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CHILD DEVELOPMENT

A PRACTITIONER'S GUIDE

Third Edition

DOUGLAS DAVIES

Series Editor's Note
by Nancy Boyd Webb

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tioning well most of the time, cannot always withstand the new pressures of growth toward adolescence.

Developmental research documents that children's assessment of their abilities, their academic motivation, and the strength of their interests all tend to decline during preadolescence (Ripke et al., 2007). This profile stands in contrast to the optimism and positive self-assessments of younger school-age children, who tend to rate their abilities highly regardless of actual performance. Since this is a general trend, it must reflect the older child's ability to appraise himself more realistically. Preadolescents have clear ideas about what they are good at and not good at doing. Further, by age 12, they have received a great deal of feedback from adults and peers who have evaluated them explicitly or implicitly, and they have incorporated these views into their view of self (Eccles et al., 2006). The developmental stresses of entry into adolescence may also reduce self-confidence and introduce uncertainty about what the child thinks she should be like and what her interests should be.

The transition to middle school poses an external challenge to preadolescents' confidence and sense of their abilities, even when their abilities are well developed. In large middle schools where teachers and classmates change from hour to hour, the child's sense of continuity is initially disrupted. Her friends from elementary school may not be in her classes. Consequently, she may lose social support from peers during a period of stress, when pubertal development, more distant student–teacher relationships, and cultural expectations of increased autonomous behavior challenge her ability to maintain a positive outlook and to function on her own (Dotterer, McHale, & Crouter, 2009).

Preadolescent children know that they must function more autonomously as they move toward adolescence. Across middle childhood they have made impressive gains in their ability to appraise social situations, make good judgments, and "think for themselves." However, this apparent capacity for self-reliance masks the reality that preadolescents still depend heavily on their support systems, particularly parents and extended family, but also peers as well (J. P. Allen, 2008). An important task for parents during this period is to keep supporting and monitoring their child, even as he appears able to function on his own. Ongoing parental support is crucial. Parental involvement, especially with the history of secure attachment as a backdrop, buffers the preadolescent from stress and supports development in the transition to adolescence.

APPENDIX 11.1. SUMMARY OF MIDDLE CHILDHOOD DEVELOPMENT, 6–12 YEARS OF AGE

Overall Tasks

- To develop and utilize a sense of calm, educability, and self-control
- To develop real-world skills and a sense of competence
- To establish oneself in the world of peers

Attachment

- Child uses autonomous coping rather than attachment seeking in situations of mild stress (6 years+)
- Rituals symbolizing attachment persist—bedtime routines, gestures of affection (6 years+)
- Proximity seeking may be activated in situations of severe stress or during transitions, such as entry into school (6 years+)
- Attachment needs are increasingly expressed in friendships with peers (6 years+)
- Attachment remains salient as child moves through preadolescence—parental support and monitoring facilitate transition to adolescence (11–13 years+)

Social Development

- Increasing orientation toward peers, development of friendships (6 years+)
- Social skills (sharing, negotiation, etc.) develop through peer interaction (6 years+)
- Development of peer group norms and status hierarchies (6 years+)
- Elaboration of gender roles and behavior (6 years+)
- Prosocial behavior, based on internalization of values and improved perspective taking (6 years+)
- Social perspective taking: increasingly clear understanding of others' viewpoints, social expectations, and social cues (6 years+)
- Awareness of the psychological intent of others (8–10 years)
- Ability to hold two opposing viewpoints in mind at the same time (10–12 years)
- Clearer understanding of emotions and emotional nuances in self and others (10–12+)

Language and Communication

- Basic facility in syntax and grammar established (6–7 years)
- Gradually increasing understanding of nuances in meaning and more difficult grammatical features such as the passive voice (6–7 years+)
- Gradually increasing ability to put thoughts and feelings into words (6 years+)
- Narrative ability—child can tell an organized story (7 years+)
- Understanding of wordplay, jokes, figures of speech, metaphor (8–10 years)
- Growing ability, especially for girls, to articulate and share complex emotional concerns (10–12+)

Play and Fantasy

- Play is increasingly sublimated into a work orientation, emphasizing physical skills and intellectual competence (6–7 years+)

- Play continues to be an important source of pleasure and discharge, but now is increasingly ritualized into games (6 years+)
- Fantasy play is increasingly ritualized and rule-governed (6 years+)
- Uses of fantasy include displacement of feelings and wishes into imaginary scenarios and imagining the self in more competent or grown-up roles (6 years+)
- Interest in collections and hobbies (7–8 years+)
- Interest and growing ability in games involving planning and strategy (10–12 years)

Cognitive Development

- Increasingly accurate perception of reality (reality testing) (6 years+)
- Reversibility—systematic ability to analyze perceptions by thinking back over them (6–7 years)
- Improving understanding of cause and effect; decline in magical thinking (6–7 years)
- Decentration: Decline in egocentrism and increase in decentered thought allow child to distinguish between subjective and objective reality (6–7 years+)
- Concrete operations: Processes of logic and reasoning can be applied to understand immediate reality (6–7 years+)
- Developmental spurt in cognitive functions at about age 7: spatial organization, visual organizational ability, time orientation, distinctions between parts and wholes, seriation, auditory processing (6–8 years)
- Memory: Improved registration and categorization of memory contributes to mastery of academic tasks (6 years+)
- Executive processes: new skills in thinking about problem solving, sustaining attention to intellectual tasks (7–8 years+)

Self-Regulation

- Application of cognitive strategies to self-regulation: logical thinking, representational competence, conscious control of arousal and anxiety, using thinking to delay acting on impulses, conscious intent to stay focused on attainment of goals (6 years+)
- Internalization of values, expectations, rules, and social norms fosters self-control (6 years+)
- Psychological defense mechanisms become more effective in limiting anxiety (6 years+)
- Desire to receive approval of peers sets limits on impulsive behavior (6–7 years+)
- Capacity to see conflicting views and tolerate ambivalence improves self-control (10 years)

Moral Development

- Decentered thinking and perspective taking enable child to better understand and empathize with the needs of others (6 years+)
- Development of the conscience (superego) as an internal force controlling behavior (5–7 years)
- Cognitive understanding of rationales, rules, and norms of correct behavior (6–7 years+)
- Social conformity and acceptance of authority supports adherence to rules and expectations (6 years+)
- Moral perspectives evolve from emphasizing equal treatment for all (6–7 years), to emphasizing merit as basis for reward (8–9 years), to recognition of need to balance recognition of merit with benevolence (10–12 years+)

Sense of Self

- Self-esteem based on awareness of competence, status in peer group (6–7 years+)
- Identification with parents, other adults, and peers as role models (6–7 years+)
- Capacity for self-control influences self-esteem and self-concept (6–7 years+)
- Increasing awareness of identity—personal characteristics, gender expectations, racial and ethnic identity (7 years+)
- Awareness of racism, negative stereotypes applied to the self (7–8 years+)
- Increasing capacity for self-observation (8 years+)
- Ability to make comparisons between past and present characteristics of the self (7–8 years+)
- Internalized values create need to gain self-esteem by pleasing oneself, not just others (8 years)
- Capacity for accurate self-appraisal becomes more acute in preadolescence, with corresponding awareness of one's stronger and weaker competencies (11–12+)

CHAPTER 12

Practice with School-Age Children

ASSESSMENT

The assessment process for school-age children should recognize the increasing complexity of the interaction between the children's developmental progress and the increasingly complicated environments they enter. School-age children are most often referred because of behavioral, social, or academic problems that show up at school. Assessment should draw on multiple sources of information, including parents, other caregivers, and teachers as observers of the child, as well as the evaluator's first-hand observations. Only rarely can evaluation findings based on one session be considered reliable and complete. The child should be observed in multiple contexts, ideally both individually and in a family session, and also at home and at school.

Scales of developmental level and symptomatology assess child behavior and specific problems. These include comprehensive instruments, such as the Achenbach System of Empirically Based Assessment (Child Behavior Checklist) (Achenbach & Rescorla, 2001, 2007), which now includes a multicultural version, and more specialized questionnaires on problems such as ADHD, depression, and anxiety disorders. Self-report instruments that ask the child to assess himself should be viewed with caution. They often do not produce accurate information about the younger school-age child, because he tends to deny problems and frequently can figure out which answers will make him appear "normal." After about age 9, children's self-reports tend to become more accurate (Kazdin & Weisz, 2003). While scales, symptom checklists, and structured interview protocols are helpful, they should not be considered as substitutes for observations and clinical interviews of the child. (For good reviews of the range of assessment scales and structured interviews, see Friedberg, McClure, & Garcia, 2009; and Matson, Andrasik, & Matson, 2008).

Assessment of the child's progress in the following domains helps specify areas of strength and areas requiring intervention.

Developmental Level

Sarnoff (1976) defines psychopathology in the middle years as resulting from "the inability of the child to produce at appropriate times the pliability, calm and educability expected in a latency age child" (p. 186). If we observe this inability, it may mean that the child is failing to master the developmental tasks of middle childhood. Questions about the child's functioning in several developmental domains must be considered. Is she relying on unrealistic fantasies? Are her coping strategies and defenses more like those of a younger child? Does she remain more egocentric than expected? Does she withdraw from peers or show an inability to get along with them? Does she have difficulty regulating impulses? Are there cognitive or language deficits or academic difficulties that are suggestive of learning or language disorders? Since the same symptoms can represent different problems, a careful assessment of the child's history and functioning in multiple environments is necessary.

