Social Work Practice with Children and Families

Nancy Boyd Webb, *Series Editor*

Working with Adolescents: A Guide for Practitioners
Julie Anne Laser and Nicole Nicotera

Child Development: A Practitioner's Guide, Third Edition
Douglas Davies

Helping Bereaved Children:
A Handbook for Practitioners, Third Edition
Nancy Boyd Webb, *Editor*

Social Work in Schools: Principles and Practice
Linda Openshaw

Working with Traumatized Youth in Child Welfare
Nancy Boyd Webb, *Editor*

Group Work with Adolescents:
Principles and Practice, Second Edition
Andrew Malekoff

Mass Trauma and Violence: Helping Families and Children Cope
Nancy Boyd Webb, *Editor*

Culturally Competent Practice with Immigrant
and Refugee Children and Families
Rowena Fong, *Editor*

Social Work Practice with Children, Second Edition
Nancy Boyd Webb

Complex Adoption and Assisted Reproductive Technology:
A Developmental Approach to Clinical Practice
Vivian B. Shapiro, Janet R. Shapiro, and Isabel H. Paret

CHILD DEVELOPMENT

A PRACTITIONER'S GUIDE

Third Edition

DOUGLAS DAVIES

Series Editor's Note
by Nancy Boyd Webb

THE GUILFORD PRESS
New York London

APPENDIX 7.1. SUMMARY OF TODDLER DEVELOPMENT, 1–3 YEARS OF AGE

Information in parentheses shows when developmental features unfold and tasks become salient. Since there are individual differences in rate of development in children, I have indicated time ranges encompassing normal development. I have indicated when a process is a salient part of development during the whole period by including the whole period (1–3 years) in parentheses.

Overall Tasks

- Balancing attachment and exploration, with increasing movement toward autonomy and individuation
- Internalization of parental values and standards
- Developing the ability to symbolize, through mental representation, play and communication

Attachment

- Continuing transactional patterns of regulation of arousal and affect (1–3 years)
- Working models of attachment develop, allowing the toddler to develop some autonomous self-protective and self-soothing behaviors, especially between 24 and 36 months
- Use of transitional (comfort) objects for self-soothing and to cope with separation (16–36 months)
- Attachment relationship supports progressive development, including behavior modeling, social referencing, helping the toddler understand the world, encouraging language and communication, and supporting autonomous behavior (1–3 years)

Social Development

- Toddlers' egocentric view of the world, combined with their need to feel autonomous and in control, limits their ability to share or acknowledge others' different intentions (16–36 months)
- Beginning understanding of reciprocity develops through play with peers (2–3 years)
- Imitation of parental behavior implicitly incorporates a beginning understanding of social expectations (2–3 years)

Cognitive Development

- Intense interest in understanding and learning about the world (1–3 years)
- Development of conscious expectations, based on memory of prior experiences; awareness of violations of expectations (18–36 months)

- Ability to observe and imitate others facilitates learning (1–3 years)
- Conscious goals and plans: Toddlers can formulate plans, consciously remember them, and persist in trying to realize them (18 months+)

Language and Communication

- Language learning: After gradual growth in vocabulary from 12 to 18 months, there is a burst of language development motivated by the toddler's growing wish to communicate her experience (1–3 years)
- Two- and three-word sentences are used (18–24 months)
- Rapid development of vocabulary, syntax, grammatical structures, as well as idiomatic usage and pronunciation patterns used by parents (2–3 years)
- Beginnings of mental representation using words, narrative, and verbally mediated thinking (18–36 months)
- Use of language to understand and "construct" the world: asking questions, telling about experiences, talking to oneself, crib talk (2–3 years)
- Social uses of language develop: using language to share experiences, putting wishes into words, and a beginning ability to slow down impulses by verbalizing them (18–36 months)
- Limitations in language ability are a common source of frustration (and angry behavior) over not being able to communicate (18–36 months)

Symbolic Communication and Play

- Sensorimotor play: exploration of properties and functions of objects (1–2 years+)
- Pretend play: imitation of ordinary activities (e.g., pretending to eat) or caregiving behavior (12–18 months+)
- Symbolic play: substituting one object for another, sequences of actions in pretend (16 months+)
- Play becomes used as the child's symbolic commentary on his experience, as well as a means to represent and emotionally discharge reactions to stressful situations (18–36 months)
- Play of toddlers often provides a more complex representation of experience than they are able to express in words (18–36 months)

Self-Regulation

- Beginnings of autonomous self-regulation emerge; however, because toddlers' internal means of coping with stress are limited, they continue to rely on dyadic strategies of coping, based on the attachment relationship (1–3 years)
- Toddlers are subject to many sources of uncertainty and anxiety, and have difficulty exerting autonomous control over impulses; impulse control slowly improves during the toddler period (1–3 years)
- Coping mechanisms of toddlers include the following: dyadic regulation through

attachment relationships; self-stimulation as an outlet for tension; play as a vehicle for mastering stress; language as a means for communicating distress; imitating and internalizing parents' ways of regulating anxiety (1–3 years)

Moral Development

- Young toddlers' mobility and strong motivation to explore inevitably causes parents to limit their behavior, often to protect them from danger; the toddler begins to experience a discrepancy between his wishes and his parents' limits (1–2 years)
- Parents' direct approval and disapproval, especially when accompanied by strong affects, supports internalization of parents' rules; at this point, the toddler tries to control his behavior in order to gain the parents' approval and avoid punishment (1–3 years)
- Internalization of standards: Toddlers notice deviations from expected norms and become concerned if their expectations are violated; they evaluate their own performance, feeling good if they have done well and bad if they have not; they have learned their parents' expectations for behavior—all these factors support the development of self-control (18–36 months)
- Beginnings of prosocial behavior: beginning capacity for empathy may cause toddlers to comfort distressed peers and may help older toddlers inhibit aggressive impulses (18–36 months)

Sense of Self

- Self-assertion: Insistence on having things their own way and pursuing their own goals imply toddlers' increasing sense of self-importance (14–20 months)
- Self-recognition: Midway through the second year, toddlers can recognize themselves in a mirror, confirming a new sense of consciousness of themselves (18–24 months)
- Egocentrism dominates toddlers' view of self and others; they tend to emphasize their own needs and point of view over those of others (1–3 years)
- Separation–individuation: awareness of psychological differences and autonomy from parents; toddlers are more vulnerable to separation anxiety and more likely to activate attachment behavior during the most stressful period of separation–individuation, occurring at about 18–20 months (16–36 months)
- Theory of mind: awareness that others have thoughts, feelings, and intentions that may differ from one's own (16–18 months+)
- Beginnings of an autonomous sense of self, symbolized by independent behavior and in language by the emerging use of the words "I," "me," "my," and "mine" (2–3 years)
- Gender identity: Sense of self includes awareness of gender identity (2–3 years)

CHAPTER 8

Practice with Toddlers

ASSESSMENT

As with infants, assessment of toddlers frequently combines observational with structured approaches. The toddler's capacity for symbolic expression through behavior, play, and—increasingly—words permits the clinician to observe how the toddler represents her experience. Observation of toddlers' representational play often becomes the vehicle for clarifying possible meanings of their behavioral symptoms. In the assessment of Jared (Chapter 7), for example, his repeated playing out of the incident when his father smashed the glass door demonstrated his ongoing fears and helped recast his "aggressive" behavior as symptomatic of anxiety about being attacked and hurt. Practitioners can also learn about the more immediate precipitants of toddlers' symptoms through naturalistic or structured observations at home or in child care settings.

