaining it to the mother and her children. She acknowledged the daughter's anger and mother's fear, giving voice to their internal experiences. At the same time, the clinician modeled appropriate behavior for the mother by not ignoring her daughter's aggression and remaining helpless in the face of it, demonstrating that safety within attachment relationship comes from setting limits regarding violence.

Identifying Traumatic Reminders within the Attachment Relationship

In session 20, Mrs. Cruz reported that Anthony had wet his bed the night before, which surprised her because he had not done this since the early weeks of treatment. The clinician asked Mrs. Cruz if anything had changed in their life recently that might have triggered this regression for Anthony. Mrs. Cruz thought for a while and said, "Well, my husband came home late from work last night—around 3:00 A.M.—because he's taken on a later shift at his job." With some questioning from the clinician, Mrs. Cruz explained that Mr. Cruz had been passing by the children's room when he saw Anthony standing up in bed, as though frozen there. The child stared at his father and began to urinate while standing on his bed. The clinician asked Mrs. Cruz if her husband had ever come home in the middle of the night before. Mrs. Cruz paused and said, "Yes. He used to leave the house after our fights and not return until very late at night." The clinician then suggested that, for Anthony, seeing his father return home in the middle of the night might have reminded him of other times that his father had come home late, after episodes of violence. His father's late return home could be a "traumatic reminder" for Anthony, the clinician explained. "I wonder," the clinician asked, "how we might help Anthony understand the difference between the present and the past?" Mrs. Cruz turned to Anthony, who was playing with a puzzle on the floor. She said, "I want you to know that Mommy and Daddy are not angry with each other now. Daddy came home late last night because he has a new job and he needs to work at night sometimes. But we are not fighting with each other." Anthony nodded his head but didn't say anything. Mrs. Cruz said to the clinician, "It's really hard to think about how much he might remember." The clinician nodded and said, "It must be difficult to realize this. I think we are learning that, although much of your conflict with their father was in the past, it is still feeling very present for the children."

Anthony's frozen posture and urination when he saw his father return home late at night appeared to be disorganized behavior, possibly resulting from Anthony's contradictory urges to approach his father for comfort and avoid his father because of fear. In this case, the attachment figure served as a traumatic reminder for the child. Mr. Cruz's late return home triggered Anthony's disorganized behavior, highlighting the potential overlap between posttraumatic stress responses and disorganization within the attachment relationship.

Children exposed to trauma may continue to be reminded of the frightening experience by cues in their environment. When these traumatic reminders remain unidentified by the caregiver, the child's sense of security is undermined because the child continues to feel fear, often unpredictably and without alleviation. Caregivers who fail to recognize and understand the meaning of the traumatic reminder also may unwittingly exacerbate the child's symptoms by rejecting or punishing the child (Lieberman & Amaya-Jackson, 2005). Once a traumatic reminder has been identified for a child, the most effective intervention is to remove the trigger from the child's environment. When this is not possible, the caregiver can gradually expose the child to the reminder in a safe and modulated way. With older children who have adequate language skills, the caregiver can help anticipate the occurrence of the traumatic reminder and help the child cope with resulting negative emotions. By talking about the nonviolent meaning of his father's late return home, Mrs. Cruz was helping Anthony gradually disassociate this experience from its previously frightening meaning.

Creating a Trauma Narrative within the Attachment Relationship

One of the primary CPP therapeutic strategies is to help children and their parents construct a joint trauma narrative that weaves their often fragmented memories of the trauma into a fabric composed of events, cognitions, and emotions. The story may be told verbally or through play, depending on the child's developmental level and facility with expressive language. Play is used as a frequent port of entry because children often use play to depict their innermost experiences (Erikson, 1950; Slade, 1994).

In the Cruz family, Maria, at age 5, had begun to put her experience of her father's violence into words. After a few treatment sessions, she was able to talk about her fears "when Mommy hit Daddy" and about her memories of hearing her parents fighting in their room at night. Anthony, however, did not join in her storytelling until relatively late in the treatment. Only 3 years old, and having experienced some regression in his expressive language following the violence, Anthony gravitated toward toys rather than words to describe his experiences. His play at the start of treatment was quite constricted, focusing on building small towers with blocks or playing with small cars on the floor. There seemed to be little symbolic meaning in his play throughout the early stages of treatment.