History of Developmental Interferences

In taking the child's developmental and interactional history, possible developmental interferences—such as exposure to violence, chronic parental fighting, divorce, the loss of family members, abuse, and trauma—should be noted. Very often, the child's inability to proceed with normal development in middle childhood is tied to defenses and coping mechanisms established in response to anxiety-provoking experiences during early childhood. For example, a history of physical or sexual abuse may result in a child's using withdrawal into fantasy and dissociation as preferred defenses. Such children may appear quiet and shy but seem "normal" in that they do not have behavioral problems. However, when they begin school, their reliance on daydreaming and dissociation makes it hard for them to concentrate on learning. As with all emergency-based coping strategies, dissociation helped the child survive the abuse, but if it persists as a defense, it will interfere with developmental tasks in middle childhood.

Reality Orientation

Assessment of orientation to reality helps determine the child's developmental level. Middle childhood is characterized by increasing appreciation of the demands of following rules, doing well in school, and being perceived as similar to one's peers. The school-age child is motivated to succeed and willing to practice to develop skills. It is useful to analyze whether she is giving priority to the demands of external reality (parents, school, peer relationships) or

whether she is drawn toward magical thinking as a defense against feelings of inadequacy or vulnerability in the real world.

Problems That Interfere with Developmental Tasks in Middle Childhood: Language Disorders, Learning Disabilities, and ADHD

In many cultures, including the United States, adequate development during middle childhood is judged by the child's ability to master increasingly complex cognitive tasks. Success in these tasks is measured by the child's school performance. The evaluator of a school-age child needs to be alert for problems that may compromise the child's ability to learn. Three prominent contributors to academic difficulties are language disorders, learning disabilities, and ADHD.

Language Disorders

Language disorders are often diagnosed during the preschool years. Sometimes preschool children with language disorders are referred for evaluation because of behavioral problems, particularly for oppositional behavior, which may be at least partly the result of the child's ongoing frustration at not being able to understand or make herself understood. Language disorders include difficulty articulating words and problems with receptive or expressive language.

When we observe language problems, referral for a speech and language evaluation is necessary. Since hearing impairment is a common cause of language disorders, a hearing test may also be needed. If English is not the first language of the child, the referral request should ask for an assessment of the child's abilities in her first language, in order to distinguish between actual language disorders and problems associated with second-language acquisition (Canino & Spurlock, 2000).

Some children who have less overt language disorders may escape notice until they reach elementary school age. Rather than having an obvious articulation problem, these children may have trouble organizing what they want to say and expressing themselves. Children who have a history of a language disorder during the preschool years often develop reading and writing disorders during the school-age years. In particular, children with problems in receptive language are more likely to have learning disorders in the area of reading. Their difficulties with differentiating speech sounds contribute to problems in "segmenting speech into phonemes" represented by the written alphabet and associating letter symbols with sounds (Lyon, Fletcher, & Barnes, 2003, p. 544). Recent brain imaging studies suggest that reading/writing disorders are an extension of the neurobiological mechanisms underlying expressive and receptive language problems (Pennington, 2009).

Learning Disabilities

Learning disabilities (LDs) tend to become evident when the child reaches school age and begins to have difficulty with specific academic tasks in the early grades. Genetically based neurobiological impairments involving problems with memory, logic, information processing, or visual–spatial organization usually underlie these academic problems (Lyon et al., 2003). However, environmental influence on brain development may also contribute to an LD. For example, "A child without genetic risk factors for dyslexia may end up with RD [reading disability] because the environment does not provide adequate spoken language and preliteracy input" (Pennington, 2009, p. 4). A child may have difficulty taking in information, remembering it, mentally sorting it/organizing it, or expressing it—or some combination of these. LDs represent specific rather than generalized developmental problems, in the sense that a child with an LD may have normal intelligence and function well across most areas of development but have specific cognitive deficits that affect her ability to read, write, do math problems, remember information and instructions, or integrate information. At the level of brain functioning, the sources of LDs are usually complex in the sense that multiple neural circuits and different brain areas are implicated (Johnson, 2005). It is beyond the purpose of this section to describe the whole range of LDs; instead, I illustrate their potential developmental impact and importance in evaluation by briefly discussing dyslexia.

Dyslexia, or "word recognition disability," is the most common LD. The child with dyslexia has difficulty decoding single words and organizing sequences of words. Her reading is slow and laborious. Because she must put so much energy into the cognitive task of decoding, her comprehension ability suffers. Without intervention, this child faces an increasingly difficult struggle, since school tasks assume proficiency in reading. In a general evaluation, a practitioner can ask parents about the child's reading ability and review report cards. Simply asking a child if she likes to read may expose anxiety or negative reactions in a kid with dyslexia. One can ask a child to read a passage appropriate to her grade level aloud and observe for fluency, errors, and level of frustration. If this initial screening suggests a reading disability, the practitioner can refer the child for specialized testing by an educational psychologist. Even when a practitioner is not a specialist in LDs, his or her early identification of a reading problem can make an important difference in a young child's academic development. When dyslexia is diagnosed and effectively treated in the early elementary years, its long-term negative effects can be prevented (Torgesen, 2005).

Assessing LDs in the Context of Culture. In a multicultural society such as the United States, it is important to view the results of testing in the wider context of the child's culture, so that cultural differences are not mistaken for learning or language disorders. Students who speak English

as a second language may not perform well on tests conducted in English. African American children who speak "black English" may be misdiagnosed because their language does not match the "standard English" of the test instruments. In assessing culturally diverse children, it is necessary to look cautiously at the results of tests that have been normed on white middle-class children. If items on cognitive tests reflect real and assumptive worlds that are unfamiliar to the child, the child's actual cognitive abilities may not be elicited, and scores will be lower (Garcia Coll & Magnuson, 1999). Canino and Spurlock (2000) note: "Normal but underachieving culturally diverse students whose language at home differs from that used in school are often overrepresented in programs for the learning disabled" (p. 29). The best antidote to this problem is for the tester to be familiar with the culture of the child being tested so that he or she has a broader context for understanding a child's performance.

Secondary Effects of LDs. In a vivid memoir of her struggle with a LD in mathematics, Abeel (2003) describes her sense of self during a fourth-grade math lesson:

> Inside I sink, flutter, and tighten. I open my eyes wider and try, even though I know it is impossible, to stretch the opening of my ears. I work at not allowing myself to blink, convinced I must have blinked when Mr. Mummert went over a key part of the problem, or my ears must have missed a key phrase that would tie all of this together ... a wave of guilt and embarrassment moves through me. ... I dart a look at the clearly comprehending faces of the rest of the class. I feel so far from everyone, removed, alone in my ignorance. I am terrified there is really something wrong with me. (p. 23)

Children with LDs often become withdrawn or disruptive when they are unable to do academic tasks, and they may get labeled as having behavior problems or depression and be referred for mental health evaluation. If testing shows clear learning or language disorders, specialized educational intervention—special periods with a teacher consultant, tutoring, language therapy, and so on—will be needed. Psychotherapy is obviously not the treatment of choice for academic skills disorders, but it is sometimes needed to help children deal with the emotional fallout of their learning problems.

Attention-Deficit/Hyperactivity Disorder

If a child's problems revolve around hyperactivity, difficulty concentrating, short attention span, tendency to get overstimulated easily, impulsivity, and distractibility, one needs to assess for ADHD. Because ADHD is three to six times more common in boys than girls (Barkley, 2003), I use the masculine pronoun in the following discussion.

ADHD compromises the school-age tasks of learning to maintain calm, sustain attention, and think in organized sequences. A child with ADHD may enthusiastically start an activity or a learning task requiring these qualities, but as his attention wanes, he cannot sustain the task through its various steps. Then off-task behavior, often perceived as disruptive, begins to emerge. Further, he has more difficulty than a normal child in inhibiting responses to stimuli extraneous to learning tasks, and thus is much more often distracted and off-task. His learning often has a hit-or-miss quality, since he may not attend to directions or he may rush through schoolwork. Because kids with ADHD have more difficulty in inhibiting impulses, they often cannot wait for their turn, interrupt when others are talking, talk constantly about what they are thinking, and begin a task before they have finished listening to the directions. They tend not to use internal speech to anticipate the future, plan actions, and think through alternatives. Overall, their capacities for executive functioning and self-monitoring are impaired compared to children without ADHD (Barkley, 2003; Nigg & Nikolas, 2008). All these characteristics make it difficult for them to function well in school.

By the early elementary years, peers begin to avoid or reject the child with ADHD. The reasons for rejection include these children's frequent interpersonal intrusiveness and violation of social boundaries, their unpredictable impulsiveness, their perceived failure to abide by "the rules"—which are so important to school-age children—and their perceived obliviousness to situational and social cues. Over time, the negative responses of others may contribute to a negative sense of self.

To make the ADHD diagnosis, symptoms must be present persistently *across* situations—at home and at school. If a parent reports symptoms of ADHD in a 7-year-old at home, but the teacher reports that the child is able to concentrate and complete work adequately and is not unusually active or fidgety, this criterion is not met, and the clinician should look for other explanations for the child's behavior at home. The following areas of evaluation will help clarify the ADHD diagnosis.

History. Parents will often recall a school-age child with ADHD as *always* having been hyperactive, impulsive, and inattentive. By contrast, the child whose ADHD-like symptoms are based on anxiety or on reactions to stress or trauma may be remembered as developing normally up to the time that ADHD symptoms began to manifest. Obviously, it will not be easy to differentiate between these two types if the child and family have had chronic exposure to severe stressors, such as ongoing domestic and/or community violence, sustained poverty and homelessness, or living in a dangerous neighborhood. School-age children who were chronically traumatized by abuse or neglect during their earliest years may have such poor regulatory capacities that they appear to have ADHD. A retrospective study of trauma history in school-age children diagnosed with ADHD found that 26% had experienced chronic abuse trauma in their early years (Ford et al., 2000). For such

children, PTSD is likely to be a more accurate and useful primary diagnosis (Watts-English et al., 2006).