Developmental testing of toddlers may be more difficult than at other stages of development because toddlers frequently do not cooperate with an agenda that differs from their own. The toddler's desire to assert herself and to explore on her own terms sometimes conflicts with the demands of structured testing. These are not insurmountable obstacles, however. Clinicians who test toddlers usually become skilled at adapting the pace and order of test items to achieve a compromise with the toddler. They learn to engage parents to help the toddler stay on task. While testing is useful, especially when the presenting problems include possible developmental delays, observation and interaction with the toddler often provide the most telling information about psychological, interactional, and developmental issues (Bagnato, 2007; Meisels, 1996). In addition, the assessment questionnaires described in Chapter 6 encompass toddler development: Infant–Toddler Developmental Assessment (IDA) and the Ages and Stages Questionnaires (ASQ, ASQ:SE). The ASQ instruments are particularly helpful because they are written to be given at intervals of 2 months (ASQ) or 6 months (ASQ:SE), and thus can be

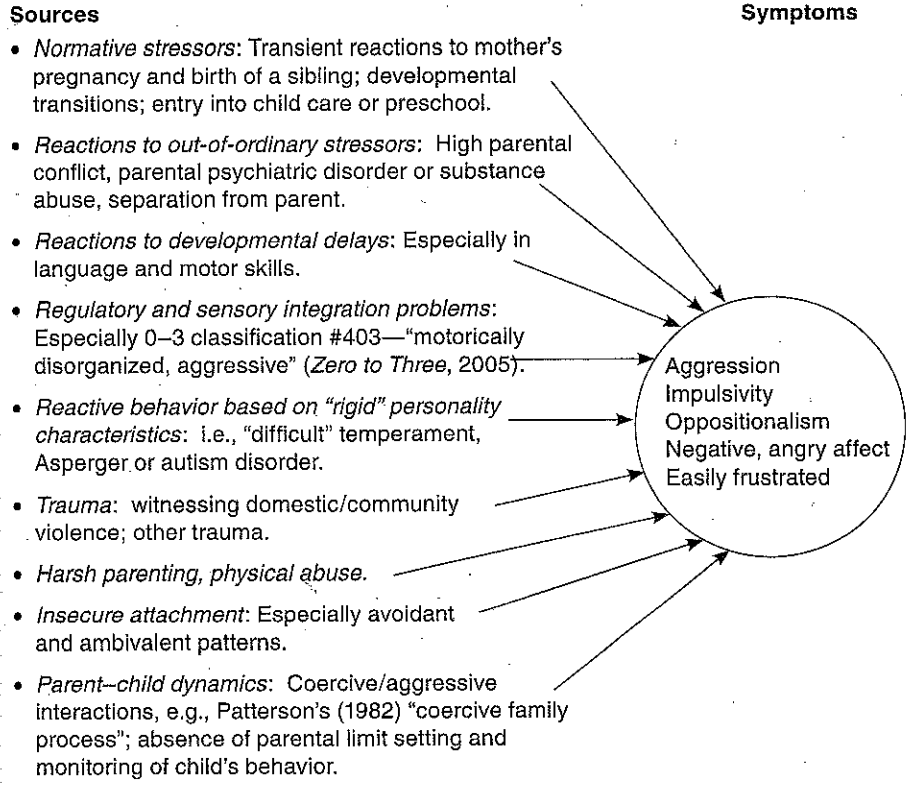
used to track a child's development over time (Bricker et al., 1995; Squires et al., 2002).

Assessing Behavioral Symptoms

Referrals of toddlers and preschoolers often focus on behavioral problems, including aggression, angry outbursts, impulsivity, and acts reflecting difficulty managing frustration or arousal. Especially because toddlers' communication abilities are not yet well developed, it is common for parents and other caregivers to stress behavioral issues as opposed to possible internal or interactional sources of the behaviors. However, a list of a young child's behavioral symptoms does not clarify the *reasons* for the behaviors. The same behaviors can be influenced by radically different causes, so when we are confronted with an evaluation of a toddler or preschooler with aggressive or out-of-control behavior, our goal must be to understand the sources of the child's behavior. Figure 8.1 illustrates the range of possible sources for the same set of symptoms in young children. It is very important to understand the sources of the symptoms, because intervention must be appropriate to the problem if it is going to be effective. For example, we would provide very different interventions for a toddler whose aggressive behavior is a symptom of trauma versus another toddler whose aggression is a symptom of language and communication delays. The clinician's task is to sort out which pathway provides the best explanation for the symptoms and include in the evaluation an account of the developmental, situational, and transactional processes that led to the symptoms, as well as those processes that maintain their existence.

Assessing Secure Base Behavior

Although assessment must consider the full range of developmental tasks and accomplishments of toddlers, secure base behavior and the balance between attachment and exploration are especially sensitive indicators of the toddler's functioning (Lieberman & Van Horn, 2008). Since these issues can be only assessed in the context of the toddler's primary relationships, *toddlers must be seen with their parents*. The function of attachment is to provide the child with a sense of protection and security. A lack of responsiveness or inappropriate responses by parents can interfere with the toddler's ability to internalize adaptive ways of managing fear and anxiety. When the toddler does not feel secure, because of a history of unreliable protection in the attachment and the resulting failure to internalize self-protective processes, "the child's ability to engage in a confident exploration of the environment is disrupted, and alterations in the balance between exploration and attachment behaviors (secure-base behavior) are observed" (Lieberman & Pawl, 1990, p. 379). Lieberman and Pawl identify three patterns of distortion in secure-base behavior:



Some Assessment Issues

- Does the behavior seem to be triggered by anxiety? (In this case, the source of the anxiety will need to be addressed.)
- Does the behavior reflect symbolic meaning? (Assess for trauma or reactions to stressors.)
- Does the behavior reflect working models of relationships? (Observe parent–child interactions.)
- How much has the behavior been reinforced? Is it currently being reinforced by the responses of parents, caregivers, or other children?
- Is the behavior misinterpreted by others (e.g., a motorically active, poorly regulated child whose behavior is mischaracterized and responded to as if it is intentionally aggressive)?

This figure shows that there are many causal pathways to the same set of symptoms in young children. A task of assessment is to sort out which pathway seems most prominent, so that the causes of the symptoms and the interactional processes that maintain them can be addressed in intervention.

FIGURE 8.1. Behavior Problems in Toddlers and Preschoolers: Multiple Sources/Common Symptoms

Counterphobic Recklessness and Accident Proneness

The attachment history of toddlers who put themselves in dangerous situations involves a failure of protection. Parents have exposed the child to danger or have discounted, minimized, or ignored the child's distress, leading the child to rely less on the attachment relationship for a sense of protection. When such infants become toddlers and the urge to explore becomes paramount, they seem to court danger, "as if trying to discover how much risk they have to endure before the mother intervenes" (Lieberman & Pawl, 1990, p. 382). These reckless toddlers have high levels of anxiety and reactivity to stress.

Inhibition of Exploration

These children, in a manner surprising for toddlers, avoid exploring the environment and instead appear as passive, vigilant, or unemotional watchers. They cling to the parent and are very distressed by separation. Two types of distorted parenting were identified to explain the behavior of these inhibited toddlers: parents who "needed" their infants and discouraged or punished autonomous exploration, and parents who were unpredictable and abusive, which seemed to encourage their toddlers to withdraw and to be cautious about making a move.

Precocious Competence

The toddler reverses roles with her caregiver, as shown in vigilance of the parent's moods and caretaking of the parent. The toddler gains a sense of security by staying close and attending to the parent's needs, but at the cost of autonomous exploration. This pattern is associated with parents who are self-absorbed because of depression or other conflicts that make them emotionally unavailable. These toddlers perceive a fragility in their parent that leads them to become emotionally self-reliant because the parent cannot be depended upon (Lieberman & Van Horn, 2008).

Assessing Self-Regulation

The transition from mutual regulation to autonomous self-regulation is a major task of toddler development. The child's (and parents') success in making this transition is a sensitive indicator of developmental progress. Adequate self-regulation is a foundation for upcoming and ongoing tasks, including the development of social skills, extended attentional focus, cognitive strategies for learning, and executive functioning. Compromised "regulatory processes have cascading consequences" for future development (Calkins, 2007, p. 274). If a toddler shows difficulties in self-regulation—often expressed through overly reactive, affectively intense, and "out-of-control" behavior—it is crucial to assess the sources of these problems and to understand what interactions or circumstances tend to maintain them (Bagnato, 2007).

Observing Behavior in Context: Functional Assessment

Functional assessments of behavior are commonly used in schools and can be used in child care settings and also be adapted for use by parents. A functional assessment of behavior is a simple but useful observational approach to understanding behavior problems. It is particularly relevant for toddlers because it relies on careful observation of behavior, as opposed to what the young child says.

Functional assessment starts with the assumption that the behavior problems of young children are not random but rather have motives, functions, and meanings. From this perspective, difficult behavior represents a solution to a problem or need, may be an implicit communication, and is likely to represent a "chapter" in a longer and more complicated story. Understanding the function of behavior requires an A–B–C analysis, *A* meaning antecedents, *B* meaning behavior, and *C* meaning consequences. This approach asks us to contextualize a child's challenging behavior so that we can understand how it functions for a child (O'Neill, 2005).