Twenty-five sessions into treatment, Mrs. Cruz reported that she and her husband recently had been arguing at home, and that both children seemed upset by it. While Mrs. Cruz spoke, the children played on the floor, building an elaborate tower. Several minutes later, Anthony approached the wooden dollhouse in the corner of the playroom. He picked up a boy and a girl doll and placed them on two beds. The clinician commented that it looked as though the dolls were going to sleep. Anthony nodded seriously. He then picked up a male doll and a female adult doll and placed them downstairs, below the children's room. He began hitting the two dolls together forcefully, again and again, without any comment. The clinician said, "It looks like those dolls are really getting hurt. I wonder if you're showing us something that you've seen or heard before?" Anthony continued with the play, making the female doll shout, "Stop it, I hate you!" The clinician looked at Mrs. Cruz, who seemed distressed watching her son play. Maria was also watching her brother. She then entered into the play. She grabbed the father doll and placed him in a car that she then drove away. The clinician said, "I wonder if Anthony and Maria are telling us about a time that you and their father fought, and then their father left the house? And the children were upstairs in their room, listening to everything? It must have been scary for the children." Anthony said, "Daddy pushed and yelled at Mommy and I was scared." The clinician nodded and said, "It is so scary to see your daddy hit your mommy." Mrs. Cruz moved to comfort her son. She put her arms around him and then looked at her daughter and said, "Mommy and daddy did fight, and it was scary. And daddy went away to jail. But we are trying not to fight anymore. We don't want you to be scared anymore."

It was not until relatively late in the treatment that Anthony began to engage in storytelling about his frightening experiences. Children take their own time to develop and mature, and it is important for clinicians to respect their rhythms in spite of external pressures to "cure" them quickly. By providing toys that might serve as props for his narrative but also allowing Anthony to approach his frightening memories at his own pace, the clinician strove to meet Anthony at his own developmental stage while also trying to foster growth. Although Mrs. Cruz initially seemed to struggle watching her son play out the scene of violence, she eventually was able to engage in the narrative and provide comfort for her son. This may not have been possible for her at the start of the treatment, when she had seemed more avoidant of reminders of the violence.

Throughout the remainder of the treatment, Anthony continued to elaborate on the scenes of conflict and violence he had witnessed as a toddler. With the therapist, his mother, and at times, Maria, helping to put words to aspects of his play, Anthony constructed a narrative of his traumatic experiences. Over time, Anthony also added scenes of reunion and reconciliation between his father and the rest of the family, suggesting that he was creating a story not just of trauma but also of recovery.

A Good Good-Bye: Planning the End of a Close Relationship

For all clients involved in psychotherapy, but particularly for children and parents who have experienced trauma, a thoughtful termination of treatment is essential. For children and parents who have experienced separations from their caregivers, losses, or unexplained absences of important figures in their lives, ending relationships may be extremely painful. During the course of CPP, the clinician may acquire the role of surrogate attachment figure through the consistent focus on providing a haven of safety for the child and parent. The termination of treatment may be difficult for clients and clinician, but it also provides an opportunity to experience a "good good-bye." The clinician can convey that separations and loss can be acknowledged and anticipated, and that these experiences do not always mean a loss of love (Lieberman & Van Horn, 2005).

In session 30, the clinician reminded the family that they would be ending treatment in a few weeks. Mrs. Cruz turned to her children and said, "We've been coming here for almost a year, and now it's time to end—remember that we came here because we wanted help with some of the scary things that happened before?" Maria was drawing and Anthony was playing with Play-Doh. Both children nodded solemnly. The clinician added, "We've talked about how your daddy hit your mommy, and how both of you saw that happen." Maria replied, "Daddy said really mean things to mommy. But he doesn't say mean things anymore. He's a lot nicer now." The clinician replied, "Yes, your mom told me that your dad has made a lot of good changes, and he's safer now." Both children nodded. The clinician looked at Mrs. Cruz and said, "Your mom told me that she wanted your dad to come back and live with you, but only if he could be safe and not say and do such mean things. And it sounds like that has happened. Is that right, mom?" Mrs. Cruz said that was true. The clinician asked, "Do you feel as though things have worked out the way that you had hoped?" Mrs. Cruz replied, "Yes, it was the right choice. I didn't want my children to grow up without a father."