History taking should also inquire about ADHD in the child's siblings, parents, and other relatives. There is evidence that the neurobiological deficits characterizing ADHD are genetically inherited, and it is not unusual to hear that one of the child's parents or other close relatives had symptoms of ADHD as a child (Barkley, 2003).

Observation. Very often, children with ADHD appear more active, restless, fidgety, and will shift rapidly from one activity to another, even in a one-on-one situation in a practitioner's office. One's subjective impression is that the child is in "overdrive" and doesn't seem able to slow down. Some children with milder ADHD, however, will not appear driven in the first office visit, possibly because the environment is novel and therefore more compelling of their attention, or because being in an office with one person is much less overstimulating for the child than being in a busy classroom. It is often very helpful, and eye-opening, for the practitioner to observe the child in the classroom.

Teachers' Reports. It is very useful to speak with the child's teacher to learn about the details of his classroom behavior. The descriptions of teachers often bring life to the general categories of impulsivity and hyperactivity: "In the space of 5 minutes, he tapped his pencil on the desk, dropped it on the floor three times, got out of his seat three times without—as far as I could tell—intending to go somewhere, and even when he was sitting still, he was kicking the seat of the student in front of him, not maliciously, just out of nervous energy. It almost goes without saying that he wasn't paying attention to the lesson."

Rating Scales. It is also useful to have parents, teachers, and other adults who interact regularly with the child fill out rating scales designed to assess for the symptoms of ADHD. The Conners Third Edition (Conners, 2008) and the ADHD Rating Scale–IV (DuPaul, Power, Anastopoulos, & Reid, 1998) are valuable tools for this aspect of assessment. Initial ratings can serve as baseline data, and parents and teachers can fill out the same scale to help assess the effectiveness of treatment.

Assess for LDs. Either an LD or ADHD can lead to similar symptoms in the school setting. A child with an LD may look like a child with ADHD as he reacts behaviorally to frustration or attempts to avoid academic tasks he is unable to do. But this child may not show the symptoms of ADHD in situations where his learning deficits are not exposed. However, there is a comorbidity rate of 20–30% between ADHD and LDs (Barkley, 2003), which means that some children struggle with both conditions and that their development is doubly at risk. Therefore, if one condition is present, the clinician should consider evaluating for the other.

Treatment for ADHD. If information from these areas of inquiry converges on a diagnosis of ADHD, multimodal treatment combining parent training, classroom intervention, and medication is indicated. The stimulant medications commonly used to treat ADHD are quick-acting and, assuming the dosage is at a therapeutic level, can produce changes in the symptoms of many children within a few days. For approximately 75–90% of accurately diagnosed children, medication can have a dramatic impact on their functioning, especially in terms of removing interferences to learning and changing their relationship with parents (Pennington, 2009). However, these changes do not *automatically* lead to major improvements in academic and social abilities. The child with ADHD has, for years, experienced himself and the world through the lens of ADHD symptoms. Stimulants "do not provide the catch-up learning that many of these children need; nor do they erase the debilitating effects of past experiences on ADHD children's motivation" (Henker & Whalen, 1989, p. 220). Consequently, additional interventions that focus on helping the child learn new cognitive strategies, as well as unlearn habitual responses deriving from ADHD, are needed for the effects of the medication to be maximized. The best results come from interventions combining behavior modification programs at home and at school, catch-up tutoring, and medication (Anastopoulos & Gerrard, 2003). Cognitively oriented play therapy is also often useful to help the child develop skills in self-monitoring, impulse control, and executive functioning (Riviere, 2006).

A Cautionary Note. The prevalence of ADHD in different cultures varies widely, from 3.8% in Holland to 19.8% in the Ukraine (Barkley, 2003; Skounti, Philalithis, & Galanakis, 2007). This variableness suggests that cultural assumptions and values influence the perception of symptoms of the disorder. In the United States, where prevalence is estimated at 3–7% (Pastor & Reuben, 2008), ADHD has become a "popular" diagnosis in recent years with the number of ADHD diagnoses increasing by an average of 3% per year between 1997 and 2006 (Pastor & Reuben, 2008). This popularity is related to increasing public awareness of the disorder as well as to trends in mental health care emphasizing brief treatment in managed care and pharmacological intervention. These trends may resonate with American cultural biases toward a quick and easy solution to problems. The practitioner must be aware that some parents will initiate an evaluation having already made the diagnosis themselves. A number of studies show that teachers are more likely to "diagnose" ADHD than parents (Skounti et al., 2007). Some teachers—especially those who must cope with many disruptive children in their classrooms—may press for an ADHD diagnosis and medication. While it is important to respect parents' and teachers' impressions, the clinician must do his or her own careful evaluation that covers the areas described above before making the diagnosis. Table 12.1 provides a summary of assessment issues for school-age children.

TABLE 12.1. Summary of Assessment Issues for School-Age Children

General considerations

- Assessment should consider how the school-age child functions in a wider range of environments: family, school, peer group, and outside organizations such as sports teams.
- Clinical interviews with the child that combine play, structured tasks such as drawing, and conversation provide a valuable view of the child's perspectives, capacity to relate, and functional abilities.
- The parents' history of the child's development and experiences provides the evaluator with contexts for understanding the child's current functioning and symptoms.
- Family sessions allow the evaluator to directly observe patterns of interaction and possible functions of the child's problems for the family.

What to observe and ask about

- Developmental level across multiple areas of functioning; history of developmental interferences.
- Quality of adjustment in the transition to elementary school.
- Quality of relationships with peers: Does the child have friends with whom she shares interests? Does she feel socially competent in her peer group?
- Reality orientation and interest in skill development: Is the child aware of social and school expectations? Is he motivated to work on developing age-appropriate skills?
- Executive functioning: Does the child show age-expected ability to think about thinking, use reversible thought, and formulate alternate problem-solving strategies based on awareness that a previous solution failed?
- Specific developmental issues that compromise mastery of school-age developmental tasks: language and learning disorders; problems of attention, overactivity, and self-regulation.

Concerns/red flags

- Persistent behavior problems in school.
- Academic problems that may be secondary to learning and language disorders, ADHD, developmental interferences based on stress and trauma history or reactions to current family or environmental stressors.
- Problems that reflect ADHD, trauma history, depression, or intrinsic regulatory deficits: attention/concentration problems, restlessness/hyperactivity, impulsiveness.
- Impulsive, aggressive, oppositional, or defiant behavior toward adults and peers.
- Poor peer relationships: frequent conflicts with peers, bullying or being bullied; social withdrawal; social immaturity; rejection by peers.
- Generalized anxiety, separation anxiety, and persisting insecure attachments, often reflected in school refusal, overdependency on parents, difficulty entering the world of peers, or poor focus on skill development.
- Problems in executive functioning reflected, in older school-age children, in low skills in self-monitoring, flexible thinking, anticipating consequences, and planning ahead.

INTERVENTION

Some of the typical goals of therapy with school-age children are the following:

- To remove emotional barriers that prevent them from feeling competent in work and with peers
- To help them move from action-based modes of expression to modes involving language, thought, and fantasy
- To help them move away from the compensations of magical thinking and toward a more reality-oriented stance
- To help them develop coping strategies that permit them to maintain a capacity to learn

The developmental advances of middle childhood permit a broad array of intervention approaches and techniques, including the following.

Cognitive-Behavioral Interventions

School-age children's new cognitive skills—decentration, perspective taking, logical thinking, improved understanding of cause and effect, and increasing executive functioning—make possible interventions that help them make sense of negative affects or stressful experiences. For example, in sexual abuse treatment a 9-year-old girl can cognitively grasp the accuracy of a statement that differentiates the abuser's motives and behavior from her own: "He is responsible for what he did to you. You did not cause it to happen, and it is not your fault." Further, the school-age child's capacity for decentered thinking can be drawn on to help her differentiate between herself in the abuse situation and her overall self. This opens the way to cognitive interventions that aim to strengthen the child's self-image and separate the abuse from her sense of self (Friedberg & McClure, 2002).

The school-age child often responds well to interventions that emphasize identifying and countering negative emotions and thoughts. In the context of play, the child can be helped to identify "one-way" thinking and feeling and to problem-solve regarding situations that evoke negative feelings. Children who have internalized dysfunctional schemas, such as acting on impulse or giving up in the face of a difficulty, are capable of learning more adaptive responses through the therapist's psychodeucation and modeling (Friedberg et al., 2009).

> Daniel, age 8, had recently been diagnosed with ADHD and put on Ritalin. He continued, however, to become easily overwhelmed with anger and negativity when he could not carry out an age-expected task. These responses represented a carryover of the cumulative effects of ADHD

symptoms on his sense of personal efficacy. Even though medication had improved his ability to sustain attention and complete tasks, he continued to give up easily when frustrated. In a treatment aimed at helping Daniel catch up on cognitive skills that were underdeveloped because of ADHD, increase his problem-solving abilities, and enhance self-esteem, I constantly looked for opportunities to work on these goals.