When a behavior, such as hitting or emotional outbursts, is identified as a regular problem, the observer looks for antecedents—what is happening *just before* the behavior occurs. For an anxious young child at a child care center, the antecedent may be a transition from one activity to another; for an easily overstimulated toddler with sensory-processing problems, the antecedent may be the increased intensity of play and hubbub that begins when a teacher announces that it is time to clean up (Interdisciplinary Council on Developmental and Learning Disorders, 2005). It is also necessary to consider more remote antecedents, referred to as "setting events" or circumstances. Perhaps a child is more volatile on those days when his parent must go to work early; he's dropped off at a family day care home at 7 A.M., and he knows the separation from his parent will be longer than usual. In some cases, a setting event may be an extreme stressor, such as witnessing domestic violence, a parental separation, or other events that disrupt the child's sense of continuity or traumatize him.

When we look at consequences, we ask, what happens after the challenging behavior? What reactions do caregivers and other children have? By considering these reactions, we can begin to understand what is reinforcing the behavior. For example, if one child pushes another child and takes her toy, and a caregiver ignores what happened, the first child may be reinforced in her use of aggression as a means of getting what she wants. For other children, especially those with ambivalent attachments to parents, a punishing, upset, or concerned response by the caregiver may be reinforcing because these children have learned that it is better to get negative attention than no attention at

all. While the responses of others often make children feel as if their negative behavior has paid off, it is also important to go beyond learning theory and to consider that sometimes aggressive behavior persists because children are angry, frustrated, anxious, or traumatized, not primarily because it is reinforced. In those cases it will be necessary to focus on understanding the immediate antecedents and setting events that contribute to the ongoing anger or other disruptive behavior.

Note that this simple approach to assessment is helpful because of its power to *reframe* the understanding of behavior and to direct attention to the *meanings* of the behavior instead of to the behavior in isolation. Functional assessment calls attention to *A* and *C*, the two aspects of a three-part sequence that are more under adults' control than the behavior itself. By modifying the antecedents and consequences, we may be able to change the behavior (Kaiser & Rasminsky, 2003). Although functional assessment concentrates on identifying contexts of problematic behavior, it also can implicitly identify times when a child's behavior is adaptive. For example, after a sharp focus on when and why a sensory-defensive toddler becomes disorganized in his behavior, parents and caregivers may realize that there are many times across the day when she is more organized—for example, when a toddler care room is quieter, or when she is involved in continuous play—which can help them appreciate her strengths as well as understand her difficulties.

Functional assessment requires observation, preferably systematic observation, across several days at regular intervals, particularly at times when a child is likely to be disruptive. Careful observation gives us a chance to develop hypotheses about the function of the behavior *before* we intervene. From these hypotheses, practitioners and caregivers can collaborate on interventions now informed by a contextual understanding of young children's behavior. Table 8.1 summarizes assessment issues for toddlers.

ASSESSMENT OF TODDLER DEVELOPMENT: A CASE EXAMPLE

The evaluation presented here illustrates issues of toddler development when a child is not functioning at the expected developmental level. Marcel, age 2 years, 8 months, presented with intrinsic developmental difficulties. Marcel's difficulties in navigating the developmental tasks of the toddler were primarily caused by his deficits in language and affect regulation, though the parent–child transactions that had been shaped by his mother's responses to those deficits also played a role in Marcel's presentation.

In assessing children with atypical or delayed development, it is crucial to examine their optimal level of functioning and areas of developmental adequacy, as well as areas of delay (Greenspan & Meisels, 1996). It is essential to identify areas where a child's functioning is age-appropriate or has the potential to become age-appropriate, because these areas of relative strength can

TABLE 8.1. Summary of Assessment Issues for Toddlers

General considerations

- A balanced assessment aims to identify optimal levels of functioning and areas of strength and potential, as well as areas of deficit.
- Observation, rather than testing, is often the most useful approach to the assessment of many toddlers, including those with developmental delays. As with infants, observation of the toddler in multiple settings—home, child care center, and office—provides a full picture of the child's range of functioning.
- Functional assessment can clarify meanings and functions of behavior, providing guidance for intervention.
- Emerging representational abilities in the toddler permit the clinician to learn directly how she has constructed and given meaning to experiences, particularly stressful or traumatic ones.
- Since the attachment relationship remains essential to the child's capacity for adaptive coping, toddlers should be observed with their primary caregivers. These observations should focus on the quality of attachment, the balance of exploratory and secure-base behavior, and the caregivers' attitudes toward the toddler.

What to observe

- Secure-base behavior and the balance between attachment seeking and exploration; toddler's capacity for coping with brief separations.
- Assess whether child shows age-expected skills in the following areas: social referencing and adaptive joint attention, language, representational play, internalization of standards, capacity for autonomous behavior.
- Parental adaptation: Is the parent responding appropriately to the toddler's increasingly independent goal setting and behavior?
- Capacity for self-regulation: Does the toddler show age-appropriate skills in controlling impulses and aggression? Does she turn to caregivers for help with self-regulation? How do caregivers respond?

Concerns/red flags

- "Insecure" base: Toddlers who are either overly self-reliant (distanced from parent) or overly dependent (clinging to the parent at the expense of exploration); toddlers who become "caretakers" for parents they experience as vulnerable and needy. These disturbances may reflect insecure attachment or responses to stress and trauma.
- Frequent impulsive, negative, aggressive behavior (note that assessment is crucial here, because these common symptoms in toddlers can derive from a range of different sources).
- Difficulties in self-regulation: The toddler becomes behaviorally disorganized and does not demonstrate an ability to self-regulate or to draw on a caregiver for help.
- Delays in social and communicative abilities: Joint attention and social referencing; for older toddlers, difficulties in reading social cues, theory-of-mind understanding.
- Delays in language and representational play.
- Play and behavior reflective of stress and trauma.
- Parental difficulties in coping with toddler's autonomous behavior: Harsh punishment, inconsistent limit setting, poor monitoring of child's behavior.
- Parental overexpectations of child's abilities, especially in the areas of self-regulation and capacity to inhibit forbidden actions.

become the basis of an intervention plan to address the areas of delay. This case example illustrates the uses of a careful developmental assessment. It also demonstrates how intertwined the toddler's developmental tasks are and how difficulties in one area can interfere with the accomplishment of tasks in another area. Marcel's development was very uneven, with age-appropriate functioning in some domains and severely delayed functioning in language and regulation of affect and behavior. These delays led to severe symptoms that overshadowed Marcel's areas of adequate functioning. Because of the severe language delays, it was difficult to assess his overall cognitive abilities. Between the ages of 2 and 3 years, cognitive progress proceeds in tandem with advances in verbal abilities. Marcel was moving ahead in the development of awareness of self and others, and he was not autistic—he wanted to communicate and was aware of the possibilities of communication. However, he was tremendously frustrated because he could not use words to communicate and thus experienced a great disparity between his cognitive abilities and desire for interaction, on the one hand, and his ability to communicate what he was thinking, on the other. Finally, the case illustrates how consultation after evaluation became an important intervention on behalf of this child. Following the assessment, I was able to frame Marcel's difficulties and strengths in a way that helped a school-based early intervention program plan services for him and his mother.

Referral: A Toddler Out of Control

Marcel was the only child of his 24-year-old single mother. His father rarely visited and was not involved in his life. Ms. Montgomery was supported by AFDC (Aid to Families with Dependent Children) and was not working outside the home. The family was African American. Marcel and his mother lived alone, but extended family members lived in their neighborhood. A school early-intervention program referred Marcel for evaluation at age 2 years, 8 months.

Presenting problems included severe language delays, short attention span, "hyperactive" behavior, and frequent severe tantrums. The school district had attempted to evaluate him using standardized tests, but he refused to cooperate with the examiners. His refusals were characterized as "lack of motivation." Estimates of his abilities were based on observation and suggested delays in several areas. Language was estimated at 15 months, a very significant delay since it represented less than half his chronological age. A normal hearing test had previously ruled out hearing loss as a cause of his language delays. Cognitive abilities were estimated at 20 months, while self-help skills were at the 24-month level. His fine motor coordination was seen as significantly delayed, at about the 2-year level, while his gross motor abilities were judged to be age-appropriate. His social abilities were seen as at the 10-month level. This extremely low estimate was based on his "antisocial" behavior, which the school program's report described in detail. Marcel ran around the classroom, threw toys, opened desk drawers and threw the contents about, pushed books and personal items off the teacher's desk, and tore pictures off the wall. When the teachers tried to restrain him, he hit and kicked them. He was, according to the report, "completely out of control." Apparently in desperation, a teacher put him on top of a tall file cabinet, which stopped his behavior briefly. The school intervention program referred him for a pediatric neurology examination in order to discover whether neurological dysfunction explained his extreme behavior and with the hope that medication could be prescribed.