Shortly after this interaction, the clinician asked Mrs. Cruz how she felt about ending treatment. She said, "I've really benefited from coming here, and the children have, too." The clinician asked her what kinds of things had gotten better, and Mrs. Cruz explained, "I've been able to talk with them about what happened, about the scary things. I can talk to them now not only about the good things, but also about the bad things that happen, about good feelings and bad feelings. Also, last week the kids made a mess in the living room, and they dropped some glue on the floor. I would have reacted differently a year ago. I would have gotten really angry. Now I don't get upset about the small things. I keep them in proportion more."

Mrs. Cruz's words suggest that this was a successful treatment for her and her children. She no longer avoided discussing their father's violence with them, and she was now able to help them acknowledge both their positive and negative feelings toward her and her husband. She seemed to have gained insight into her past tendency to react quickly with anger to her children's misbehavior, and she felt more in control of her responses to them. Mrs. Cruz was no longer the helpless parent that she had appeared to be at the beginning of treatment; she was now more mindful and in control of how she cared for her children. A posttreatment assessment revealed that Mrs. Cruz no longer had a PTSD diagnosis and was experiencing minimal anxiety in her daily life. She also reported more pleasure in parenting and increased trust and collaboration with her husband.

The children's well-being, in turn, was significantly improved. Anthony no longer was wetting his bed at night, having tantrums at home or at school, being inappropriately aggressive with his sister, or showing fear of his father. His expressive language had improved considerably. His traumatic stress symptoms had improved to the point that he no longer met criteria for PTSD. In his final play and separation-reunion experience with his mother during the posttreatment assessment, Anthony was able to complete a complex puzzle with some help from his mother, and he was able to tolerate the frustration of having to end his play before he had completed his goal of building a tower out of blocks. When his mother left the room during the separation–reunion task, he noted her departure but actively engaged with toys until her return, when he welcomed her back into his play.

Maria also seemed to have benefited from the therapy with her mother and brother. Like her brother, she now went to bed at an early hour each night and she no longer saw "monsters" when she closed her eyes. She woke up rested and ready to start the day. She was less aggressive and controlling toward her mother and was more cooperative with her. In the separation–reunion episode at the end of treatment, Maria said good-bye to her mother when she left the room, and she included her mother in her gentle play with a baby doll when her mother returned.

OUTCOMES OF CHILD–PARENT PSYCHOTHERAPY: WHAT THE RESEARCH REVEALS

CPP appeared to have helped Maria, Anthony, and Mrs. Cruz decrease their trauma symptoms and improve their attachment and caregiving relationships. But are the results generalizable to other families? Research now has documented the benefits of this treatment approach for preschool children who have witnessed domestic violence and their mothers on a larger scale. Following 1 year of CPP, children displayed significantly fewer behavior problems and posttraumatic stress symptoms and diagnoses than children who received cases management and treatment as usual in the community. Their mothers also reported significantly less avoidance of traumatic memories related to the violence (Lieberman, Van Horn, & Ghosh Ippen, 2005). These outcomes were maintained 6 months after treatment ended (Lieberman, Ghosh Ippen, & Van Horn, 2006).

Although we are still analyzing data regarding treatment effects on the quality of child–parent relationships in this sample of preschoolers exposed to domestic violence, previous research suggests that CPP can benefit the attachment relationship. For example, in a sample of low-income Latina mother–infant dyads, infants receiving CPP displayed significantly less anxious attachment and significantly enhanced partnership with their mothers, compared to those in the nontreatment control group. Their mothers, in turn, showed higher levels of empathy and interactiveness with their children (Lieberman, Weston, & Pawl, 1991). CPP also has been shown to be effective in improving maltreated preschool children's attachment-related representations of themselves and their mothers, as well as their expectations of the mother–child relationship (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002). Finally, toddlers of depressed mothers who received CPP showed a significant

increase in attachment security and a reduction in disorganized behavior with their mothers, compared to those in a nontreatment control group (Cicchetti, Toth, & Rogosch, 1999). Taken together, these findings suggest that CPP effectively integrates an attachment and trauma framework to help children and their parents recover from frightening life events.