Daniel expressed interest in playing UNO, and I encouraged this because it was a way to practice skills such as thinking ahead and organizing his strategies. He was a fairly competent player, but sometimes he quit in the middle, saying that he didn't like this game, that it was too hard. Yet he kept wanting to play. I began to notice that he became frustrated when he had a lot of cards in his hand. Since the object of UNO is to win by discarding all your cards, I first thought that he was complaining because he was afraid of losing. But then I noticed that he was having trouble *physically* holding the cards—he couldn't fan them out if he had a lot; sometimes he'd drop one or two and look at me anxiously to see if I'd seen what they were. I put this into words, saying, "It's really hard to pay attention to the game when you're worried about not being able to see all your cards or dropping them. It is so frustrating, and I think you feel like just quitting—am I right about that?" Daniel seemed relieved that I had identified his struggle and nodded. I made this statement at a point when he seemed frustrated, based on the dictum that the most effective cognitive interventions occur when the client is experiencing negative emotions (Friedberg & Gorman, 2007). Then I suggested an alternative solution to a problem he was stuck on: "I think it would be easier to play if you put your cards face up on the table, and we put something between, so I can't see your cards." Daniel liked this idea and enthusiastically built a wall of blocks across the table between us. He named it the "card wall." He put some cards face up on his side and asked if I could see them. I said that I couldn't and invited him to come around to my side of the table to check. He was pleased and our game resumed. I complimented him on his idea to build a wall with the blocks. For several sessions he began by building a card wall. And, in fact, without the distraction of worrying about keeping his cards in order or dropping them, he played more skillfully and became more confident in his abilities. I had suggested a solution, but more importantly, Daniel had learned experientially by building and using the card wall that he was capable of problem solving and overcoming feelings of helplessness.

The older school-age child's ability to analyze cause-and-effect sequences and use reversible thought also implies that he can sometimes understand the connections between thoughts and impulses and behavior, and can realize that a feeling may have caused him to act, as demonstrated in the following case example:

> Mark, a 10-year-old with many fears and inadequate defenses and coping skills, was provoking fights at school. His foster mother called me before [illegible] and told me that he had been sent to the office for fighting the

> preceding day. I asked Mark what had happened, and he said, "Two guys jumped on me. They held me down and punched me." I began working backward, asking him how the fight got started. He said, "They told me 2 weeks ago that they were going to get me. So I saw them out in front waiting for the bus, and I knew they were waiting for me." I asked if they'd said anything to him, and he said, "No, maybe they didn't see me." When I said I was still not sure how the fight started, he said, "Well, I kicked one of them in the stomach." My approach was to go over this situation in detail, clarifying that his provocative aggression was based on his fear of being beaten up. This fear made him attack even though he hadn't been attacked. Because he was afraid, he had put himself into the exact situation he feared. I expressed my concern that he'd put himself into a dangerous situation when he didn't need to do so. I said, "I don't like you to get hurt, and it makes me feel bad for you when you do something that makes other people want to hurt you." We also discussed alternative ways of responding. I asked, "What else could you do if you're worried about those guys?" We explored several possibilities: Stay away from those kids; tell the teacher; stick with your friends so you feel safer; stay back until the bus comes, get on after they do, and don't sit by them. I also tried to help him appraise the severity of the threat in retrospect: "It's good to be careful and be ready to do something if they really do come after you, but if they threatened you 2 weeks ago and still hadn't done anything by yesterday, maybe they were just talking big." In subsequent sessions, I helped Mark identify situations with peers that tended to trigger his anxiety, and continued to examine more adaptive ways of responding. Using role plays, we practiced ways he could stand up for himself without attacking other children.

This cognitive approach models thinking through fears and gaining some control over them through the use of reasoning. It also asks the child to think before he acts, to consider alternative ways of responding, and to evaluate what happened (Kazdin, 2003). Although treatment focusing on the cognitive skills draws on the developing executive function in middle childhood, it does not require autonomous self-reflection or insight, abilities that are still beyond those of the school-age child. The therapist functions as a teacher or "auxiliary ego," helping the child utilize reasoning abilities and making suggestions of more adaptive ways to deal with anxiety (Chethik, 2000). The cognitive approach aims to facilitate development by calling attention to and exercising the school-age child's new ability to think things through. The therapist helps the child practice age-appropriate cognitive skills whose development has been impeded by maturational delays or by reliance on appraisal styles and coping mechanisms formed by early experiences of trauma or neglect (Friedberg et al., 2009).

School-age children can be engaged in behavioral treatment more easily than younger children. The school-age child's understanding of cause and effect enables him to conceptualize how rewards can be contingent on appropriate behavior. This understanding enables him to see the possible benefits of

controlling defiant or aggressive behavior (Barkley, 1997). In behavior management programs involving token economies, the child's participation can be enlisted because he sees that he will be rewarded for changing his behavior. His firm knowledge of time supports his motivation because he can understand, for example, that if he does his homework without protest four out of five school nights, he will earn a reward on the weekend. Such programs depend on the child's developing cognitive skills, including thinking logically, using cognitive strategies to control behavior, and self-monitoring. Further the child's active and externalizing orientation in middle childhood is likely to make him interested in a treatment program that emphasizes control over behavior rather than understanding of feelings.

Group Treatment

Group intervention is particularly appropriate for school-age children because of their compelling interest in peer relationships. School-age children think groups are "normal," in the sense that they spend a lot of time in groups at school. Groups can be helpful for children who have similar issues, such as difficulties in social skills, or similar experiences, such as parental divorce or incarceration of a parent. School-age groups have the potential to help children cope with internal difficulties and at the same time to increase their skills in relating to peers. In the middle years children are particularly motivated to be accepted and validated by peers. Group experience can be powerfully affirming at this age, especially for children who face difficult or stigmatizing experiences, such as chronic illness, peer problems because of poor social skills, parental substance abuse, or the death of a family member (Botta, 2009; Webb, 2003). Most children's groups are focused around scripts and structured tasks—which, from the child's perspective, makes them seem similar to familiar classroom activities. Dealing with issues in a group has several advantages that derive from the developmental characteristics of middle childhood (Kalter, 1998; Ludlow & Williams, 2006):

- Children get support from one another. Especially when groups are composed of children at about the same level of development, they can identify with one another.
- The group provides "safety in numbers." Children do not feel singled out or stigmatized, as they often do initially in individual or family treatment.
- Being with peers who have similar situations or symptoms reduces conscience-driven anxiety about self-revelation.
- By becoming aware of other children's experiences, the individual child's experience is normalized.
- By observing how other group members have coped with or solved problems, children can expand their own range of coping devices.

Individual Play Therapy

Individual treatment that combines play, structured activities, and talk is an effective approach in middle childhood. However, practitioners beginning to work with school-age children often feel that the child is "resistant" or "lacks insight" or "doesn't seem to know he has problems." Such observations are largely accurate, and, from a developmental perspective, they are normative. School-age children usually do not talk about their problems in a sustained way. In individual treatment, many children actively avoid talking about worries, painful experiences, and problems. This is consistent with the following characteristics of middle childhood:

- *External orientation.* School-age children are more oriented to the outer world than to their internal consciousness, and they tend more toward doing than toward feeling.
- *Defenses.* Their defense mechanisms are more adequate to prevent painful, forbidden, or anxious thoughts from coming into consciousness; they are also more adept at conscious suppression.
- *Conscience.* School-age children tend to resist talking about symptoms and problems—such as getting into fights, disrupting class, or defying a parent—because they are associated in their mind with being bad. Because the conscience is now internalized, badness is felt inside. Consequently, the child resists talking about problems in order to avoid feeling guilty.
- *Social awareness.* School-age children are very aware of what is appropriate socially and highly invested in being like everyone else—in being "normal." They often worry that their friends will find out that they are in therapy. To have a problem is to feel abnormal, defective, or crazy.

> One day, while waiting for an 8-year-old boy to come for his first appointment, I looked out of my office window and saw his mother pulling him bodily out of the car. He was crying and resisting. He had gotten himself together by the time they got into my office, I think because he didn't want to embarrass himself by crying. Partway through the hour, we were playing with puppets. He hid behind a chair and stuck his puppet up and said, "I'm not crazy." This gave me a chance to address his fear. I said, "Sometimes kids think that I'll prove they're crazy, but that's a mistake—that's not why kids come to see me. They come because they have some worries, and I know how to help with worries."

Displacement

The school-age child tries to avoid difficult feelings and worries through conscious suppression, unconscious defenses, or displacement of personal experiences and inner concerns into play and fantasy. A child's "fictional" story about the content of a drawing or play scenario allows her to express worries

or represent difficult experiences. Yet, displacement into play provides psychic protection for the child, allowing forbidden impulses, strong feelings, and conflicts to be looked at and experienced as if disconnected from the self. Children can unconsciously use the displacement of symbolic play and action to describe their emotional dilemmas. When we enter the child's fantasy world through the medium of play or other displacement activities such as drawing, storytelling, or therapeutic games, we can learn about the child's inner experience of his difficulties without requiring the child to talk directly about them. The practitioner must also learn to respond to the play and fantasy with displaced interpretations, so that the child's defenses are not challenged too strongly. An example of a displaced interpretation would be to speak in universal terms about "how girls feel" instead of "how you feel"; or to talk about "another boy I knew who had some worries" and then tailor the story to fit the child's problems. In many cases the eventual goal is to make connections between the play and the child's actual problems, including talking directly about the problems, helping the child understand how they began, and exploring more adaptive ways of coping with them.

This chapter presents two examples to illustrate the use of displacement and other developmentally relevant approaches in work with school-age children. The first case presents a 7-year-old whose early history of chronic trauma threatened to interfere with the transition to middle childhood. The second demonstrates the ability of a child with previous adequate development to use the cognitive skills of middle childhood in coping with family stressors during two periods of treatment at 8 and 11 years of age.

WORKING TO MASTER THE TRAUMA OF REPEATED ABUSE: A CASE EXAMPLE

Michael was a 7-year-old boy in foster care who presented with manifest sadness, statements that he wished he was dead, and aggression and sexual behavior toward his younger biological sister, who lived in the same foster home. He was working at grade level in school and did not show behavior problems there. He was in an excellent foster care placement and had made a strong attachment to his foster mother.