The physical examination showed no clear signs of neurological dysfunction. The medical report contained imagery and a tone similar to those in the school report. During the examination, Marcel ran against the door, hurtled around the room, and fell on the floor, constantly screaming and crying. He refused to cooperate with the examination and was "completely impossible to control." The pediatric staff could not capture his attention, and the resident evaluator commented, "Not much interests him." Marcel did not comply with his mother's demands, but it was noted that she was very patient with and invested in him. The report ended with the awed and decidedly nonclinical impression that neither the resident evaluator nor his medical supervisor had "ever seen anything like Marcel." A psychiatric evaluation was recommended.

Impressions of Referral Reports

These reports made clear that Marcel showed difficulties in several areas of development. It appeared that he had few adaptive strategies for coping with stress. I wondered if he might be unusually sensitive to novel situations. The previous evaluators were perplexed and awed by his intense, disturbed behavior. Their descriptions conveyed that he was incomprehensible and very difficult to empathize with. Both reports described him as lacking in motivation. This is a very unusual comment about a toddler, since so much of a toddler's behavior reflects the strong motivation to master his environment. The school report referred to his "destructive and dangerous acting-out behavior." Such language is commonly used to describe delinquent adolescents. It seemed extreme as a description of a 2-year-old. Because Marcel was African American, I was concerned about this characterization, since it might later contribute to stigmatization based on racist stereotypes of African American males (Canino & Spurlock, 2000).

The image of Marcel that emerged was a child who was incomprehensible, out of control, and dangerous. A child like Marcel understandably evokes in adults strong reactions that cause them to want to restrain and control him. The parent of a young child with serious behavioral problems often feels helpless and alarmed by the intensity of the child's behavior. However, a focus on the surface of behavior may prevent parents and others from understanding its potential meanings and may lead to controlling and punitive responses. But

efforts at restraint, which ignore the sources of the child's distress, often elicit an escalation of the behavior. Marcel's behavior was so extreme that even seasoned evaluators were emphasizing the need to control him rather than formulating an understanding of his behavior.

Since Marcel seemed incomprehensible and possibly unreachable, the school had not been able to develop an intervention plan. Their request to our program was for intervention recommendations and medication. In my experience it is unusual for a request for medication to figure so prominently in a referral of a child so young. When such a request comes in, it is usually because the child's behavior is not only extreme but also unexplained. When extreme behavior in a toddler does not yield to a biological, developmental, or psychosocial explanation, parents and professionals, in desperation, may hope that a medication can be prescribed that will at least moderate the behavior.

Assessment Plan

I decided to spend my limited evaluation time observing Marcel in free play and interaction with his mother. This is consistent with "best-practice" approaches to the developmental assessment of young children (Bagnato, 2007). The interview was videotaped so that I could carefully review Marcel's developmental abilities later.

Marcel's "deficits" had already been described in the two previous evaluations that attempted to impose structure on his behavior. Formal evaluation had not succeeded and had yielded only estimates of his developmental levels. There are a number of limitations in the use of structured testing for toddlers, not least of which is toddlers' frequent refusal to cooperate. Furthermore, formal tests, which have been standardized on samples of normal children, may not "bring out the unique abilities and potential of children with atypical or challenging developmental patterns" (Greenspan & Meisels, 1996, pp. 24–25). Since most test instruments designed to assess development after age 2 rely heavily on *verbal* directions and therefore on the child's ability to understand language, Marcel's language delays put him at a great disadvantage. I speculated that language-based tests—even assuming that Marcel would cooperate with them—would reveal his already known language deficits but perhaps obscure his capacities in other domains. I wanted to see what he was like in a more relaxed situation, without the pressure of formal testing. I wanted to see if his behavior told a story that made sense and to learn if he demonstrated areas of strength upon which an intervention plan could be built.

Parent–Toddler Interview and Observation

For the first 20 minutes of the 90-minute interview, Marcel did not fit the image of the previous evaluations. While I spoke to his mother and the school social worker who had driven them to my office, Marcel played with toys on the floor. He sustained his play and only approached his mother a few times to

show her a toy. His preference for exploratory play was typical for a toddler. I did not observe any evidence of distress or attachment-seeking behavior. He seemed to regard his mother as a secure base and to feel comfortable exploring a new environment in her presence. However, other observations immediately raised questions of developmental delays.

- Marcel played exclusively at the sensorimotor level, looking at the toys, seeing what noises he could make with them. He moved from toy to toy in a restless way. I did not see any clear examples of symbolic play or imitation of adult behavior that would be typical for an older toddler.

- He said nothing. Toddlers often accompany their play with noises or verbal commentary, but Marcel was strikingly silent for nearly 20 minutes.

- He did not show evidence of understanding what we were saying. An older toddler with normal language development often responds to adult conversation about himself, especially when a parent expresses anxiety, concern, or negative feelings about him. His play may become more agitated, or he may become distressed and approach his parent. When Ms. Montgomery gave a concerned description of his frequent extreme tantrums, Marcel continued to play by himself. I suspected that his lack of reactiveness meant that he could not understand his mother's words.

- During his solitary play, his affect was serious and subdued. Playing did not evoke a range of affects. His affect did not change when he was spoken to; he seemed alone and out of contact with us.

History Taking

While I observed Marcel, I asked Ms. Montgomery about his development. I learned that pregnancy and delivery were normal, and, except for colic during the early months, she did not recall any problems during the first year. Motor milestones were on target. She said that her sister had thought that Marcel was not a very responsive infant. However, she had not been concerned during the first year because she usually knew what Marcel wanted, and he seemed to enjoy being held and cuddled. During the second year, the capacity for imitation was present, but language and symbolic play did not develop. By 18 months, Ms. Montgomery had become concerned about Marcel's lack of social responsiveness and his lack of language. He was increasingly oppositional and began to have tantrums that she could not help modulate. Ms. Montgomery seemed highly invested in Marcel but perplexed and dismayed by his behavior.

Family history was positive for speech delays and severe stuttering by Ms. Montgomery during early childhood. Her younger brother was diagnosed with hyperactivity and learning disability in middle childhood. Ms. Montgomery was poor but received emotional support from her mother and sister

who lived nearby. However, she said that recently her mother had been pressuring her to spank Marcel when he had a tantrum. She said she was reluctant to do so because "I know there's something more wrong than just being contrary." Marcel's mother was a gentle woman who was trying very hard to understand him. She was a good informant about his development, which suggested she had come to know him well by being engaged with him over time. As she reported the developmental history, there were no holes in the information, as occurs when a parent has been neglectful, depressed, or abusing drugs or alcohol. Her descriptions of his development also seemed consistent with Marcel's current presentation, which suggested that her perceptions of him had been free of distortion. Her account was factual and free of attributions that connoted negative working models or unrealistic expectations of him.

Risk factors, including poverty and single parenthood, were present, but Ms. Montgomery had apparently been able to mediate the impact of these stressors up to this point. There was no evidence of risk factors such as parental psychopathology or substance abuse, which are particularly damaging to early development. Nor were there clear signs of physical or sexual abuse. These findings pointed away from a primarily psychosocial explanation for Marcel's difficulties and in the direction of intrinsic developmental problems.

Observation of Normal Behavior: Social Referencing

I noticed that as Ms. Montgomery began to feel increasingly comfortable with me during the first 10 minutes of the interview, Marcel's use of the play space changed. At the beginning of the interview, he played near his mother, a few feet from her chair. Gradually he moved away from her, while staying on her side of the room and at a distance from me. When his mother began to relate to me in a warmer and more relaxed manner, Marcel moved to the center of the room and a few minutes later picked up a Fisher–Price house and put it on the table between us. He was relaxed and curious as I showed him how the house opened up and pointed to the small figures and furniture inside. Marcel's willingness to move closer to me as his mother became comfortable with me was another encouraging sign of a "normal" behavior, a clear demonstration of social referencing. Toddlers assess the safety of a new situation or person by paying attention to their parent's affective cues. If the parent expresses coolness or wariness, the toddler tends to avoid closeness or contact with the stranger. If the parent's affect is warm and relaxed, the toddler gets the message that the stranger is a safe person. Social referencing has been studied in young toddlers who still understand very little language. The toddler's acceptance of the stranger depends not on language but on the affective tone the parent conveys to the new person (Emde, 1992). Marcel used his mother's responses to guide his own behavior, suggesting that he saw her as a reliable beacon and secure base. Since such trust of the parent is based on a positive attachment, this was an encouraging observation.