SUMMARY AND CONCLUSIONS

In this chapter, we have proposed that the assessment and treatment of traumatized children should be conducted using a dual attachment and trauma framework. Traumatic experiences impact the quality of children's attachment relationships with their caregivers, and at the same time, children's attachment relationships can moderate the impact of trauma on their development. CPP is based on these principles, and on the resulting conclusion that children's recovery from trauma must take place within the context of their critical relationships with their caregivers.

The case of a child witnessing domestic violence highlights the interplay of attachment and trauma. Domestic violence directly challenges the child's trust that caregivers will be reliable protectors from harm. It also has frightening, potentially traumatizing effects on both the child and caregiver, which can lead to negative attributions, anger, and failure of the parent to respond to a child's cues for comfort and security. Any of these pathways can lead to a disorganized attachment relationship.

Domestic violence is but one example of a traumatic event that can derail a previously secure relationship between child and parent. Children rely on their caregivers to help them make sense of and regulate their emotional responses to all kinds of frightening events. Therefore, all traumatic experiences in young children's lives—whether the result of impersonal, external forces or acts perpetrated by the parent—have the potential to dysregulate the attachment system through their negative effects on individual family members and their relationship patterns (Lynch & Cicchetti, 2002). The negative impact of traumatic events on the family system can shed light on the elevated rates of disorganized attachment in high-risk populations (van IJzendoorn et al., 1999), where young children and their parents are more likely to be exposed to family violence, community violence, and other traumatic stressors. While consistent with Bowlby's (1969/1982) focus on the importance of real-life events in shaping attachment patterns, these findings suggest an

extension of Bowlby's attachment theory beyond the parent–child relationship to include other external stressors in the family's life. We propose that, by assessing trauma, child vulnerability, and the quality of the attachment relationship, clinicians and researchers can build much-needed bridges between trauma and attachment theory, incorporating sustained clinical attention to the role of environmental factors in the etiology and perpetuation of a child's mental health problems (Lieberman, 2004; Lynch & Cicchetti, 2002; Pynoos et al., 1999).

In the case of the Cruz family, the clinician drew on research findings regarding disorganized attachment in infancy, controlling behavior in preschool years, and parental helplessness to inform her assessment, case conceptualization, and interventions during treatment. Attachment-based research measures such as the Strange Situation and the AAI have provided a wealth of empirical results with rich clinical implications, but to date, there has been relatively little discussion about how these measures and their findings might be applied to clinical work. There is an inherent tension between clinical work and research. Clinicians attempt to understand the individual child as deeply and thoroughly as possible in the context of his circumstances, using information about normal development and developmental psychopathology to help the child. In contrast, researchers aim to make generalizations across groups of children, using standardized assessments with precise approaches to measurement and coding. Generalizations that apply to groups may or may not be applicable to any one individual, with the result that the clinician must be constantly on the lookout for confirmatory clinical evidence when applying general principles to a particular child. At the more concrete level, both the Strange Situation and the AAI require intensive training to learn their protocols and achieve coding reliability, and clinicians may not have the opportunity or inclination to do this training. In addition, the Strange Situation relies on a highly structured series of time-limited separation and reunion episodes; clinicians may feel that this protocol is not appropriate to an unstructured therapeutic context.

In our own clinical research with children and parents, we have used these measures to enhance our understanding of the quality of family relationships and the relational impact of trauma. However, we believe that classifying children or adults according to their attachment patterns is less important than identifying the psychological and interpersonal process that might lead a child to engage in avoidant, ambivalent, or disorganized behavior with a parent. All children may show avoidance with a caregiver at some point; the question is where the

avoidance falls on a continuum from normal to disordered interaction patterns (Fraiberg, 1981/1987). Knowing the context of these behaviors is critical in understanding their meaning. Clinicians can play a valuable role in interpreting and contextualizing the information provided by the Strange Situation or AAI because they have a detailed knowledge of the child's individual characteristics and life circumstances, beyond the behavior elicited by a brief separation and reunion episode in the laboratory. If clinicians choose not to use structured attachment measures, they can still mine the rich literature on attachment, based on groups of children, to inform their approach to a particular child.

The case study of the Cruz family illustrates that the themes of attachment and trauma run throughout CPP for children who have witnessed domestic violence or other traumatic life events. Danger and safety, helplessness, protection, aggression, separation, and loss are simultaneously trauma and attachment themes, interwoven in the play and narratives of children who have had frightening experiences. Using both an attachment and trauma lens enables the clinician to make interventions that speak to both the frightening nature of children's experiences and the impact of these events on their relationships with their caregivers. In so doing, treatment addresses not only children's traumatization, but also their recovery.