Michael's early experience up to age 4 was chaotic. His father was physically and sexually abusive to him and his two sisters. He took nude pictures of them and prostituted his older sister, which Michael sometimes witnessed. The children also witnessed frequent violence between their mother and father. Both parents abused alcohol and cocaine. The children often were left alone while the parents were away at bars or procuring drugs. All three children were removed for neglect and abuse when Michael was 4. They were returned to their mother after 6 months in foster care, but were removed again 4 months later when it was discovered that the father was living with the family and continuing to abuse the children. Michael's older sister was assessed as severely disturbed secondary to trauma and was placed in a residential setting. Michael and his younger sister returned to the same foster home and were eventually adopted by that family after parental rights were terminated.

A sexual abuse treatment agency referred Michael to the clinic where I was on staff because he was showing symptoms of depression and had threatened to hurt himself. Michael had been in sexual abuse treatment for 1 year. During this treatment, Michael had described a number of incidents of sexual abuse, primarily involving fondling of his genitals by his father. He revealed that his mother did nothing to protect him. Treatment had focused on psychoeducation regarding sexual abuse. Michael was told that his father's behavior was wrong and that no adult had the right to sexually abuse a child. Additionally, the therapist worked with his foster parents to structure the home environment so that Michael and his sister would not be able to act sexually toward each other. The therapist and foster parents repeatedly defined appropriate boundaries and behavior for Michael and his sister.

This intervention had been very helpful to Michael. However, as he gained some control over impulses to act out sexually and aggressively, he became more anxious and depressed. The switch in emphasis from behavioral to emotional symptoms was an effect of intervention as well as development. He had been helped to remember and describe in words a number of traumatic experiences of sexual abuse, at a time when increasing cognitive capacities permitted better verbal encoding of memories. He had gained a perspective that emphasized the wrongness of the abuse and the responsibility of the perpetrators of abuse, at a time when internalization of moral values was proceeding. He had been helped to limit his sexualized behavior, at a time when the ability to exert self-control becomes an important component of the conscience and the sense of self.

Formulation of Presenting Symptoms

From a psychodynamic point of view, Michael had begun to rely less on "acting out" as a defense against anxiety. Acting out serves the defensive function of relieving unconscious tension through action. Acting out is very common response to trauma-based anxiety and environmental reminders of traumatic events. Michael's sexual abuse treatment had helped him gain some control over tendencies to act out. At the time of referral to me, his foster mother noted a significant decline in sexualized behavior. However, it appeared that chronic trauma in his experience had not been fully addressed. Consequently, even though Michael relied less on acting out as a means of discharging trauma-based anxiety, the anxiety remained internalized as depressive symptoms. Trauma is a risk factor in the development of depression (Pynoos et al., 1996). When the affective and cognitive symptoms of trauma persist, the child may become increasingly distressed and depressed because of his inability to control the symptoms.

I hypothesized that for Michael the restriction of acting out as a means of

discharge intensified the internalization of emotional symptoms, resulting in increased anxiety and depression.

Approaches to the Treatment of Trauma in Middle Childhood

My approach to Michael's treatment was to see if he could use the emerging developmental abilities of middle childhood to reduce his depression, increase self-control, and master the traumas of his early years by creating a *trauma story* that would contain and reduce the affective power of the traumatic memories. Traumatized children—especially when the trauma is abuse by caregivers—often have not been helped by adults to process the experience verbally when it occurred (Fivush, 1998). In working with traumatized children, we try to help them develop representational competence retrospectively. The experience of trauma overpowers coping capacities, supplanting thinking and words with raw and overwhelming affect. The sense of personal continuity and narrative memory are also severely disrupted, so that the child's representation of traumatic events is imagistic and distorted rather than an organized narrative. This is particularly likely, as was true for Michael, when trauma has been chronic. Even when children do have clear memories of traumatic events, the fearful arousal associated with the traumatic memory causes them to suppress or avoid the memory, often through acting-out behavior.

Helping clients put their story into words is a well-accepted principle in the treatment of traumatized adults. This principle holds for children too. We want to help traumatized children (1) develop an understanding of what happened; (2) create a narrative of the traumatic events that is coherent and as accurate as possible; (3) name the affects that accompanied the trauma; (4) label the traumatic events as *past* rather than current events, so that the trauma is regarded as an incident, or series of incidents, in the narrative of the child's past life, not a fearful lens for viewing the world; (5) process the trauma from their current, more advanced cognitive perspective, taking advantage of the fact that representational competence improves as cognitive development proceeds (this is particularly important for the child who was very young at the time of the trauma); and (6) think through more adaptive ways of coping with stress, to supplant maladaptive coping based on hyperarousal or numbing (Cohen, Mannarino, & Deblinger, 2006; Davies, 2008).

To reach these goals with school-age children, the therapist must utilize their primary representational modes, including play, reenactment, and other types of symbolic expression. Very often, the play of traumatized children is disorganized and lacking in narrative, simply repeating, over and over, an image of the traumatic events. It becomes the therapist's job to help the child structure this seemingly chaotic play into a narrative that clarifies what happened, establishes sequences of cause and effect, and describes the child's affective reactions (Gil, 2006). Michael's case presents the process of helping a young school-age child move from play expression of concerns about trauma to describing traumatic events in words and creating a verbal narrative. I do not present the entire case narrative but rather use sessions from the early months of treatment to illustrate the use of displacement techniques in the creation of a trauma story.

Posttraumatic Play in Michael's Early Sessions

In order to learn how Michael was remembering and constructing his traumatic experiences during the first 4 years of his life, I took a less directive approach than that taken by the therapist at the sexual abuse treatment agency. I encouraged Michael to play and hoped that by observing his play, I would begin to learn how his traumatic experiences continued to influence his affects and view of the world. During the early sessions, Michael played while I watched. His play had many of the characteristics of posttraumatic play: It was driven, repetitive, and restricted in content. As he played with dinosaurs, the biting, roaring, and killing were unremitting in an amoral universe where everyone fought everyone else and there was no protection for anyone. These chaotic enactments seemed to reflect a world without order, imagery that is common in children who have spent their early years in families dominated by substance abuse.

Michael's play symbolically demonstrated how adaptations to trauma can interfere with emerging developmental tasks. In early middle childhood, children implicitly learn that there is a social order that sets standards for behavior and a "social contract" that provides rewards for appropriate behavior. When a child has suffered gross violations of the social contract, as Michael had when his parents abused him, he experiences "a disruption of a belief in a socially modulated world" (Pynoos et al., 1996, p. 340). Michael's pessimism about this issue was reflected in his early play in treatment. There was no evident order in the play world he created, only repetitious violence. This play also reflected the difficulties Michael faced in creating a coherent narrative, an accomplishment that preschool children practice and school-age children achieve. As is typical of posttraumatic play, there was no developing story in Michael's play, but rather a single repetitive scenario involving a violent "bad guy" who never died.

Creating a Safe Therapeutic Environment

Unlike many children his age, Michael did not invite me to join the play. This was consistent with the self-reliant and mistrustful attitude he had developed in response to betrayal and abuse by his parents. A few times during the first few sessions I asked Michael to tell me about the dinosaurs—what made them so angry, why they were fighting each other. In response to these mild questions, Michael looked startled. This response told me that he might be experiencing my questions as intrusive and perhaps my simply noticing what he was doing made him anxious. Abused children frequently adopt a watchful, unobtrusive style, remaining quiet and self-contained in order to keep the

abuser's attention away from them. It appeared that Michael was generalizing this style: He had adapted to the abusive situation by becoming hypervigilant and by overregulating affects. His need to feel in control, both of his environment and his feelings, had to be respected. In response, I tried to be friendly but undemanding. I realized that I would need to pace my interventions carefully and respond first to Michael's strengths before beginning to address his anxiety (Pearce & Pezzot-Pearce, 2006).

During these sessions Michael also spent time drawing, and his drawings showed artistic talent. In contrast to his reactions to my questions about his play, he was at ease talking about the content of his drawings. Discussion of his artwork seemed a safe vehicle for building our relationship. His early drawings were about more neutral subjects than his play. He drew planet Earth with green land masses and blue oceans, then he drew other planets. Over the first month of treatment, a routine developed in which Michael would begin the session by drawing several pictures, then play chaotically with dinosaurs or action figures. I suggested another element to this routine—a return to drawing at the end of the session. I did this because I wanted Michael to experience a sense of structure and control in our sessions. I did not want him to associate his therapy primarily with the posttraumatic play that heightened his anxiety, and I did not want him to leave sessions filled with anxiety. Traumatized children who are not helped to seal off traumatic material during a session are more likely to act out after the session. They may learn to view therapy as a time when they are flooded with affective arousal and resist coming to sessions.

Michael's Drawings: Identifying Developmental Strengths

In assessing any child, it is important to identify areas of strength and developmental adequacy. When Michael drew and talked about his drawings, he demonstrated many of the normal characteristics of a younger school-age child. He was calm and thoughtful. He would take a moment to look at what he had drawn, then comment on it. For example, after he had drawn the head of a bird, he pointed to the eye, which he had drawn as an outer circle of black, an inner area of yellow, and a black dot in the middle, and said, "That's the way a bird's eye looks." Then he said, "I couldn't get the beak right." Drawing seemed to symbolize the forces of progressive development in Michael, in contrast to his compulsive play, which symbolized an internal preoccupation with trauma. Drawing was a more neutral activity that was completely under his control. Consequently, he had more ability to defend against anxiety and posttraumatic reminders while drawing. His drawings covered many different subjects that interested him and reflected some of the cognitive abilities and interests of school-age children. He applied internal standards of accuracy to his work, as when he commented that he had not gotten the bird's beak right. He explained the content of his drawings in a coherent way and implicitly used them to create a sense of organization to his world. For example, he drew a careful picture of his room at home, showing the placement of his bed, chest of drawers, the location of the door and windows, and many other details. When we attempt to understand the meaning of children's drawings, it is essential to ask them to explain the drawing, as opposed to assuming that we understand its meaning by looking at it. Often a child's verbal account clarifies concerns that are not obvious or are only hinted at in the picture (Malchiodi, 1998). My asking about the picture of his bedroom led Michael to tell me that he didn't like to sleep in his room by himself and that he was glad his foster brother shared the room with him. I asked him what he was afraid of, and he was evasive. Nevertheless, drawing opened the way to his first words about the anxiety that was registered nonverbally in his play.