A Critical Incident

As Marcel played with the house, he suddenly became upset. He screamed and banged his fist against the house. His mother thought that he'd had trouble fitting a car into the garage and pointed to the garage opening, saying, "That car goes right there." Marcel looked at the house and screeched again. He tried to push the house off the table, then began to jump up and down. He jumped so hard he fell down. He began to cry loudly. He slammed the car against the house. Then he approached his mother crying very loudly and signaling gesturally that he wanted to be picked up. She picked him up, and for a few seconds he seemed to feel comforted. Then he arched away from his mother, crying harder and kicking. Ms. Montgomery held him for several seconds, trying to restrain him from bucking, then became frustrated and put him down. He lay on the floor, crying and kicking at the legs of her chair. She became angry and told him to stop it. He stopped kicking and began moving around the room in a "hyperactive" way, still crying. While this tantrum was going on, his mother confirmed that they occurred often, and she frequently did not know what caused these catastrophic reactions.

Marcel's tantrum was stunning in its intensity and duration. At first he had tried to use his attachment relationship to modulate his apparent frustration with the house. When that failed, he was unable to regulate his own affects and became disorganized, collapsing into helpless, rageful jumping and screaming. He had almost no capacity to control the escalation of a negative feeling once it had started. His mother looked perplexed by his intense behavior and also demoralized because she did not know how to help him modulate it. I could identify with her sense of helplessness and with the reactions of professionals who had previously evaluated him. This was the behavior that had been seen as "completely out of control," dangerous, and inexplicable.

However, I had paid careful attention to the sequence of Marcel's behavior and formed a hypothesis about the causes of his extended tantrum. My position differed from that of an evaluator who assesses a child by trying to get him to do a structured task. I was free of the pressure—and frustration—an evaluator can feel when a child refuses to perform. It looked like Marcel's tantrum had been precipitated by his inability to do something with the garage door of the house. I wanted to assess whether he could regulate affect and behavior if he was helped to refocus on the point where things began to go wrong. I encouraged him to come back to the house, pointed to the garage, and said, "Let's figure this out. Did something go wrong with the house?" In response, he banged the car against the house and tried to push it into the garage. His angry response seemed a way of saying "Yes!" Already this was encouraging because his anger focused on a problem instead of being expressed in diffuse and aggressive discharge. When I helped him put the car in the garage, Marcel's affect changed dramatically. He calmed down and became interested in play again. For a minute we played together at the sensorimotor level, moving the car in and out of the garage. When he started

another tantrum because he could not get the garage door closed, I helped him by showing him the small handle, and he quickly calmed again. Marcel could remain calm and focused if I physically demonstrated solutions to what had frustrated him and put into words what was happening. After the frustration was mastered, he was able to follow my suggestions about where to put people and furniture in the house. He also imitated me when I showed him how to ring the doorbell. As Marcel continued to play with the house, he said "Dee, dee, dee" in an excited and pleased tone and then said two words, "uh car, uh truck." Afterward, Marcel played independently with the house and other toys for about 15 minutes without the need for outside support.

Making Sense of Marcel

A different view of Marcel emerged from this interaction. His behavior was no longer incomprehensible. When I responded to him in terms of the actual source of his frustration (the car that wouldn't fit, the garage door he couldn't close) and helped him master a previously difficult task, his affect modulated and his behavior became much more organized. I immediately pointed out to his mother that his extreme behavior was a response to frustration with the house and that she had been correct in seeing that. His response to my help with the garage door made clear that he was not an "unreachable" child. On the contrary, he was very responsive to my support and suggestions. This suggested he could be open to instruction based on a reciprocal relationship. When I framed his tantrum as caused by a frustration with the house, he responded positively. This response suggested that it would be fruitful to think of his problems as based on a primary deficit in communication that had secondary effects on his relationships and his ability to regulate arousal and affects.

Functional Assessment of Marcel's Behavior

My observations of Marcel's behavior served as a spontaneous example of functional assessment. As I watched Marcel prior to his tantrum, it appeared that he was enjoying playing with the house. The antecedent event that seemed to set his tantrum in motion was his difficulty fitting the car into the garage. The "story" here seemed to be "I can't get the car in the garage, and it's so frustrating." Since Marcel had a severe language delay, a second, related, antecedent was that he did not have the verbal ability to communicate what was distressing him. The more remote antecedent, or setting circumstance, was a long history of difficulty in communication between Marcel and his mother. Consequently, he could not anticipate that his mother could help him regulate his intense arousal. The consequences of the tantrum were frustration and demoralization on the part of his mother because she could not understand what he was trying to communicate. This was followed by Marcel's frustration that his mother was unable to help him with the problem with the house

and with his feelings. Frustration over the house escalated into frustration over not being understood. The consequence was that Marcel's tantrum intensified. With a theory about the cause, or antecedent, of Marcel's tantrum, I was able to test out an intervention on the spot.

Formulation

Marcel's behavior told a story that led to a clinical hypothesis that encompassed his intrinsic developmental problems and the transactional difficulties they created. Marcel was hyperreactive and easily distressed. He was motivated to communicate his distress. His approaches to his mother indicated that he saw her as a resource for dyadic regulation of affect. But his deficits in communication made this nearly impossible. His mother, who was strongly invested in him, frequently could not understand him. This made Marcel feel out of touch with her, which had a disorganizing effect on him and led to, or at least intensified, his tantrums. Unlike an autistic child, Marcel was clearly motivated to communicate and be understood by others, but he was unable to convey his internal states in understandable ways. He had so few words that he could not use language to help his mother and others understand his needs.

Interactive coping depends on the ability of the toddler to signal and engage a caregiver, who can then take steps to help the child cope with a stressor (Williamson, 1996). Marcel and his mother had not been able to evolve the more complex communication system one expects to see between toddlers and parents. As a result, their ability to use their attachment to help Marcel deal with distress was seriously compromised. The lack of dyadic regulation led to many interchanges that were frustrating on both sides. Essentially, they experienced frequent interactional mismatches that they had no strategy for repairing (Tronick, 2006). For his mother and other adults, it was distressing to try to understand and fail; for Marcel, it was affectively disorganizing to try to communicate and fail. By the time of the evaluation at age 2 years, 8 months, this communication failure had a long history, resulting in negative expectations for both Marcel and Ms. Montgomery, not only about their ability to communicate but increasingly about the viability of their relationship. Toddlers who develop a negative model that says, essentially, "My parent does not help me when I am upset" are easily aroused and angered when they need the parent's help. It is likely that Marcel's tantrum blew up so quickly and intensely because it was primed by negative expectations. Over time parents' inability to help the child regulate emotions leads to higher reactiveness to stress and poorer self-regulation (Rodriguez et al., 2005).

The interactional sequence following Marcel's difficulty with the house was not only frustrating for Marcel and his mother but led to an escalation of mismatched responses and ultimately to demoralization in Ms. Montgomery and what appeared to be a profound sense of abandonment in Marcel. When Marcel first became distressed, he demonstrated secure-base behav-

ior by turning to his mother for help. This was an appropriate use of their attachment relationship and was typical for a toddler who becomes anxious or encounters difficulty during exploratory play. However, Marcel was unable to communicate the particular meaning of his distress, which might be stated as "I can't get this car in the garage, and I'm feeling angry and helpless. I need help both with the car and to get control of my feelings." Lacking the words to convey this, he simply approached his mother for comforting. His mother then *thought* he wanted to be cuddled and picked him up. Marcel immediately became angry, feeling that his mother had failed to understand him. His mother also began to feel helpless and responded by trying to control the symptomatic behavior by restraining him. Then she gave up and pushed him away. The desire of both to communicate was thwarted by Marcel's diffuse signals and by his mother's inability to decipher what they meant. The interaction became aversive for both, and the original tension, instead of being resolved, increased and was transformed into an interactional tension. In this type of interaction, there is no closure, and Marcel had to fall back on his own capacity for regulation of affect, which, when he was under stress, was limited to diffuse or aggressive motoric activity that others tended to view as "out-of-control" and incomprehensible behavior.