REFERENCES

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation.* Hillsdale, NJ: Erlbaum.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed). Washington, DC: Author.

Belsky, J., & Fearon, R. M. P. (2002). Infant–mother attachment security, contextual risk, and early development: A moderational analysis. *Development and Psychopathology, 14*, 293–310.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation: Anxiety and anger.* New York: Basic Books.

Bowlby, J. (1979). On knowing what you are not supposed to know and feeling what you are not supposed to feel. *Canadian Journal of Psychiatry, 24*(5), 403–408.

Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment.* New York: Basic Books. (Original work published 1969)

Busch, A., & Lieberman, A. F. (2006). *Maternal attachment representations predict children's IQ following exposure to domestic violence.* Manuscript in preparation.

Chemtob, C. M., & Carlson, J. G. (2004). Psychological effects of domestic violence on children and their mothers. *International Journal of Stress Management, 11*(3), 209–226.

Cicchetti, D., Toth, S. L., & Rogosch, F. A. (1999). The efficacy of toddler–parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment and Human Development, 1*(1), 34–66.

Cohen, J. A., Mannarino, A. P., Berliner, L., & Deblinger, E. (2000). Trauma-focused cognitive behavioral therapy for children and adolescents: An empirical update. *Journal of Interpersonal Violence, 15*(11), 1202–1223.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., et al. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390–398.

Crowell, J. A., Feldman, S. S., & Ginsberg, N. (1988). Assessment of mother–child interaction in preschoolers with behavior problems. *Journal of the American Academy of Child and Adolescent Psychiatry, 27*(3), 303–311.

Erikson, E. (1950). *Childhood and society.* New York: Norton.

Fraiberg, S. (1981/1987). Pathological defenses in infancy. In *Selected writings of Selma Fraiberg* (pp. 183–202). Columbus: Ohio State University Press.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery. *Journal of the American Academy of Child Psychiatry, 14*, 387–421.

Freud, S. (1955). Beyond the pleasure principle. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 18). London: Hogarth Press. (Original work published 1920)

George, C., Kaplan, N., & Main, M. (1984, 1985, 1996). *Adult Attachment Interview Protocol.* Unpublished manuscript. University of California at Berkeley.

Hesse, E. (1999). The Adult Attachment Interview: Historical and current perspectives. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 395–433). New York: Guilford Press.

Hesse, E., & Main, M. (2000). Disorganized infant, child, and adult attachment: Collapse in behavioral and attentional strategies. *Journal of the American Psychoanalytic Association, 48*(4), 1097–1127.

Koenen, K., Moffitt, T., Caspi, A., Taylor, A., & Purcell, S. (2003). Domestic violence is associated with environmental suppression of IQ in young children. *Development and Psychopathology, 15*, 297–311.

Lieberman, A. F. (2004). Traumatic stress and quality of attachment: Reality and internalization in disorders of infant mental health. *Journal of Infant Mental Health, 25*(4), 336–351.

Lieberman, A. F., & Amaya-Jackson, L. (2005). Reciprocal influences of attachment and trauma: Using a dual lens in the assessment and treatment of infants, toddlers, and preschoolers. In L. J. Berlin, Y. Ziv, L. Amaya-Jackson, & M. T. Greenberg (Eds.), *Enhancing early attachments: Theory, research, intervention, and policy* (pp. 100–124). New York: Guilford Press.

Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child–parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the Academy of Child and Adolescent Psychiatry, 45*(8), 913–918.

Lieberman, A. F., Padrón, E., Van Horn, P., & Harris, W. (2005). Angels in the nursery: The intergenerational transmission of benevolent parental influences. *Infant Mental Health Journal, 26*(6), 504–520.

Lieberman, A. F., & Van Horn, P. (2005). *Don't hit my mommy!: A manual for child–parent psychotherapy with young witnesses of family violence.* Washington, DC: Zero to Three.

Lieberman, A. F., Van Horn, P., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child–parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(12), 1241–1248.