Drawing as a Displacement of Posttraumatic Anxiety

Another picture allowed us to expand the discussion of Michael's fears a bit. He drew an ocean scene. First, he drew a boy on a surfboard. Then, as he drew the line of the water across the page, a huge wave threatened to engulf the surfer. Near the wave, Michael drew a large shark's fin sticking above the water. Before completing the picture, Michael made a revision. He changed the boy into a heavily armored dinosaur. This change seemed a response to the dangers in the picture: He had given the boy on the surfboard some protection, perhaps making him invulnerable. In response to my questions, Michael explained that the dinosaur was not in danger from the wave because he could jump right over it, and that the sharks would not be able to hurt the dinosaur. It is helpful to watch the process of the drawing carefully—to note what a child draws first, emphasizes, does quickly and without care, what he erases, what he revises. When I asked Michael if he had changed the picture before finishing it, he laughed and agreed. I asked why he had decided to change it. He pointed to the big wave and said, "At first this was going to be just plain water, and he was going to be a person. And then the fish was going to bite him." Connecting the themes of danger and need for protection, I said, "So, maybe it was looking like this person could get hurt out here by the sharks or the wave, but if you turn him into a dinosaur, he can keep himself safe because he's so strong and protected by his armor." In this drawing, he was able to peek at his feelings of vulnerability and then compensate for them. This picture suggested Michael's strong motivation to master his fears, which could more easily be expressed because of his complete control of what he drew.

Displaced Interpretations of Posttraumatic Play

After Michael began to feel comfortable talking about fearful themes in his pictures, it became possible for him to tolerate some commentary on his play. During the second month of treatment, he brought a collection of plastic action figures that included superheroes and villains from cartoon shows as well as the Teenage Mutant Ninja Turtles. I was pleased because I felt that

his decision to bring these toys from home reflected his growing investment in our relationship. First we looked over the figures together. Then Michael launched into his usual play, with figures killing each other. After watching for several minutes, I noticed that one superhero figure was defeating all challengers. I asked who he was, and Michael said, "He's a bad guy." This figure was eaten by sharks and blown up by bombs, yet he continued to defeat the other figures. I said, "It seems like this bad guy can't be stopped or killed. He keeps coming back." The play continued with this theme, and I realized it was a clear metaphor for the situation of the abused child. A few minutes later I told Michael I wanted to tell him a story that his play made me think of: "Sometimes if a kid has had bad things done to him by a grown-up and it keeps happening over and over again, the kid feels like the bad guy keeps coming back. Even when the kid is taken away from the person who was hurting him and begins to live with a family that takes care of him, sometimes a kid can still worry about getting hurt, even though he's safe now." Michael's response was to tell me a story about a kid he knew who had "a bad guy coming back." He said, "Now the bad guy doesn't know where he lives. I think his name was Michael."

Since his story mirrored mine, I decided to expand it. I told him that I had known a kid whose dad had hit him and touched his privates. His dad should not have done those things. But since the kid was living with his dad, he couldn't get away, so he always felt like his dad was like a bad guy who would always come back. Even when he was safe with a new family, he remembered the bad things his dad had done and felt scared. Although I was speaking in displacement about "another kid," I was tailoring my story to match the themes of Michael's play representing repeated physical abuse. After this story, Michael's play changed. The bad guy figure was punished for his misdeeds: He was forced to swallow bombs, which blew up inside him, and then a Ninja Turtle figure killed him. Although the play was still violent, it had changed from hopeless posttraumatic play, in which the bad guy dominated, to the defeat of the bad guy. The triumph of a good guy—a Ninja Turtle who might be considered a self-representation—suggested that Michael could imagine a different outcome to the experience of being abused.

This theme continued in the next session, when for the first time he divided the dinosaurs into good guy and bad guy teams and then had the good guys repeatedly defeat the bad guys. There was more order in this play. The good and bad dinosaurs faced each other individually. After each fight, two more dinosaurs were brought forward. Compared with the chaotic play during the first few months of treatment, this play resembled a game with rituals and rules, and thus was more typical of a younger school-age boy's play. I asked Michael to take a break from play and told him a story about a kid who had played in a similar way. I said, "This kid always beat on the bad guys, and we figured out that he played that way because he was mad at someone who had hurt him. He wanted to punish that person, and his play was a way of imagining that." I told Michael that the therapist at the previous agency had told me

that his father had hurt him. Michael agreed. I asked him to tell me about it, and he recounted some instances of his father's sexual abuse. He made clear that he had hated what had happened to him and that he thought his father had been wrong. Since Michael was able to talk about being sexually abused, I asked him to tell me other things that happened when he lived with his mom and dad. My aim was to expand the scope of our discussion in order to help develop a trauma story that would include more than sexual abuse.

Expanding the Trauma Story

Sexually abused children in the child welfare system are far more likely to be referred for mental health treatment than physically abused or neglected children. The alarm sexual abuse understandably creates may lead professionals to make it the primary focus, even when other forms of maltreatment have also been documented (Burns et al., 2004; Chaffin, 2006). In result, treatment may be too narrow in scope. Sexually abused children often have been traumatized in other ways. It is important to observe for other traumatic events, even though the prioritized problem is sexual abuse. Effective treatment gives the child a chance to fully represent his difficult experiences. Michael's representation of traumatic early history did not focus on sexual abuse, even though he was able, perhaps because of his previous sexual abuse treatment, to talk about it. Rather, Michael described many instances of his father's violent behavior. He had witnessed his father beat his mother and sisters many times. He said, "My dad chased my mom with a knife. One time he threw a glass at her and it broke on the wall." I asked how he had felt at these times. He said, "Sad. Scared, too. I was afraid my mom would get killed. Sometimes he would bust down the door."

I asked if he still worried about getting hurt by his dad now, even though he was safe living with his foster family. He said that he wasn't worried because his dad didn't know where he lived. However, he indicated that he *was* afraid by immediately telling about a dream in which a man broke into his house, chased him, found him in every place he hid, and finally shot him. I said, "That was a very scary dream. It reminds me of how kids feel when grown-ups are doing bad things to them. The grown-ups are so strong, that the kid can't really stop them, so all he can do is try to hide. But that's the reason you're not living with your dad anymore—because he did all those mean things." Michael agreed and then talked about times his father had slapped his face and spanked him with a belt. I empathized with his fear and said that his father was wrong to have hurt him, his sisters, and his mom. When I asked if he continued to worry about being hurt by his dad, Michael said that if his dad came to school, he would run away or climb to the top of a high pine tree. Michael was imagining how he could protect himself. However, in his fantasy, as in his subjective experience of the abuse episodes, he faced his father alone. To counter this posttraumatic representation, I suggested that he could ask adults to help him. My aim was to help Michael see, from the perspective of

his more advanced developmental level, that he had more resources to deal with trauma than he'd had as a young child.

At the end of this session, I said, "I'm really glad you could tell me about all this. Now I know what it was like for you. Now you're probably feeling a lot safer. I would like to keep talking about what you remember." My impression was that Michael gained some relief by talking about these memories of his father's violence and his fears. The emphasis of Michael's trauma story changed. Although his sexual abuse experiences had probably been traumatic, the more profound sources of his posttraumatic stress were his memories of being physically abused and witnessing his father's violence. He had been presenting his anxiety about violence and damage in his play since the very first session. As we continued to piece together his story over many sessions, I constantly tried to help him integrate his memories with the affects he had experienced. I made frequent comparisons between his past and present experiences, aiming to help him differentiate his fears from his present reality of living in a caring and protective family. In this work I was repeatedly aided by Michael's emerging developmental capacities to understand cause and effect, to take a decentered view of past events, and to think in more logical and organized ways about his experience.

USING DEVELOPMENTAL STRENGTHS: A CASE EXAMPLE

Stacey, age 8, was referred to me by her mother, Ms. Kline, a few weeks after she had decided to separate from Stacey's stepfather. Ms. Kline and her husband had been married for 2 years. Stacey's biological father had died in an auto accident when she was only 3 months old. Ms. Kline had raised Stacey and her older sister as a single parent until she married, when Stacey was 6 years old. Ms. Kline reported that Stacey had developed an affectionate relationship with her stepfather, Bill, and that she seemed depressed. Ms. Kline said that Stacey and her sister had felt betrayed when they overheard their stepfather angrily say he was glad to be leaving the family. She was worried about the impact of Bill's angry statement, even though she had told the girls that the divorce was not their fault. Over the next month, Stacey frequently called him, but he often did not respond to her messages. Within 4 months he had moved to another state and contacted her even less often.

Stacey demonstrated many of the qualities we expect in a school-age child who is developing adequately. She was thoughtful, calm, articulate, and self-possessed. She immediately showed a capacity to use displacement to represent her concerns, which seemed to center on anger about the divorce and feelings of abandonment. She drew two pictures: One was of an angry man whose head appeared to be exploding; the other was an idealized image of her family, including her stepfather, having a good time on the roller coaster at an amusement park. These pictures conveyed the reality of an angry divorce, followed by a denial in fantasy that expressed her wish that the family would

be reunited and happy again. The choice of a roller coaster may also have expressed Stacey's anxious sense of the precariousness of her parents' relationship. Her work on these drawings was careful, demonstrating the motivation to do a good job that is typical of well-developing 8-year-olds. She was calm as she drew and as she explained the pictures, suggesting that she was expressing conflicted issues without consciously relating them directly to herself. This was a sign of adequate development in the area of self-regulation (Sarnoff, 1987). Although the picture of the angry man surely represented her stepfather and perhaps her own anger about the divorce, she simply explained, "This is a guy who's blowing his top." When I asked what had made him mad, she said, "Who knows?"