Assessing Areas of Developmental Adequacy or Potential

My observations confirmed the developmental deficits or delays found in the previous evaluations. Marcel showed serious delays in receptive and expressive language, which were likely related to deficits in auditory processing. He was hyperreactive to external stressors and internal frustration. His capacity for self-regulation, even under mild stress, was poor. Because of his difficulty in communicating in ways his mother could understand, mutual regulation of affect was also compromised. However, assessment must also identify areas of developmental strength or potential because doing so not only provides the parent with a sense of hope about her child but also helps the practitioner frame a treatment plan that uses the child's areas of strength to approach the areas of deficit.

A crucial aspect of my assessment of Marcel was seeing that he was capable of joint attention. In fact, he was highly motivated to share my focus on the house. He could not express this interest in words, but he demonstrated it by looking where I looked and imitating my behavior. Joint-attentional behavior has been identified as an important condition for language learning. Typically, when parents look at an object or an event with a child, they talk about what they are seeing, implicitly teaching the child the names of objects and actions and gradually helping the child think about what she is seeing in words (Huttenlocher, 1999). This process had probably been derailed for Ms. Montgomery and Marcel because his language deficits prevented him from taking up the child's role in the process, which is to imitate the parent's utterances. Ms. Montgomery acknowledged that her behavior had been shaped by Marcel's

lack of response. She had decided that he was "not ready to talk yet, or maybe he didn't like talking," so she had talked to him less and less. I had engaged him as one might engage a very young toddler. Instead of relying primarily on words, I pointed out parts of the house and physically demonstrated how to do things that had previously frustrated him. I accompanied my actions with words but did not expect Marcel to grasp what I said. It was helpful to think of him as being like a toddler early in the second year, who is beginning to learn language but who needs concrete demonstrations as a bridge to language learning (Goldin-Meadow, 2007).

The assessment of Marcel's motivation was another crucial issue. It was very important to notice that, although he constantly struggled with feelings of failure and incompetence, he was still trying hard to communicate and master his environment (Wigfield, Eccles, Schiefele, Roesner, & Davis-Kean, 2006). Marcel was not an unmotivated or apathetic child; rather, he appeared to have strong wishes to express himself and be understood. From this perspective it was possible to think about the intensity of his tantrums as a measure of his frustration at not being able to communicate. Further, seeing Marcel as motivated to make sense of the world and to communicate his feelings and ideas made him seem much more like a normal toddler than a child whose behavior was beyond comprehension. Marcel certainly was not "normal," because of his severely delayed language development and auditory processing skills as well as poor regulatory capacities; yet, his motivations were typical for a toddler. The observational assessment of Marcel illuminated several areas of developmental adequacy or potential. These included the following:

- Strong motivation to communicate and to master his environment
- Positive (though not always functional) attachment with his mother
- Interest in exploratory behavior
- Capacity for autonomous affect regulation when not under stress
- Capacity to use interactive coping to deal with distress
- Capacity for joint attention

These observations confirmed that Marcel's overall developmental maturation had been proceeding, even though one area, language and symbolic communication, was seriously impaired. Brazelton (1990) notes that "the force of the central nervous system as it develops is relentless" (p. 1664). Even in an infant or young child with deficits, the maturational thrust "tries to force around that defect, to push beyond what's holding the infant back" (Brazelton, 1990, pp. 1664–1655). Marcel's strong desire to communicate, marked by the intensity of his anger, frustration, and behavioral disorganization, could be seen as the force of development as it tried to overcome a defect. Brazelton (1990) also notes: "This is a critical force for recovery from a defect in an impaired infant, if it can be harnessed properly" (p. 1665).

An Intervention Plan Based on Developmental Understanding

This observational assessment, combined with the findings of the previous evaluations, suggested an approach to intervention that addressed Marcel's deficits by making use of his existing developmental strengths and potentials as well as the strengths in the parent–toddler relationship. To be effective, the intervention would need to address transactional issues between Marcel and his mother as well as Marcel's language and communication deficits. The following recommendations were offered to the early intervention program.

Toddler–Parent Developmental Guidance with a Specialist Trained in Infant Mental Health

This part of the intervention would attempt to build upon Ms. Montgomery's investment in Marcel and the adaptive aspects of their attachment relationship. Goals would include the following: helping Ms. Montgomery learn to observe and understand Marcel's behavior as reflecting attempts to communicate; helping her develop more empathic communication with him as she came to understand him better; and helping the two of them move toward an increasingly shared affective experience and "vocabulary" of gestures and words. The communication difficulties between Marcel and his mother had caused a relative failure in the functioning of the secure base. Marcel wanted to use his mother as a secure base when distressed, but since he could not communicate the content of his distress, he experienced his mother's caregiving as frequently off the mark and unreliable. On her side, Ms. Montgomery was baffled by Marcel's intense distress and consequently did not know how to help him regulate arousal. Although it is likely that Marcel had an intrinsic regulatory disorder (Calkins, 2007; Zero to Three, 2005), it was clear that his mother was relatively unable to help him regulate intense affects. An additional goal, therefore, was to increase Ms. Montgomery's skill in dyadic regulation, both as an end in itself and as a bridge to Marcel's self-regulation (DeGangi, 2000). The essential aim of the parent–child work would be to help Ms. Montgomery read Marcel's behavior accurately so that her responses would be more appropriate to needs implied by his nonverbal behavior. If Marcel could feel that his mother understood him more often, his ability to use her as a secure base would be strengthened.

Speech Therapy in the Context of an Intensive Early Intervention Program

Because of Marcel's severe language deficits and possible deficits in auditory processing, he needed speech therapy carried out at a basic language-learning level. I suggested in my report that "those who work with him will need to start where he is developmentally, responding to him much as one would to a young toddler. This will involve putting everything he does into words, providing a kind of running commentary, and being ready to provide concrete hands-on help if he becomes frustrated." I also suggested that if his progress in spoken language was slow, it would be useful to teach him some basic hand signing in order to give him some means of communication. This would lay the groundwork for verbal communication as his language skills developed.

Continuing Periodic Assessment

I suggested that I evaluate Marcel periodically to assess the effects of interventions and to provide consultation to the practitioners working with him and his mother. I hoped that periodic assessments—approximately every 6 months—would help Ms. Montgomery see Marcel's progress. During the first 3 years of life, development is rapid and responses to intervention are often more obvious than at later stages of development. Periodic assessments can provide a sense of progress and hope to the parent, since the evaluator can often point out real signs of developmental advances (Meisels, 1996).

No Medication

The request for medication to control Marcel's extreme behavior had figured prominently in the referral. This was a delicate issue, since the referring professionals hoped that medication would be recommended. In recent years there has been an increasing trend toward medicating very young children, especially those presenting with serious behavior problems. These medications are prescribed "off-label," meaning that their effects on young children have not been studied. Children under age 3 are being diagnosed with ADHD and prescribed stimulants, and it is not unusual to learn that a toddler with severe problems with aggression has been treated with Risperdal, an antipsychotic used to treat schizophrenia. Recent research reviews have questioned the wisdom of this growing practice, because there have been very few studies of the safety and efficacy of psychotrophic medications for children under 4, and because use of medications is seen as a stopgap in the absence of available mental health services (Barbaresi, 2003; Staller, 2007; Zito et al., 2000). Rather than simply focusing on symptoms, my report carefully detailed the dynamics of Marcel's extreme behavior. My intention was to provide a framework for understanding his tantrums and aggressive behavior in terms of developmental delays and interactional problems. I hoped that if Marcel's behavior could be seen as making sense and if the parent–toddler and speech therapy interventions began to show results, there would be less pressure to medicate him. In my report I indicated that I had consulted with our psychiatric staff and noted that we were unwilling to recommend medication for a child as young as Marcel unless other types of intervention were unsuccessful.

Follow-Up

Marcel entered a preprimary early intervention program. He established a good relationship with his primary teacher and made steady progress in language development, with slower improvement in reactivity and affect regulation. His mother had attended school with him frequently and was borrowing some of the teacher's approaches to playing with him and setting limits. At the time of the follow-up assessment, 6 months after the first, Marcel's play was more organized and accompanied by more verbalization. He did not have any tantrums during the session. Ms. Montgomery played with him in a more sustained way, yet she said that she still often felt at a loss to understand his behavior. Significantly, the infant mental health referral had only just been made, and Ms. Montgomery had not yet begun to receive the same level of intervention and support that Marcel was receiving at school.