Lieberman, A. F., Van Horn, P., & Ozer, E. J. (2005). Preschooler witnesses of marital violence: Predictors and mediators of child behavior problems. *Development and Psychopathology, 17*(2), 385–396.

Lieberman, A. F., Weston, D. R., & Pawl, J. H. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development, 62*, 199–209.

Lynch, M., & Cicchetti, D. (2002). Links between community violence and the family system: Evidence from children's feelings of relatedness and perceptions of parent behavior. *Family Process, 41*(3), 519–532.

Lyons-Ruth, K., Bronfman, E., & Atwood, G. (1999). A relational diathesis model of hostile–helpless states of mind: Expressions in mother–infant interaction. In J. Solomon & C. C. George (Eds.), *Attachment disorganization* (pp. 189–212). New York: Guilford Press.

Lyons-Ruth, K., & Jacobvitz, D. (1999). Attachment disorganization: Unresolved loss, relational violence, and lapses in behavioral and attentional strategies. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 520–554). New York: Guilford Press.

Main, M., & Cassidy, J. (1988). Categories of response to reunion with the parent at age 6: Predictable from infant attachment classifications and stable over a 1-month period. *Developmental Psychology, 24*(3), 415–426.

Moss, E., St-Laurent, D., & Parent, S. (1999). Disorganized attachment and developmental risk at school age. In J. Solomon & C. C. George (Eds.), *Attachment disorganization* (pp. 160–186). New York: Guilford Press.

Osofsky, J. (2003). Prevalence of children's exposure to marital violence and child maltreatment: Implications for prevention and intervention. *Clinical Child and Family Psychology Review, 6*(3), 161–170.

Pynoos, R. S., Steinberg, A. M., & Piacentini, J. C. (1999). A developmental psychopathology model of childhood traumatic stress and intersection with anxiety disorders. *Biological Psychiatry, 46*, 1542–1554.

Roisman, G. I., Padrón, E., Sroufe, L. A., & Egeland, B. (2002). Earned-secure attachment status in retrospect and prospect. *Child Development, 73*(4), 1204–1219.

Scheeringa, M. S., & Zeanah, C. H. (1995). Symptom expression and trauma variables in children under 48 months of age. *Infant Mental Health Journal, 16*(4), 259–270.

Schuder, M., & Lyons-Ruth, K. (2004). "Hidden trauma" in infancy: Attachment, fearful arousal, and early dysfunction of the stress response system. In J. D. Osofsky (Ed.), *Young children and trauma: Intervention and treatment* (pp. 69–104). New York: Guilford Press.

Schuengel, C., Bakermans-Kranenburg, M. J., & Van IJzendoorn, M. H. (1999). Frightening maternal behavior linking unresolved loss and disorganized infant attachment. *Journal of Consulting and Clinical Psychology, 67*(1), 54–63.

Slade, A. (1994). Making meaning and making believe: Their role in the clinical process. In A. Slade and D. P. Wolf (Eds.), *Children at play: Clinical and developmental approaches to meaning and representation* (pp. 81–107). New York: Oxford University Press.

Solomon, J., & George, C. C. (1999). The place of disorganization in attachment theory: Linking classic observations with contemporary findings. In J. Solomon & C. George (Eds.), *Attachment disorganization* (pp. 3–32). New York: Guilford Press.

Stamper, J., & Lieberman, A. F. (2006). *Traumatic stress symptoms and cognitive performance in preschoolers exposed to domestic violence.* Manuscript in preparation.

Toth, S. L., & Cicchetti, D. (1996). Patterns of relatedness, depressive symptomatology, and perceived competence in maltreated children. *Journal of Consulting and Clinical Psychology, 64*, 32–41.

Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Development and Psychopathology, 14*(4), 877–908.

van IJzendoorn, M. H., Schuengel, C., & Bakermans-Kranenburg, M. J. (1999). Disorganized attachment in early childhood: Meta-analysis of precursors, concomitants, and sequelae. *Development and Psychopathology, 11*(2), 225–249.

Zeanah, C. H., Danis, B., Hirshberg, L., Benoit, D., Miller, D., & Heller, S. S. (1999). Disorganized attachment associated with partner violence: A research note. *Infant Mental Health Journal, 20*(1), 77–86.

Zero to Three/National Center for Clinical Infant Programs. (2005). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood* (rev. ed.). Washington, DC: Author.