When I asked Stacey about the arguments her mother and stepfather were having, she looked very somber and explained calmly, "They're getting a divorce." When I suggested that many kids were upset about parents fighting and deciding to divorce, she denied being upset but admitted that her sister was. When I suggested that her second picture showed a time when her family was happier and that now she and her sister might be sad, she ignored this comment and told me a story that she said she'd read in a book: "A prince wasn't getting along with his wife, so he ran away. A wizard turned him into a frog and put him in a pond, and his wife was in the pond and she was a frog too, so they got back together." I said that maybe she wished her mother and stepfather would get back together, and she responded in a rational tone, "My mom told me they're not," essentially stating the facts while avoiding acknowledgment of the reunion fantasy in her story.

Stacey showed the school-age child's ability to repress and compartmentalize painful affects. She was much more disturbed by the loss of her stepfather and her sense of an intact family than she let on. Her defenses and capacities for conscious suppression and self-distraction kept her sad and angry feelings at a distance. Her mother had explained the reasons for the divorce to her, and Stacey had a good cognitive understanding that her parents had been arguing frequently for over a year. At age 8, she did not seem to blame herself for the divorce, as egocentric preschool children tend to do. Her ability to observe the conflict from a relatively decentered perspective lessened fantasies of self-blame. Because of her strong identification with her mother, she did not, at least immediately after the separation, struggle with questions about which parent to be loyal to, which is a very common reaction of younger school-age children (Kelly, 2000). Stacey's primary reactions to the divorce focused first on an overall sense of deprivation and disruption and then increasingly on her anger and confusion regarding her sense of being betrayed by her stepfather. These became the main themes of a therapy lasting 6 months.

Displacement Activities in Intervention

During the first month of therapy, which coincided with her exposure to several arguments between her mother and stepfather over the division of prop-

erty, Stacey produced a "book" of drawings to which she added each week. The pictures symbolized Stacey's primary concerns about her parents' divorce. The first several pages showed sharks swimming in the ocean foraging for food. I commented that the sharks looked upset and possibly angry. Stacey said that they were very angry because there was not enough food. I offered a displaced interpretation, suggesting that when parents divorce and are fighting about who gets the house and furniture and money, kids sometimes worry that they won't have a place to live or money to buy food. In a subsequent session, a picture showed people living in houses near the ocean. Some of the people foolishly swam in the ocean and were attacked by the hungry sharks. In a later picture, the houses turned out to be sitting on earthquake faults and were destroyed. These images condensed Stacey's feelings of anger, deprivation, and fear. Even though she was consistently calm as she drew, the content of the pictures showed her internal sense that a disaster had befallen her and her family. In a parent session with Ms. Kline, I asked her to assure the children that she would be able to support them however the property settlement turned out. In a family session Ms. Kline empathized with their distress, saying that she was able to take care of them and that the conflicts she and her husband were having would diminish as the divorce was settled. I also attempted to discuss these issues with Stacey's stepfather, but he was unwilling to talk with me.

After her mother and I put her feelings of anger and disruption into words, Stacey stopped drawing, and we began to play Connect Four, a paper-and-pencil game that involves joining lines to form squares. We also played cards. In these games, she controlled everything. She shuffled the cards, dealt them, and acted as the authority on the rules. She was a good player who frequently beat me because of her skill; however, if she began to lose, she would look me in the eye with a defiant smile and openly cheat. I commented that she wanted to be in control, even to the point of cheating. She laughed and agreed. I asked if she would cheat if she were playing with a friend. She looked surprised and said, "No way." I had expected this answer, because it appeared that Stacey's game play in therapy had some special functions and that it was not subject to the same standards of fairness that would be used in play with a peer. This type of play continued over several sessions, with Stacey keeping running score sheets of her victories. I understood Stacey's pleasure in controlling the games as a reversal of her recent real experiences. I told her, "When I can't do anything to win, it reminds me of how kids feel when something happens that they can't stop from happening. Like if their parents decide to get a divorce. Maybe the kids don't want that to happen, but they can't stop the grown-ups from doing it. Or, like what's happened to you with your stepdad—I think you'd like to see him more, but he's so wrapped up in his own worries that he doesn't call you. I've known other kids this has happened to, and it made them really angry and sad." Stacey listened carefully and said, "I don't care that much." At this point she was unable to tolerate sad feelings. However, my comment about her stepfather's inconsistent behavior seemed to give permission for Stacey to express angry feelings more directly.

Displacement Play and Transference

School-age children often use competitive games in therapy to express strong emotions and transferences in activity that is displaced from the real situation of conflict. Just as the game is used as a safe vehicle for expressing negative feelings, the adult opponent in the game, the therapist, becomes a stand-in for significant adults. Since the context is "play," the child can displace toward the therapist feelings and impulses that she might be too anxious to express directly toward parents. Stacey was very angry at her stepfather, and she felt frustrated by her inability to control when she could see him. These feelings were presented in our games through making fun of my inability to win and her insistence on controlling the game. At the same time, she was friendly toward me and looked forward to our sessions.

Therapy created for Stacey both a safe place to express anger and disappointment and a consistent relationship that symbolically took the place of her damaged relationship with her stepfather. These themes came through clearly in a note she wrote after a game:

> Stacey RULES at Connect Four against Douglas Davies! Cause he isn't too good! But don't tell him I said that. I think he would get mad, knowing his temper.
> Love, Stacey

Stacey's note simultaneously put me down and expressed affection for me. A few weeks later she expressed her love and anger toward her stepfather in transference to me even more directly when she made me a Christmas card. She spent 10 minutes carefully coloring it. On the front she had written, "Merry Christmas. Love, Stacey. Please turn over." On the other side she had written, "You are so stupid!" She laughed uproariously when I turned it over. I laughed with her and said she had played a good trick. I said I was reminded of how kids do not like to be tricked by grown-ups and sometimes want to pay them back. I said, "I think you have felt tricked by Bill. When he and your mom were together, he was nice to you and had fun doing things with you. Now he almost never sees you. I think that's felt like a terrible trick."

Working Through Reactions to Parental Divorce

In the next session Stacey returned to her book of drawings. This time she drew a family living in a house that was in a safe place. The family—a mother and two daughters—seemed to represent her family in its new configuration, without a father. She said, "Before they were in a spot where an earthquake shook down their house, but this time they read about earthquakes in *National Geographic* and found a place where there weren't any quakes. Also,

they built a better house." I asked if they were still near the ocean with the sharks. She said, "Yeah, but they don't swim in the ocean now. They're smart now. They learned not to swim there because the dad did, and he was eaten by sharks." I said, "The dad?" In response she quickly undid the implied aggression toward her stepfather by saying, "Really, it was a very old man who had a heart attack in the water, and they ate him after he was dead." Compared to her first drawings, this depiction of a family showed some acceptance of the new composition of her family. Ms. Kline had told me that she and her husband had settled the divorce issues and were not arguing now. The image of the family as safe suggested Stacey was aware that the conflict had diminished. Her anger toward her stepfather was still strong, as represented in the father who was eaten by sharks; however, her anger was still not acceptable to her on a conscious level, so she denied it by modifying the story of who had been eaten by sharks. Nevertheless, her angry feelings were quite intense, as indicated by the next picture she drew, a river full of piranhas. Moving back into the displacement of transference, she threatened to draw me in the water with the piranhas. When I expressed mock alarm, she laughed and said, "All right, I won't put you in there. Let's play Connect Four."

During the first 3 months of treatment, Stacey used displacement through drawing and games to symbolically approach her feelings about the loss of her stepfather. Through a combination of displaced and direct interpretation I helped her acknowledge her feelings in their real context. Gradually, during the next 3 months she was able to talk about her disappointment and anger directly. She began to complain about her stepfather's failure to see her regularly. She was critical of him for making promises and failing to keep them. When he told her he would be moving away to attend a distant university, she continued to describe her mixed feelings in sessions. She said that she wished he would stay but accepted his explanation that he needed to complete his education. She continued to be angry at him, and I felt that her anger was partly a defense against sad feelings. However, Stacey denied this when I suggested it. In fact, over several sessions talking directly about her feelings regarding the divorce and her stepfather's move seemed to accomplish some working through of the disruption of her life. This was evident in her mother's reports that Stacey was happier. Her affect in sessions was more buoyant, and the controlling play declined. During the termination process, I asked Stacey what advice she might give other kids whose parents were divorcing. Her answer implicitly expressed the school-age child's tendency to use cognitive strategies to regulate affect: "Tell them to think that it happened for a good reason."

Work with a Preadolescent School-Age Child: Stacey's Second Treatment

Two-and-a-half years later, Ms. Kline again called to ask me to see Stacey, who was now 11. Ms. Kline told me that she was planning to marry again within a few months and that Stacey seemed angry and anxious. She was often rude

and sarcastic toward her mother and sometimes toward her mother's fiancé. She was arguing constantly with her older sister. It appeared that Stacey was worried about her mother's upcoming marriage, and that her previous experience of divorce and loss formed the context of her anxiety. When her mother made plans to marry again, Stacey felt threatened by the possible repetition of making an attachment to a father and then losing him.