INTERVENTION: PARENT–CHILD THERAPY

Intervention with toddlers involves an extension of the principles of infant–parent psychotherapy. Developmental attachment theory provides a rationale for seeing the parents and child together rather than either the toddler or parent alone (Lieberman & Van Horn, 2008). Even though the toddler is becoming an autonomous self, he still requires the support of the attachment relationship as it expands to include helping him understand the world. In joint therapy the therapist and parent can observe the toddler's play and behavior in order to learn about the sources of his distress or difficulties in the parent–child relationship. An important contrast with infant work, however, is that toddlers, because of their more advanced development, become more active participants in the therapy (Bennett & Davies, 1981).

Even though the toddler can't express complicated thoughts and feelings in words yet, he can increasingly represent his experiences through symbolic play. Toddlers' play often provides a more complex picture of their experience than they are able to express in words. Beginning between 18 months and 2 years, symbolic play and behavioral reenactments allow parents and therapists to learn about the child's perspective. Often the play of very young children is transparent, because it is less influenced by defensive processes than is the play of older children.

The toddler's growing facility with language also becomes available for therapeutic uses. After the burst of language learning beginning at age 18 months, words become increasingly available to the young child as ways of understanding and constructing images of the world. By age 2½ most children are well on the way to thinking in words rather than in imagery, and many older toddlers are becoming adept at expressing thoughts and feelings verbally rather than behaviorally. An awareness of toddlers' burgeoning receptive language skills is especially important in conceptualizing their treatment. Toddlers' growing ability to understand the explanations of adults can be used to further the goals of treatment. Language offers new ways of organizing experience, and, for traumatized young children, holds the potential for reorganizing the experience of trauma. With words a toddler can begin to create narratives and learn about cause and effect. Therapist and parents can name the toddler's feelings and describe stressful experiences in simple terms so that the toddler is helped to make sense of them.

"Dialogues" between the toddler's behavior and play and the parent's or therapist's words can become the vehicle for understanding and resolving the toddler's problems. For example, Jared (in Chapter 7) specified the sources of his symptomatic behavior in play by repeatedly having the dinosaur break down a door and bite the baby inside. His mother realized that he was representing a frightening event that both of them had experienced. This enactment allowed her to see beyond Jared's aggressive behavior to the fear and anxiety that were fueling it. The therapist and Jared's mother put the events and affects expressed in his play into words: "It was so scary when Daddy broke the glass. The glass hit you. Mom's not going to let Daddy do that again." The expression of empathy and clarification in words helped Jared represent his experience at a verbal level and provided him with reassurance that his mother was aware of his fears and intended to act protectively.

Lieberman (1992) points out, however, that it is important not to overestimate the toddler's ability to make use of verbal interventions and recommends that therapists find ways to talk about "big feelings in toddler-size words" (p. 570). The younger the toddler, the more strongly this caveat applies. It is frequently useful for the parent, with the therapist's coaching, to join in the toddler's play as a means of nonverbally dramatizing empathy and protective responses to the child's anxiety. For example, when Jared continued to raise questions and fears about his father's violence in play, by having a father figure crash into the family in the middle of a meal, his mother picked up the mother figure and had her push the father figure out of the house, saying, "No, the mom's not going to let the daddy do that."

Representation and Trauma

The toddler's advancing capacity for representing the self in the context of experience carries liabilities when the child encounters stressful or traumatic events. The toddler may construct images of stressful experiences that reflect misunderstandings, confusions of cause and effect, and egocentric perspectives. Jared, even though he had not seen his father for 6 months, implied an ongoing expectation of his father's violent return through his nightly checking to see if all the doors were locked. In the toddler, in contrast to the infant, anxiety can take the form of conscious mental imagery that influences the toddler's view of self and reality. The toddler remembers and thinks about difficult experiences, such as a long separation from a parent, and worries

that it will occur again. These ideas create anxiety and are often the basis for toddlers' symptomatic behavior.

By early in the second year, children can retain behavioral or "action" memories of events even though they cannot describe the event in words (Bauer, 1996). That is, they can remember and communicate behaviorally about traumatic events (Fivush, 1997, 1998). Since receptive language development runs a bit ahead of expressive language, it is possible to begin working on the goal of helping a child construct a narrative of trauma midway through the second year by having caregivers put into words what the child is expressing behaviorally.

The capacity for internal representation means that traumatic experiences may affect a toddler's working models, even when the parents are trying hard to provide a sense of security. The practice implication of this fact is that toddlers' misunderstandings and overgeneralizations need to be addressed directly in treatment. Because the toddler forms her own impressions and thoughts, guidance-based intervention with the parent alone usually is not sufficient to mitigate the toddler's anxiety. Toddlers need an opportunity to represent their concerns and to have them responded to specifically—which means that, in most cases, the toddler will be included in sessions with the parent, and therapy will be structured to elicit the toddler's representations of her experience (Davies, 1991). A recent study of intervention with maltreated 3- and 4-year-olds demonstrated that parent–child therapy based on attachment theory was superior to a parent-only intervention focusing on teaching parenting skills. Young children treated in the parent–child therapy model showed more positive self-representations and more positive views of their parent over the course of intervention (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002). From a developmental perspective, attachment-based treatment of toddlers and preschoolers is particularly timely, because it can improve the parent–child relationship and alter the child's representational models of caregiving and of the self in a positive direction *before* the young child's working models have become stabilized.

Attachment and the Treatment of Toddlers

In the treatment of toddlers and parents, *a primary goal is to strengthen the adaptive features of the attachment* (see Table 8.2). In some cases the focus will be on the parent's own negative or insecure attachment history as it contributes to his or her negative perceptions of the toddler. In less severe cases, the focus may be on the interaction between parental vulnerabilities and the toddler's self-assertion. For example, some parents who have found pleasure in the child as an infant react negatively to the toddler's growing autonomy, experiencing the child's assertion as a struggle for control. Treatment concentrates on reframing the toddler's behavior as developmentally appropriate and exploring alternatives to the establishment of mutually coercive interaction patterns. In other cases, the work focuses on restoring function to a previously adaptive attachment that has been compromised by developmental changes, stress, or trauma. Especially in cases of trauma, the young child's sense of feeling protected within the attachment relationship has been violated, even when the parent was not involved in the traumatic events. Therapeutic efforts must focus not only on helping the child master the trauma, but equally on restoring a sense of protection in her relationship with parents. Overall, "the most powerful change agent for young children's development and symptomatology is their relationship with their primary caregiver" (Scheeringa & Zeanah, 2001, p. 811).

TABLE 8.2. Toddler's Developmental Capacities That Can Be Utilized in Intervention

- Ability to represent and raise questions about experience through symbolic enactment and play (begins between 15 and 18 months).
- The toddler's strong motivation to know and understand experience makes him interested in pursuing salient issues in treatment.
- Receptive language ability permits the toddler to understand simple explanations of stressful experiences and reassurance (begins at 15–18 months).
- Receptive language ability also enables parents to prepare the child in advance for potentially stressful events, such as brief separations or doctor visits (begins at 15–18 months).
- Expressive language ability permits the toddler to articulate worries, questions, and concerns in simple ways (begins at 20–24 months and increases rapidly with language development).

PARENT–CHILD THERAPY WITH AN ABUSED TODDLER: A CASE EXAMPLE

When she was 2 years and 8 months old, Kaitlin was physically abused by a 14-year-old female babysitter. Kaitlin's mother found bruises on her back, abrasions and bite marks on her arms and thighs, and blood in her diaper from scratches in her perineal area. Her parents took her to a hospital, and a finding of physical abuse was substantiated. The babysitter confessed that Kaitlin had wanted to play with her while she was watching TV, and that she had bitten Kaitlin hard on the arms and legs, hit her a number of times, and scratched her genital area, causing abrasions with her fingernails.