Because of their advanced cognitive abilities, older school-age children are capable of analyzing problems within their families and realistically worrying or being angry about them. Since these concerns are conscious, though kept private, it is often possible to move fairly quickly from displacement to direct discussion of the problems, especially when, as was true for Stacey, the child has had a previous relationship with the therapist. Even though many school-age children are unwilling to initiate a discussion of problems, they are often responsive when a therapist puts the problem into words accurately.

In the second round of therapy, occurring 2 years after the first, Stacey's way of presenting and working on her concerns showed similarities and differences from the first treatment. She still utilized the displacement of a transference relationship, alternating between seeking my interest and approval and playfully acting rude and rejecting me. This transference revealed both sides of her ambivalence about her mother's remarriage: She wanted a father but resisted that wish because of her anxiety about loss. She still chose to play Connect Four and card games with me. This seemed to be Stacey's way of reestablishing our relationship and affirming its continuity.

Despite these similarities in presentation, there were also important differences that reflected her gains in development during the intervening 2 years. The preadolescent Stacey was more consciously aware of what was bothering her than she had been 2 years previously. With some help, she could discuss her worries, as opposed to expressing them in displacement. When we played games, she always played fairly. She might playfully make fun of me when I lost, but she did not cheat or change the rules. Because she was able to think about what was bothering her and to tolerate ambivalent feelings more easily, she had less need to hide her concerns from herself via displacement. This did not mean that she could talk with ease about her worries, but she responded more readily when I commented on transference behavior or directly brought up concerns about her mother's remarriage.

Although older school-age children often resist talking directly about problems, they frequently agree with direct interpretations that are phrased in concrete terms and presented with empathy for their feelings. Once the therapist has established a solid relationship with an older school-age child, direct interpretation can be used to help the child organize and understand emotionally painful experiences and memories. For example, early in the second period of treatment, I tried to help Stacey connect her anxiety about her mother's new relationship with her memories of the divorce. I said, "Other kids I've known have been mad and worried when their mom decides to get

married again. That's because they start thinking about the divorce and they don't want to go through that again. I think it was sad and upsetting for you when Bill and your mom divorced. You never knew your real dad, and Bill was the closest to a dad you'd ever had. But he didn't see you much after he moved out and then he moved away. That really hurt your feelings." Stacey listened thoughtfully and said, "You're right." When I said directly that I thought she and her sister were worried the new marriage would also end in divorce and they would have to go through the same painful feelings all over again, Stacey said, "I bet he'll be gone in 3 months." This comment confirmed my impression that Stacey was consciously thinking about the possibility of another loss.

Stacey brought up other related concerns. She described her mother's fiancé, Andy, as "nice" but said she didn't really know him very well. She described the pressure she felt from her mother to become close to him. I said, "It takes a long time to get to know someone well. Just because your mom is excited about marrying Andy doesn't mean you have to feel the same way right away. It seems like you like him, but you want to get to know him better." Stacey looked thoughtful and agreed. I also suggested that since she was worried that the relationship might not endure, it was normal for her to be cautious about getting close to Andy. Stacey was also alert to changes in her mother. For example, she complained that her mother wanted Stacey and her sister to be on their best behavior when Andy was around. I commented that since her mom's relationship with Andy was still new, maybe she was extra-sensitive to anything that might cause a problem. I also said, however, that if they were going to be a family, she and her sister should feel free to be themselves with Andy.

Developmental Guidance

In a parent guidance session, Ms. Kline expressed concern that Stacey and her sister were speaking rudely and sarcastically to both herself and Andy. I suggested that Stacey was showing her anxiety about the remarriage. I also pointed out that her anxiety intersected with developmentally normal behavior common in 11-year-olds: As school-age children begin the transition to adolescence, they frequently become more contentious and critical of their parents. This shift in attitude reflects the child's unconscious awareness that her coming developmental tasks involve differentiating the self from parents and learning to function more autonomously. In describing this process to Ms. Kline, I pointed out that a normal aspect of development in preadolescents was being intensified by the stress of Stacey's fears that her mother's new marriage would fail. I also pointed out that preadolescents, in spite of their apparent emotional independence, particularly need the steady support of their parents, and I suggested that Stacy might be feeling she was losing her mother to Ms. Kline's fiancé at a time of developmental transition (McGue, Elkins, Walden, & Iacano, 2005).

Utilizing the Older Child's Cognitive Abilities

When I told Stacey that her mother had said she was saying rude things, particularly to Andy, Stacey immediately agreed and said, "Yeah, my sister and I are trying to drive him away." I asked how she thought they could do that. She said, "Maybe he'll be disgusted by us bad kids and give up." This gave me a chance to revisit issues from the first treatment. I told her that perhaps she and her sister had *felt* they had driven Bill, their first stepfather, away, even though that was not the reason for the divorce. If a kid feels that, I said, she might think it's better to show how bad she can be *before* the marriage. Stacey said that she liked Andy but that she really did not want to go through another divorce.

This second treatment particularly made use of Stacey's cognitive abilities. At age 11, she could assess similar and different aspects of a situation that seemed the same. She became anxious when her mother decided to remarry because she was afraid of another divorce. But she also was able to compare the differing personalities of her previous stepfather and her new stepfather. Her new stepfather, she gradually realized, was more emotionally attuned to her and more interested in her school and sports activities. As Stacey differentiated Andy from Bill, she became less anxious about their relationship. After her mother and Andy were married, I continued to see Stacey periodically, each time reviewing her reactions to her mother's new marriage.

In the second short-term treatment when Stacey was 11, it was easier to move from displacement activities to direct discussion of problems than had been true during the first treatment. In part this was because there were differences in the presenting problems. Stacey's anxiety over her mother's remarriage was not as acute and painful as her distress over the divorce. However, Stacey's ability to approach problems cognitively, control the intensity of her feelings, and tolerate ambivalence had increased as a result of ongoing development between ages 8 and 11. Consequently, she had less need to disguise her thoughts and feelings through displacement.

A Developmental Perspective on Intervention

Stacey's case is a good illustration of "intermittent therapy," a model in which the therapist provides intervention when difficulties occur, terminates when the problems are resolved, and remains available for future therapy. The intermittent treatment model is appropriate for children because they are developing rapidly and may need help at different points. After a child and parents have been helped to master a particular developmental hurdle, then therapy can cease, with the understanding that it may resume when a new hurdle presents itself.

I saw Stacey in the first intervention for about 6 months, until she had begun to cope with the divorce and loss of her stepfather. When her anxiety about loss resurfaced 2 years later in reaction to her mother's plans to

remarry, I saw her again for about 6 months. In this model, the therapist works to establish a positive attachment relationship with the parent and child in order to support their relationship and the child's development. The therapeutic relationship then becomes used in the same way a child uses the attachment relationship: At times of stress, confusion, or anxiety, the parent and child can draw on the attachment relationship with the therapist for "refueling," guidance, or clarification. Intermittent treatment is especially likely to be needed when a child has experienced trauma or loss, because at each new level the child may need to reprocess the trauma or loss from the perspective of her new level of development. The practitioner who thinks in developmental terms can create treatment plans and interventions that respond to the child's emerging tasks and skills.

OBSERVATION EXERCISES

1. Spend 2–3 hours observing a group of elementary-age schoolchildren. Preferably observe in three contexts: the regular classroom, the playground at recess, and a special class such as gym or music.
   a. Choose one child and observe his behavior in class and his interaction with peers at recess. In class, look for attentional capacities and interest in work. On the playground, look for social abilities, place in status hierarchies, and general level of involvement with peers.
   b. Observe for gender-based behavior. Do girls and boys play in segregated groups, as the developmental literature of middle childhood suggests? Do you see instances of sustained interactions between boys and girls? Do you observe differences in the themes of boys' versus girls' play and interactions?
   c. Observe for behavior that reflects the social and moral values of school-age children. For example, do you see evidence of social rejection or stigmatization? Instances of prosocial behavior? Reactions to children who show difficulties controlling impulses? Controversies over rules or "correct" behavior? Negotiation of controversies?

2. Observe for developmental progress across middle childhood by spending 1 hour observing first graders (ages 6–7) and 1 hour observing fourth graders (ages 9–10). What differences do you see in the areas of social skills, peer orientation, physical abilities, and self-regulation?

CHAPTER 13

Conclusion

DEVELOPMENTAL KNOWLEDGE AND PRACTICE

For a concluding review of the implications of developmentally based practice, I return to the case of Jared, the toddler who struggled with ongoing fearful reactions to witnessing his father's abuse of his mother (see Chapters 7 and 8). Like many traumatized young children who experience frequent hyperarousal, Jared had begun to adopt the defense of aggression as a means of warding off danger when he felt anxious. He was aggressive both at home and at child care. His development was at risk because he was beginning to rely on aggression as a means of coping with anxiety, and also because others were already reacting negatively to his aggression. From a transactional perspective, the angry and distressed responses of child care providers and peers to his aggression fueled his anxiety and insecurity, reinforcing his sense that he needed to be aggressive to feel safe. The influence of anxiety on his perceptions and the negative feedback he was receiving created a risk that he would adopt an impulsive and aggressive style that would severely limit his possibilities for adaptive development.

Although Jared's mother was very invested in him, unwittingly she was also reinforcing his aggressive behavior. When he would hit her at home, she would become sad but would not stop him. She felt unable to set limits on him. Her sense of helplessness, based on her own traumatic abuse, prevented her from giving Jared the protection (in this case, from his own impulses) he needed in order to feel secure. Their individual experiences of trauma were being carried into their relationship. The pattern of domestic violence was being repeated, this time with Jared in the abusive role. I was concerned that if she did not set limits on his aggression, he would continue to use it to cope with anxious or angry feelings and even would be at risk to become an abuser himself.