Kaitlin immediately showed some posttraumatic symptoms, including clinging behavior, anxiety about strangers, frequent waking at night, and frantic crying whenever one of her parents changed her diaper. Her parents also showed some common reactions to trauma in a young child. They felt sad, helpless, overwhelmed, and uncertain how to help her feel better. They were not only angry at the babysitter but also angry at themselves and guilty about having left Kaitlin with an abusive person. These feelings were disabling to them, in the sense that they felt unable to help Kaitlin master the traumatic

incident. However, they did not want Kaitlin to be damaged by the trauma and were very motivated to participate in treatment. Prior to embarking on the parent–child therapy, I met with the parents and explained the approach, stating that Kaitlin should be able to use play to demonstrate her ideas about this frightening experience. I normalized her symptomatic behavior as consistent with a young child's reaction to a trauma, and said that their ability to convey understanding of what had happened and to provide reassurance that they would work to protect her in the future would help her put this experience in the past. I suggested that Kaitlin's prognosis was good, since this was a single incident of abuse, occurring in the context of a history of overall good development and secure attachments with her parents. I wanted to give Kaitlin's parents a realistic appraisal of her status, but I also intended to convey hope, because that would mobilize them to work in treatment on her behalf.

I saw this family for about 2 months. I had two main objectives: to give Kaitlin a chance to represent her experience and her ongoing worries about it in play; and to help the parents mobilize the strengths in their attachment relationship with Kaitlin, so that she would gain their help in processing the trauma and receive their reassurance that they intended to keep her safe.

We sat in a circle on the floor, and I told Kaitlin that I knew she had been hurt by Jessica (the babysitter) and that her parents and I wanted to help her feel better about it. I said that playing would help us understand her worries. Kaitlin used small dolls to replay the abuse. I said that she was showing us what had happened. Her affect was sad and anxious, but she seemed driven to play out all the events of that night. After a bigger doll hit a little doll repeatedly, the little doll was taken to a hospital and examined by nurses and doctors. I asked her parents to describe in words what was happening in the play, and Kaitlin's mother retold the story of what happened that night. When Kaitlin presented the same play scenario in the next session, I coached the parents to tell her that they knew what had happened, that they knew Kaitlin had been hurt and scared, and that they knew she was worried that she would be hurt and scared again. They told her that Jessica would never be her babysitter again and that they would make sure that any babysitter they got in the future would not be someone who hurts little girls. They told her that for now the only person they would let take care of her would be her grandmother.

Kaitlin's play in subsequent sessions, as well as her behavior at home, represented questions about how safe she was, especially at night, a time when young children are likely to feel more anxious in general, because they are separated from their parents and must give up a sense of control as they drift off to sleep. In sessions, Kaitlin had a "monster" come into the baby's room at night and bite her. At home, she was having trouble going to sleep and was often getting up and going to her parents' bedroom. I pointed out that, even though Kaitlin knew her parents had told her that they would not let Jessica come and hurt her again, she still worried about it. In play, Kaitlin's father took an active role by having a father doll kick the monster out of the house. This demonstration seemed to reassure Kaitlin temporarily, but over the next

two sessions she continued to elaborate questions in play about whether her parents could keep her safe. After the baby was put to bed, Kaitlin had her wake up and fly around the room. She would hit her head against the wall and cry. When Kaitlin's parents used their dolls to stop the baby from being hurt, Kaitlin's baby doll eluded them and kept getting hurt. I made this comment: "Kaitlin, this reminds me of how Jessica hurt you when Mommy and Daddy weren't there. It looks like the baby is showing your worry that Mommy and Daddy won't be able to keep you safe." I turned to her parents and asked them to respond. Her mother said: "We are not going to let Jessica come back to our house. We won't let anybody come into our house at night and hurt you. We'll stop them." After this, Kaitlin's play shifted to more normal caretaking play, with the daddy doll tucking the baby doll into bed.

Kaitlin's play with the doll who eluded the parents' dolls and kept getting hurt was a clear dramatization of the dilemma of a traumatized toddler. Since young children have relatively few internal resources for mastering trauma on their own, they need external support, particularly from the attachment relationship with their parents. But precisely because toddlers rely much more heavily on the attachment relationship than on themselves to maintain a sense of security, trauma creates a challenge to the attachment relationship. The traumatized toddler implicitly feels that the fact that this frightening and overwhelming event could happen to them must mean that their parents cannot keep them safe and secure. This distressing awareness often leads to behavior that shows the child is questioning the viability of the attachment relationship. Kaitlin was able to represent this issue in her play, and that depiction allowed her parents to convey that they understood her worry and that they would act to keep her safe. Near the end of treatment, Kaitlin's parents went out at night a few times, leaving her with her grandmother. This gave her a chance to experience a separation from her parents and to learn experientially that she could be safe while they were away. In the relatively short time of 2 months, Kaitlin's posttraumatic symptoms had diminished, which suggested that she had achieved some working-through of the trauma and that she was feeling more secure in her attachment with her parents.

As this case example makes clear, trauma inevitably has a relational component in infancy and early childhood. In the early years, the child depends on her attachment relationships for relief of distress and regulation of affect. Kaitlin made a good recovery from a single-incident trauma because her parents were able to empathize with and talk about her experience and to make strong efforts to restore a sense of protection and to repair an attachment that had previously been a secure one.

OBSERVATION EXERCISES

1. Spend 1 hour observing toddlers and parents in a public place. A park or playground would be best, though a shopping mall or fast-food restaurant would also be interesting sites for observation. Observe for the following:

a. *Secure base, attachment, and exploration.* If the toddler is in a place where she can play freely, note the balance she establishes between exploration and attachment. Do you see the toddler "checking in" with the parent, either visually or verbally, while she plays? How far does she move away from the parent? What does the parent do to stay in touch with the exploring toddler? What is the toddler's activity level? What evidence do you see that supports the idea that toddlers are intensely interested in learning about their immediate world?
b. *Autonomy.* What examples do you see where the toddler takes the initiative or insists on doing things his own way? How do toddler and parent react when the toddler's assertion of will runs contrary to the parent's wishes or intentions? How do the parent and toddler negotiate conflicts over safety?

2. Spend 30–60 minutes observing in a toddler room in a child care center or preschool.
   a. What individual differences among children do you notice in the areas of motor skills and language ability?
   b. What kinds of play do you observe? Note examples of sensorimotor, imitative, symbolic, and interactive play.
   c. Observe for the "mine" phenomenon, looking for instances of possessiveness or conflicts over toys. How do toddlers respond to such conflicts? How do caregivers respond when a conflict occurs?
   d. Do you see instances of empathy and prosocial behavior?
   e. Do you see instances of the presence or absence of self-control? What forms does self-control take? What appears to precipitate breakdown in the control of impulses?

INTERVIEW EXERCISE

Spend 30–60 minutes interviewing the parent(s) of an older toddler (between 2 and 3 years of age). Ask the parents to reflect on the differences between their child as an infant and toddler.

1. In general, how is she different at age 2, compared with age 6–9 months?
2. How has your relationship with her changed during the past 1–1½ years?
3. What do you recall about her during the 3–4 months immediately after she learned to walk?
4. How has her ability to communicate changed? How has her new ability to understand and use words changed your relationship?
5. Do you find it easier or harder (or perhaps some of each) to parent a toddler, compared to an infant?

CHAPTER 9

Preschool Development

The preschool period, encompassing ages 3–6, is a great transition in development. The child evolves from an egocentric toddler with limited capacity for understanding the self and the world, into a child of the middle years, who has much in common with adults in that she can think logically, maintain self-control, and empathize with others. Cognitively, the preschool child moves gradually from magical thinking to thinking that is more logical, shows understanding of cause and effect, and distinguishes between fantasy and reality. A major effect of these cognitive changes is that by age 6 the child's view of self begins to be more realistic. So, there is a corresponding movement from an egocentric, self-centered view of the world to a decentered, more objective view that understands that many events happen without reference to the self. The preschool child's relationships change as he becomes more autonomous. Relationships with peers become very interesting to the preschooler and have implications for development. In interactions and play with age-mates the preschooler gains skill in empathy, perspective taking, negotiation, and cooperation and begins to experience the pleasures of friendship. Through these interactions, the child begins to measure himself against others, introducing for the first time social comparison as a component of the sense of self.

The capacity for self-regulation and impulse control improves a great deal between 3 and 6, as the child learns interpersonal coping skills and internalizes cognitive controls and unconscious defenses. She still depends on her attachment relationships, but she slowly learns to manage anxiety by using internal resources and gaining support from others, based on generalizing her working models of attachment. In moral development there is a movement from reliance on outside approval or disapproval to a more internalized sense of values. The child gradually develops a conscience, which imposes internal standards for judging her behavior, creates possibilities for deriving self-esteem based on self-approval, and helps consolidate the child's internalization of the values, expectations, and rules of her family and culture.

The preschool child lives to play. This is the age of individual fantasy